

The White House
Office of the Press Secretary

For Immediate Release

September 16 , 1993

Statement from the White House

SENATOR PRYOR'S PHARMACEUTICAL RESTRAINT AGREEMENTS

The White House today indicated its support of Senator David Pryor's (D-AR) call for pharmaceutical manufacturers to sign voluntary commitments to restrain prescription drug price increases:

"While we are still evaluating the specifics of Senator Pryor's proposal, we applaud him for his vision, dedication and leadership in doing all he can to help make prescription drugs affordable and accessible for the American public. His challenge to the industry is precisely the type of initiative which must be met by pharmaceutical manufacturers and others in the health care industry if we are going to work together to put the brakes on health care inflation.

Under Senator Pryor's proposal, the makers of prescription drugs would commit to limiting retail price increases to the annual inflation rate. By taking this action, manufacturers would protect the American consumer from escalation of drug prices. This is important because drug price inflation has been particularly significant at the consumer level over the last twelve years.

Based on the many thousands of letters that the White House has received over the past eight months on health care reform, the cost of prescription medications is among the top concerns of Americans. Senator Pryor's approach appears to provide a realistic way to deal with medication costs during the period of transition to the new system.

The pharmaceutical industry has repeatedly stated that they are committed to keeping price increases for their products at or below the general inflation rate. Recently the President called on the industry to keep to their pledge. Senator Pryor's proposal represents a golden opportunity for the industry to make good on that pledge to the American public."

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STATEMENT BY DR. ARTHUR FLEMMING

"As the former Secretary of Health, Education and Welfare in the Eisenhower Administration, I would like to express my strong support for President Clinton's health care reform proposal. The proposal he is about to present to the nation is comprehensive, thoughtful, workable and fair -- a proposal that will lead us on the road to a nation where health security with quality care is guaranteed for all Americans and health care costs are brought under control.

I have worked for health care reform for the better part of four decades, and I have seen other health care reform efforts start with high hopes and fail. But I believe this is different. The President has presented us with a historic opportunity, and we must seize the moment. Let us get a plan on the books and begin to learn from experience, instead of engaging in endless rhetoric.

As a former U.S. Commissioner of Aging, I am particularly enthusiastic about the plan: because this proposal will mean a strengthened Medicare program -- providing greater security and expanded benefits for older Americans.

Under the President's proposal, older Americans will receive all the benefits they do today. In addition, Medicare will be expanded to cover prescription drug benefits, and there will be a new long-term care program to cover home- and community-based care. Nearly all Americans will still have to pay only 25% of the total cost of the Part B benefits they receive -- including the new drug benefit. Any increase in the premium will be consistent with the increase in benefits. Only the wealthiest Americans -- those people earning \$100,000 or more -- will pay the full actuarial value of the benefits they receive. Finally, Medicare funds now being wasted to cover fraud and overcharges will be used to pay for these new benefits.

Over the next several months, there will be likely many attempts by those opposed to reform to scare Americans about the effect of the President's plan.

But older Americans should know that President Clinton's proposal will mean greater security and expanded benefits. And I hope that older Americans -- and Americans of all ages -- will join in getting this plan on the books."

Dr. Flemming was Secretary of Health, Education and Welfare from 1958 through 1961. He was Chair of the White House Conference on Aging in 1971 and U.S. Commissioner on Aging at HEW from 1973 to 1978. Currently, he is Chair of the National Citizens' Board of Inquiry into Health in America, Co-Chair of Save our Security Coalition.

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REMARKS BY THE PRESIDENT
IN SMALL BUSINESS HEALTH CARE EVENT

W.S. Jenks and Sons Hardware Store
Washington, DC

10:15 A.M. EDT

THE PRESIDENT: Thank you very much. First of all, I want to echo what Erskin Bowles said. I thank you for taking some time off today to come in here and just visit with me about this whole health care issue and about what we're trying to do, and about your personal situations and whether we're responding adequately to them.

Let me tell you that one reason we're a little late this morning is that I started the morning -- some of you may have seen it on television -- I started the morning with about 15 people of the 700,000 people who have written letters since I asked my wife to chair this health care group -- 700,000 Americans have written us about their personal situation. A lot of them were small businesspeople. Some of the people who were there today at our morning meeting in the Rose Garden were small businesspeople. A lot of them were people with sick family members, people who were locked into jobs they could never change, all the things that you know about.

But I wanted to leave that group -- and we had another 100 people who've written letters who just were asked to come and be in the audience -- I wanted to leave that group and come straight here because it is the small business community that as businesspeople will arguably be most immediately affected, although there will be an impact on larger businesses, too.

First, I'd like to thank our host, the Siegels, for letting us come to this great small business which goes back to 1866. Most of us weren't around back then. I really appreciate you doing that. I want to thank Mayor Kelly and so many of the D.C. City Council members for being here. And we're delighted to be here.

Harry, I think we're in your district, aren't we? Your ward. We're glad to be here.

Let me just make a few opening remarks and then I'd like to hear from all of you. We have a lot of problems in this health care system. There are a lot of things that are right about it. Most all Americans get to pick their doctors. And we have high quality care if you can access it. But every month, hundreds of thousands of people lose their health insurance and over 100,000 lose it permanently, so that each year more and more people are without health care coverage. We're the only advanced country in the world that doesn't have a system to provide a basic health care package to all of its citizens.

The second thing that happens is that the cost of health care, particularly since 1980, but really before that, but especially since 1980 has been going up much more rapidly than inflation -- two and three times the rate of inflation.

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The third thing is it's hitting small businesses and self-employed people much harder than bigger employees now because they tend to be in much smaller insurance pools. So if one person gets sick in that pool or one person gets sick in the employment unit, it can rocket your costs. We were with a person today earlier who between 1989 and 1992 had their premiums quadruple from something like \$200 and some a month to over \$900 a month.

The third thing is that very often small businesspeople, to get any insurance coverage at all, have to have astronomical co-pays and deductibles, so that it becomes almost dysfunctional for their employees. And more and more small business every month are having to drop to their coverage.

Now, the flip side of that is that in the many big businesses have been able to maintain generous benefit packages but only at the expense of never giving their employees a pay raise. And we're looking at a situation that now for the rest of this decade we could, in effect, take away all the pay raises for the work force of this country to go into higher health insurance premiums unless we do something.

So it's a very, very serious problem. You also have a health care system that is widely inefficient -- none of you could run your businesses and stay in business with a system that had the administrative overhead and the paperwork burden and the bureaucracy that the health care system does. The average hospital is hiring clerical workers at four times the rate of health care providers. The average doctor in 1980 took home 75 percent of the money that came into the medical clinic, by 1990 it had dropped from 75 cents on the dollar to 53 cents on the dollar -- going to bureaucracy paperwork the way the insurance system is organized.

So what we tried to do is to come up with a plan that would require every employer and employee to contribute something; would have a cap of 7.9 percent of payroll as a maximum that anyone could be required to pay; would provide some subsidies for employers with under 50 full-time employees, which means you could have more if some of them were part-time, all the way down to 3.5 percent of payroll, depending on the wage rates; and would lower the cost increases of health insurance to all Americans.

The most controversial aspect of this is requiring all employers and employees to contribute some portion of the cost of health care. The problem is if you don't do that, it's going to be very hard to get costs under control because, unless everybody contributes, there will always be a lot of cost shifting in the system. That adds a lot of administrative costs. It also means that the people who are paying for health insurance are paying more than they would otherwise pay, because they alone pay for the infrastructure of health care -- the hospitals, the clinics, the people that are there. And they alone pay for the emergency rooms and the uncompensated care in that regard.

So we're trying to work this out in a fair way that's bearable. But I believe it will aid the American economy and will help small business growth if we do it properly. That will be a big point of controversy as we debate this over the next few months.

So I wanted to start on the first day right from the get-go, if you will, hearing from the small business community. And I'd like to -- who wants to go first? Our host. And make sure that you've got the microphone close enough to you.

Q Mr. President, we were caught up in the labyrinth of the great recession of 1990, which still -- is still festering quite a bit. In order to stay in business, we did what was prudent for business people to do -- we cut it down to the bare bones. If we

had anymore overhead added it could be, I wouldn't say a catastrophe, but it would hurt. And I was just wondering -- if you add an additional person to a small business and force us to increase prices and thereby -- further compound the economic situation in the country.

THE PRESIDENT: It would be, except most small businesses under this system will actually have lower costs. Keep in mind, most small businesses are providing some health coverage to their employees now at astronomical costs. Many small business families are self-employed and insure themselves as self-employed. Self-employed people, under our plan, will get much lower premiums -- much lower, because they'll be in big insurance pools. And they'll also get 100 percent deductibility for their insurance premiums, not 25 percent, for the first time. So those will go down. All employers who offer anything will have their employees go down now. Employers with -- employees with groups under 50 will start out, most of them, paying less than \$1 a day for employees for health insurance under our system.

ADMINISTRATOR BOWLES: And that's real coverage. I mean, that's rock solid, comprehensive coverage. If you have less than 50 employees -- and National Small Business United, which is one of the larger trade groups, just came out with some new numbers, and in those numbers they said that the average small business that doesn't supply health care to their employees has average wages of about \$7,400. Now, if that's the case, it means that small business would be able to provide real insurance coverage to its employees -- insurance coverage that couldn't be jerked away when somebody got sick, but real insurance coverage at less than a dollar a day.

For those -- they came out and talked about those small businesses that already have insurance, the two-thirds that already have insurance. They said the average wage for those businesses is \$15,600. If that's the case, then that small business will be able to offer comprehensive, real, rock-solid insurance coverage at less than \$2 a day. That's an insurance that we can afford.

THE PRESIDENT: I don't mean to minimize this, but let me tell you what the flip side of this is. Every year one of the things that adds to the cost of health care in America is cost shifting. So every time the government doesn't pay for the people we're supposed to cover or somebody else doesn't pay, and somebody shows up in an -- somebody without health insurance normally won't get health care in a preventive and primary way where its cheapest, but they'll get it when its too late, when they're really sick, often showing up at the emergency room, all those costs get shifted onto someone else. And then their competitiveness is eroded, so they eventually drop their health insurance. And more and more people keep dropping it. Pretty soon -- it's just sort of in a death spiral every year where more and more people drop their insurance, more and more people are uninsured. And then the people who are insured are paying for all them when they finally access the system.

And as I said, we're the only country in the world that does it this way. We're the only the country in the world with 1,500 separate health insurance companies writing thousands of different policies and trying to divide little small businesses up into smaller and smaller groups. Some of these groups are so small that the overhead -- that is, the insurance company administrative costs and profit -- is up to 40 cents on the dollar. And it is just -- we can't sustain the system.

I don't pretend that even a dollar a day won't be more -- per employer won't be more difficult for some small businesses. It's just that we can't figure out any way -- other way -- to fairly apportion the cost of this system and keep everybody covered, and

finally get the cost under control. The costs are spiraling out of control.

The other alternatives are nobody gets coverage, or the taxpayers pay it. And if the taxpayers pay it, then, in effect, we're raising taxes on people who are already paying way too much for their health care to pay for people who aren't paying anything.

So I think this is a fair way. And what I would ask you to do and everybody in your circumstances is when we produce the copy, the final copy of this health care plan, because we're still in extensive consultations on it but in the next several days, I'd like to ask you to go over it, calculate exactly how it will affect you, and then draw a conclusion about how you think it will impact you. Look at the specific facts, and get back in touch with Erskine Bowles and tell him how you think it will affect you.

Q My wife and I are involved with two small businesses -- one that has eight employees, WB Associates; Omni Cable, of about 35 to 37 employees. We provide health care for all. Occasionally we have some part-timers.

Our present payroll deduction for health care is about 8.2 or 8.3 percent. So your plan appears to benefit us at the outset. My concern is down the road -- two or three or four years down the road, if all the pieces don't fit into place, if we get an overuse for instance, which your plan points to, and then we have a shortfall, who and how do you pay for it?

THE PRESIDENT: Well, first of all, let me -- I'll answer your question, but let me say first of all, you're much more likely to have overutilization and exploding costs if we keep on doing what we're doing than if we adopt our plan. In other words, particularly for smaller employers costs have been going up on average anywhere from 20 to 50 percent a year. Only the very biggest employers that are able, in effect, to bargain more toughly with their own insurance providers have been able to hold their costs in line, and they've been able to do a little bit better job in the last few years simply because of their size.

So under our system you would not only start out with a lower premium than you're paying now -- so you would get an immediate savings -- you'd be part of a big alliance of employers and employees who would have some say over the governing of your big health care group, and if the evidence of every other country is any guide, if the evidence of the places which have started it in this country is any guide, the cost is going to go up much less rapidly under this system than if we stay with what we've got. In other words, the worst alternative that we can conceive is to continue to do what we've got for small business.

Now, in addition to that, we've proposed to have a backup budget cap so that if by pure competition you can't keep costs as low as we think that, you know, basically to inflation plus the growth in people participating, we'll still have a budget to limit it.

So the answer to your question is, there is no conceivable scenario, at least that I can conceive of, where you would wind up paying more under this plan than another. Also there are more incentives in this plan not to overutilize the system. Under our plan -- not just for your employees, but for the American people as a whole. Under our plan all the employees in the country would have to pay something towards their own health care up to 20 percent, which is something that many don't now.

So I think -- and if they wanted a more generous plan than we cover which is quite adequate, they would have to pay even

more. So there will be a lot of incentives not to overutilize the system and not to run the cost through the roof.

Let me also point out that over the next five years, since you mentioned the short-term period, that's the period over the next five that where we'll be realizing a lot of the administrative savings. Our country stands approximately a dime on the dollar more in paperwork than all of our competitors. That's a bunch of money in an \$800 billion health care system.

So if -- let me just say this -- if what we've tried to do in implementing this health care system is to phase it in over a period of years to build in corrections so if something goes wrong, we will find another way to control the costs -- not to increase your costs for this health care.

We are spending -- let me say -- I want to drive this home. Today, America spends 14.2 percent of its gross domestic product on health care. Canada spends 9.4 percent. No other advanced country in the world is over nine. None. Not Germany, not Japan. And in the German system, which is about 8.6, 8.7 percent of their gross domestic product, the benefits are as generous as the best plans, more generous than most, and contain a lot of primary preventive health care. So unless we just all go to sleep at the switch, this is -- you know, there is no way that you can't be better off under this new system.

But there are protections. The way we've got it written, there are basically opportunities to recalculate, to avoid imposing undue burdens on employers three and four and five years down the road. The way it's written, we'll have to have opportunities to readjust it.

The bottom line is, sir, none of us are going to do anything which put more small businesses out of work than are already doing it now, because most of the new jobs in this country are being created in units of under 50. So I wouldn't be doing this if I didn't think it was not only better for the health care of the country, but also would tend to stabilize the environment for small business so we could get back to generating new jobs.

ADMINISTRATOR BOWLES: Mr. President, the way that we talked about it when we had business groups come together was, just think -- let's use common sense for a second. Just think for a second. If you had an item on your income statement that was accounting for 14 percent of revenues, an expense item -- and you looked at all of your competitors and they were at eight to nine percent, you'd say, whoa! I've got a problem. I think -- I've got to be more efficient and more effective. But you say, well, wait a minute. Let me look at the opposite side of the ledger. Let's see what we're covering for that. Let's see what we're getting for that.

Well, when you look at the opposite side of a ledger and you look at all of our competitors, all of our competitors are covering almost 100 percent of the marketplace, and they're spending eight to nine percent. We're spending 14 percent and covering about 86 percent of the marketplace. Clearly, common sense tells you there's a lot of room to bring -- to make the system much more efficient, much more effective.

The President set up a plan that really focuses on making -- reducing these administrative costs. Doing things like making the forms more simple, uniform billing; electronic claims processing. As he said earlier, 25 cents of every dollar you spend at the hospital -- 25 cents of every dollar goes to administrative costs. It doesn't buy you a nickel worth of insurance. Common sense tells you that we can bring the costs of health care down. And probably even more importantly from my viewpoint, thinking from the

private sector, what he's done is shifted the power of the marketplace so it favors you, the owners of small businesses and the consumers, and not the insurance companies. Today we don't have any power. We're subject to the whims of the marketplace. But by shifting the power of the marketplace by letting us join in these buying groups and these regional alliances, we finally have a power to bring the costs down.

I think what he's doing is good and smart and will help small business.

Q Mr. President, my question concerns catastrophic illness and preexisting conditions. Catastrophic illness, preexisting conditions have been devastating to the small businessman should something occur within the group medical plan. What do you propose to do to put constraints on the insurance companies so that they can't rate us, forcing us to either terminate employees -- valued employees -- keep them out of the marketplace, or allow us to -- or keep us from having to go to other companies? Our rates go up on the average of 15 to 20 to 30 percent anyway, and then we're rated because of a catastrophic occurrence.

THE PRESIDENT: First of all, this is not -- as you know, this is not an unusual condition. This has happened to millions of employers in America and millions of employees. For the employer, the burden is just what you suggested, it is -- your put in this awful situation of having to fire somebody who may be a good employee and making their lives miserable, or paying enormously increased premiums.

For the employee, there's another problem for the American economy that's now come to be known under the rubric of job lock. We now live in a country where labor mobility is quite important. The average 18-year-old will change jobs eight times in a lifetime now. And we've got all kinds of folks who can never change jobs again because they or someone in their family's been sick.

What we propose to do about it is to reorganize the insurance market so, first of all, nobody can be denied coverage or dropped from coverage because of a preexisting condition; and secondly so that small business employers of people with preexisting conditions don't have undue rises in their premiums because they are in very, very large buying pools. So that the preexisting condition that one of your employees or a family member has -- say, you've got 30 employees -- or how many employees do you have? So you've got 14. That could wreck you if you're in a buying group with a couple of hundred or even a couple of thousand. But if you're in a huge buying pool with 100,000 people or more, or 200,000, then each preexisting condition would only have a marginal impact on you.

We propose to go to what is called community insurance rating. It puts you in a large pool so that that will only have a marginal impact on the increased costs to the total people in the pool, all of who will be -- all of them will be represented in bargaining for the package of health insurance benefits with the people who provide it. So it will provide a lot of protection for you as well as protection for the employees.

And it is, by the way, the way it is typically handled in other countries and the way it is generally handled in Hawaii, where 98 percent of the employees are covered by the requirement and where they have a community rating system.

Q Good morning, Mr. President. I have a computer supply business in Orlando and in Pittsburgh. We also have affiliates that operate in Canada. We've been concerned that what we've seen over the progression of years there is that there is now a movement toward private insurance on top of the employer-provided

insurance. Does this signal anything to us that the quality of health care in those types of programs may not be the economy of scale that we were looking for?

THE PRESIDENT: Well, let me say that you have that in every country where you have universal coverage, because there are some people who may want a little extra coverage on this, that or the other thing. But you also have that here, frankly. And a lot of even the better employer-employee plans here, there may be employers, for example, who go out and buy another policy. You see it in Germany also. You see it in nearly every country. But what you might call the customized insurance policy that covers an additional extra risk, you find everywhere. But that's mostly to guarantee more personalized care. Under our system, people who run out of that will have a government back-stop, if you will, to take care of people and those kinds of problems.

One of the reasons, however, we elected not to try to go to the Canadian system, even though the Canadian system is administratively the simplest -- that is, they have the lowest administrative costs of any system we studied -- the Australian system may be about there, and the British system is, but it's all government-owned. No one wanted to get that. The Canadian system is a private health provider system, publicly financed system where all insurance premiums are abolished, everybody pays a tax, and you just pay it out. It's like Medicare, but everybody's on it. And there's no administrative costs to speak of. It's very low.

We decided not to do that for two reasons. One is we thought there would be a lot of aversion to cancelling all the premiums and converting it into a tax. And people probably distrust government about as much as they do big insurance companies. Secondly, we think it is -- if you look at the German system, for example, which is more similar to what we're trying to do -- we have private insurance companies with bigger pools for small businesses. We thought that you'd have a -- more likely you'd have lower costs and better service if you could put some competition in it and give the employers and the employees some leverage and, in effect, bargaining with the health care providers for the comprehensive services that will be provided. And that, I think, will tend to keep costs down and keep services more comprehensive.

But there is no country, including the United States, where there is not some what you might call third insurance market over and above what the government does and what the employers do for specialty coverage. We don't expect -- we expect that, in effect, there will be less of that here under this plan than would otherwise be the case.

Q As a small business owner, over the years we've seen how the employer contribution to Social Security have increased. Now with this health plan, and requiring small business owners to pay about 3.5 percent in contributions, how can we be assured that over the years, that this 3.5 percent will not skyrocket into higher rates? And, secondly, on the national health board -- will the national health board take the place of insurance companies, or how would that work?

THE PRESIDENT: Will it take the place of insurance companies?

Q Will the national health board take the place of insurance companies -- private insurance companies?

THE PRESIDENT: No. First of all, the answer to your first question is none of us can totally perceive the future. What I can assure you of -- and that's what I've said to Barry before -- is

that under this system cost will rise much more slowly than they otherwise would.

Let me tell you, it is estimated that -- we're at 14.2 percent of gross domestic product now. It is estimated that the United States will be at 20 percent of gross domestic product on the health care by the end of the decade and that no other country will be over 10. Canada might be a shade over 10. If we get to the point where we're spotting all of our competitors a dime on the dollar on health care, we're going to be in trouble sure enough. It's bad enough where it is.

So costs of health care will continue to rise. What we're going to try to do is to bring the health care system's cost in line with inflation plus additions to population. That is, if the population gets older and more people need different kind of health care, of course, that will go up. But what we can't afford to do is to let health care continue to go up at two or three times the rate of inflation.

The answer to your second is, the national health board is not going to replace insurance companies, but insurance companies will -- if the little ones want to continue to do this they'll have to find a way to join with one another to get into big bargaining units because we've got to let the small businesspeople be in bigger units; otherwise they can't get their costs down.

The national health board will be responsible for making sure that there is a reasonable budget to keep the costs in line, and for making sure that we have developed reasonable quality standards to make sure that there is no erosion of quality of health care in the prescribed services.

Q Good morning, Mr. President and thank you for this opportunity. I am the President of Photo Op, Inc. You may recognize some from photo ops we've had on the campaign. I'm also a member of the National Association of Private Enterprise. In a recent poll 59 percent of our members want to chose where they buy their health insurance, whether it by from an alliance, an association or from a company. As an integral part of the free market system, they obviously see enormous benefits from having a choice of where they buy their health insurance.

My question for you is, why should we be limited in obtaining insurance from only one source and that is the alliance?

THE PRESIDENT: Well, each state will have the right to certify how many alliances they approve, and my presumption is, given just what you said, is that most states will chose to certify a number of alliances and then you can chose whichever one you want. You'll have the three basic policies that you can chose plus however many alliances there are in any given state or the District of Columbia. You can pick the one that you think will provide the highest quality care and perhaps the one that gets the better price. Keep in mind, we're talking about ceiling on payroll costs and if they get a better price you get a better price.

ADMINISTRATIVE BOWLES: Let me just add that these alliances are extraordinarily important to driving the cost of health care down, shifting the power of the marketplace in favor of a buyer rather than a seller. And within your company, your employees would have the chance to go to the alliance and chose among at least three plans. Okay? So they would be there. And if your employee chose a more expensive plan, they pay more. And if they chose a less expensive plan, they pay less. Okay? So you do have chose, and that's what the President built into this plan.

THE PRESIDENT: But as an employer, if there are more than one alliance covering your state, you would choose the alliance you wanted to be a part of.

Q Will those alliances compete with each other for prices, or will they --

THE PRESIDENT: Absolutely. What we're trying to do is get the maximum amount of competition in the system for the services that have to be provided at --

ADMINISTRATOR BOWLES: Harnessing the power of the marketplace to drive the price down -- to put power in your hands instead of in the hands of insurance companies.

THE PRESIDENT: We are trying not to turn this into a system where the government has to regulate it all or the government tries to just fix the prices. We are trying for once to get marketing power. What happens now is, the government doesn't do it, but the private sector doesn't do it either. There's no effective competition except for big buyers.

If you look at what -- and let me just say, our estimated costs, which are dramatically less than the systems now, but more than inflation, may be too high if you really get competition. The California public employees, for example, have a huge buying unit. And they can bargain for themselves. They got a three percent increase this year or something like that.

Companies with over 5,000 employees that are in a position of bargaining for themselves have averaged six percent premium increases in the last two or three years. They've been able to do what we now want small business to be able to do by allowing them to join together. But I do think you should have -- my own personal preference is you should have an option of different alliances to be in. But under the plan as it now is, that is this judgment that will have to be made on a state-by-state basis. And the reason we did that is that the states are in different circumstances. I mean, for example, the availability of the number of alliances may be quite different in Wyoming, our least populous state, than it would be in California, our most populous state. So we think it has to be a state-by-state decision.

ADMINISTRATOR BOWLES: I just wanted to add, just think for a minute, what kind of disadvantage are we, the owners of small businesses at, when we sit down with an insurance company and try to negotiate for ourselves? It's just an unfair advantage. And, two, think of the time it takes away from trying to conduct your business, trying to work with your customers. That disappears. We don't have benefits departments. We don't have those people to go out and do that. Either we have to do it or we have to use a valued employee to do it. And that takes time away from managing our businesses and selling our products. We won't have to do that in the future. We'll have the power of the marketplace on our side.

THE PRESIDENT: Yes, sir. I like your tie -- "Save the Children" tie -- I've got one just like it.

Q Thank you. I've got three quick questions, and a million more. My first question is, I've looked over what I can read in the magazine and newspapers on your plan, and I'm not against it. But you keep mentioning big government, small business. Is what your proposal for small business, is it going to be the same for big government and state government as well? In other words, are we going to be competitive in the workplace against the federal government? Are you going to make an employee with the federal government have the same plan that we have to have?

The second question: The biggest problem I see, having been with Jane Applegate a couple of weeks ago on a small business panel that's working with Mr. Bowles, one of the biggest problems in America is the banking community with tightening up on the credit that we can borrow to run our businesses. When I talk to small businesses, I'm trying to figure out how I'm going to get the capital to fund this health insurance program. And I'm wondering if you're going to work with the banking community to loosen up the credit controls.

The third question is, my employees in particular and employees I've talked to at other companies are mainly concerned for themselves that if they have to pay 20 percent out of their pocket, where are they going to get the money to pay this 20 percent out of their pocket when they're just barely making it as it is.

THE PRESIDENT: First of all, let's start with your first question. We propose to put the public employee groups in buying alliances, just like people in the private sector. And, in fact, we hope we'll have a lot of these alliances. We'll have both public and private folks within the same alliance.

We do propose to leave the -- in effect, the employees and the employers that have preexisting comprehensive health benefits, where the benefits equal or exceed what they're providing now, we don't propose to take those away from them -- those that are paying more is good. But even many of them will be better off.

For example, General Motors -- I don't think I'm talking out of school here. I believe it's General Motors is now paying about 19 percent of payroll on health care costs -- about two-thirds for existing employees; one-third for retirees. They will actually, over a period of years, have a very steep drop in their payroll costs, which will enable them to hire more people and also invest more money and do more business with their smaller contractors around the country. That's just one example.

But we do -- the short answer to your question is, yes, we want the public employees to be in the alliances as well.

With regard to your second question, we believe that the credit system should be opened up. You may know -- I've been trying since I first got in office to simplify the banks' regulatory system and to get them to be able to make more good faith loans again and to do a lot of that. And we're getting -- I must say, we're trying to do a canvass of the country now. And they're -- we're getting wildly uneven reports.

I had three congressmen, for example, from the heartland of the country the other day tell me they just had lunch together and they were all three spontaneously talking about how much different it was and how banks were loaning money to small businesses again. But as I talked to most bankers and most business people in California, New England, Florida, just to give you three examples, I hear basically no difference. So maybe Erskine would like to address that. I do think that the general availability of credit to small business is still a big problem in this country.

The third thing I would say is that most employees with modest wages will not be paying a great deal for their health care. If they get sick and have to get health care without any insurance, they may face a much bigger bill. Meanwhile, all the people who are paying something for their health care are, in effect, paying to keep the infrastructure of health care there for them.

If I were to propose to you, for example, the following proposition, that it is unfair to make some people pay the gas tax because it's tough on them, there would be a riot in this country,

because people think that we should all pay for the infrastructure of the highways. But there is an infrastructure of health care. And those of you who pay something for your health care have paid for it. You have paid just to have the hospitals there and the emergency room there and the doctors there when someone else needs it.

And we have to find a way -- it seems to me, if you want to simplify the system and control costs, one of the things that you've got to do is stop the cost shifting. So I would argue that if -- even though it might be tough, that to ask employees to pay 20 percent of the cost of health care, if you're controlling the cost and -- not only you're controlling it today and providing it to them cheaper than they could otherwise get it, but also make sure that the cost goes up more in line with inflation instead of three or four times the rate of inflation, that that is a fair thing to ask people to do.

Do you want to talk about the credit issue for a minute?

ADMINISTRATOR BOWLES: I should just add there are caps in there for the employees so that they can't pay more than a maximum amount so they don't get caught in a catastrophic situation.

The President, as you all probably know, has been sending me out to hold town hall meetings throughout the country to listen to the concerns and ideas of small businesses and then to report those concerns back to him. In addition, he did give, for the first time of any President, he gave small business a seat at the economic table. He gave us a seat on the National Economic Council, because he said he wanted to make sure he knew what was on the minds of small businesses before he made decisions, not afterwards. So I probably met in the last three months with probably, I would say, 600 to 700 bankers, listening and talking to them, finding out how we can really meet niche needs in the marketplace. Because the President is exactly right, there are places where there is enough capital, but there are still areas where small businesses remain starved for capital.

And the places where I'm hearing the biggest concerns are clearly our poor rural communities, our inner cities, with minorities and women-owned businesses. And what we've been doing is trying to develop an attack so we can take on this issue and take it on head on.

THE PRESIDENT: Let me just say -- I guess I'd be remiss if I didn't say this. Most everybody in this room will be a net beneficiary from the fact that the recent economic plan increased the expensing provision from \$10,000 a year to \$17,500 a year. And that will cover -- if any of you -- for people who don't have any insurance now and are going to provide some, that increased expensing provision will probably for many thousands of small businesses more than cover the increased cost of the premiums. They access it.

ADMINISTRATOR BOWLES: Mr. President, I did promise that I would get you back very quickly, so we don't have much more time.

Q I have a manufacturing company in Fort Worth, Texas, and have always been a strong proponent of self-regulation, and the less government the better. And I've struggled with this since 1980 and finally reached the conclusion that self-regulation here is not working. And so your proposal comes to me at a time where I recognize that something has to be done. And what I've read and heard appears to be a good marriage of government and private sector.

Something that I think that's a real concern to myself and to my employees is preventative care, because I think in the long-term if we don't look at preventative care and educate people to

utilize preventative care, our costs are not going to go down. And I would just hope that that's being adequately addressed and that we have an arm of education that tells these people about preventative care and about AIDS, about drug and smoking abuse, alcohol abuse. All of those things needs to be integrated in that system if it's actually going to in the long-term really provide the results that we're looking for.

THE PRESIDENT: Yes, wasn't that great? First of all, what I know about your situation, you will benefit, I think, considerably from this from the premium cap. But secondly, one of the things that we built into this country was a preventive and primary care component.

There are other reasons -- I don't want to pretend that the only reason health care is more expensive in America is because of the insurance system and the administrative costs, although that's a big reason, and because you don't have any buying power. But another reason is, we go way heavy on specialty care and high technology care, which is great if you need it. And it will keep us from every get down to what some other countries have. I think we're all willing to pay a premium because we know someday we or some loved one of ours may need that extra operation or that fancy machine.

But it's important to recognize that in America, for example, only about 15 percent of the graduates coming out of our medical schools now are general practitioners. In almost all the other countries with which we're competing, about half the doctors are general practitioners. They do primary and preventive care.

So we have done two things that I think are important. In this plan we will increase the money for medical research. But at the same time we will provide more incentives to the medical schools of our country to produce more primary care physicians, more family doctors, if you will. And in the health care plan, we will cover more preventive services, because it is just clear that the more you do preventive medicine, the more you lower the cost of health care, and the healthier you keep your folks.

Q I'm located here in the city of Washington, D.C., and hopefully with your help, it will be the state of New Columbia one day. But certainly one of the things that -- I have a small computer firm here in Washington but I'm here representing National Small Business United as a board member that Mr. Bowles referred to earlier. We have about 40,000 members. And our concern is that as you speak it seems like the numbers don't really add up. As all these new people come on board and come in line with health care, small businesses are going to have take the weight on much of that. Many small business now, you talk about premiums coming down, but certainly as the health care program is mandated on small businesses their level of coverage would come up, families would have to be covered and many small businesses in this particular economy that hasn't totally rebounded, as we talked about -- and we are very supportive of NAFTA, but that certainly will add more competition to small businesses. We're asking to be more competitive in a global economy and we're looking at really adding on 30 to 50 percent more in health care costs to many of the small businesses in this country and that's going to be difficult.

THE PRESIDENT: Well, now, I think the numbers do add up. Some small businesses will pay more, plainly. Those who aren't paying anything and those who are paying less than they would otherwise pay under the initial premiums set unless we are able to -- our estimate unless in the bargaining power they'll even be able to bargain for lower prices, which is conceivable. But we just -- we had to start out with something.

But there's a lot of talk about these numbers not being -- I'd just like to tell you what we've done over the last seven months. Number one, for the first time we've got government departments that agree on the numbers, that the numbers are accurate at least, and we have run these numbers through ten actuarial firms -- private sector firms.

So we have tried to get at least the first set of numbers that have ever been through this sort of vetting process from any private or public agency on health care. No one else has ever done as much work as we have tried to do to make sure the numbers work out. Keep in mind, we proposed for the government to cover the uninsured who are unemployed.

We believe you can't get costs under control and stop cost shifting unless you have some means of insuring everybody else. We believe employers should do something. There are those who may have to pay more because their premiums are quite low and we're going to increase the coverage substantially.

But all of our surveys show that is a distinct minority of the people who provide and insurance now. That many people who provide insurance now will actually get, unbelievably enough, lower premiums and more coverage. But some will pay more. I don't want to minimize that; some will. What I think all of you are going to have to do is two things. You're going to have to read the plan when you get the details, when we finally produce it, and say how's this going to affect me and can I live with it. And then you're going to have to say, how will it affect the small business sector of the economy as a whole and are we net better off.

And more importantly, I would argue to you that even those of you -- let's suppose there's an employer here in this group who will go from six percent of payroll to 7.9 percent of payroll. If you look at where you've come in the last five years -- if we don't do something to bring these costs under control, you're facing one of two decisions. You're either going to have to drop your coverage altogether with all the attendant insecurities and anxieties and problems that presents for your employees, or you're going to have to go -- or your costs are going to go through the roof.

So my argument is -- I really believe this -- this goes back to the very first question Barry asked. My argument is that in five years from now, even the people who pay slightly more now will be better off because the overall assistance cost will be controlled for the first time and we're not going to be strangled with it. That's why we tried to at least do a phase-in for the smaller employers.

Q Good morning, Mr. President. I'm from western Maryland. We have a retail operation there. I support your efforts to control health care costs and believe that market-based reforms are needed. However, we cannot finance your proposed 7.9 percent payroll cap on the backs of small business without job loss. A mandate will hurt our struggling economy. Being in a family business for over 39 years and offering health benefits to our employees, 35 of those 39 years -- in the past 18 months, my company has gone from 300 employees and 15 stores to 95 employees with five stores today. My health care costs under your current plan will triple. Mr. President, small business cannot afford this plan. Eliminating jobs and tripling my costs will not work in today's economy.

THE PRESIDENT: How can it possibly triple your health care costs?

Q We're paying currently about 2.9.

THE PRESIDENT: To do what?

Q For major medical benefits -- of payroll costs.

THE PRESIDENT: What does it cover?

Q What are they covering?

THE PRESIDENT: Yes.

Q Major medical -- 80/20. Catastrophic care.

THE PRESIDENT: Well, we tried to have a catastrophic package, remember, a few years ago? And the whole country rose up against it.

All I can say to you, sir, is that if we don't do something like this, then everybody's going to be going in the same direction you are. I mean, we are looking at a situation now where we're going to give the pay raises of American workers to the health care lobby. That's where we are now. We are looking at a situation -- if we don't do something -- maybe Erskine's got a specific answer to you. But if we keep on doing what we're doing, more small businesses will go bankrupt, more people will do without health insurance. We will go down the -- we're basically going to give our economic growth to health care for the next seven years if we keep on doing what we're doing.

And if we don't require everybody to -- some uniformity of coverage, then everybody will want the lowest common denominator and the government will wind up picking up the bill for all the other health care costs. I mean, there is no way we can, I don't think, solve every problem. But if there is something we can do for people like between 50 and 100 employees -- if there's something else we need to look at, we ought to do it. But I still believe -- I will say to you -- every study shows -- the National Small Business United study shows -- that the vast majority of small business people will come out way ahead economically on this. So the question is, are we going to lose more jobs doing what we're doing? Are we going to lose more jobs with the alternative? I argue to you that we have killed this economy now unconscionably for the last 12 years by letting health care costs go up as they have.

ADMINISTRATOR BOWLES: What the NSB study showed, again, was average payroll was \$7,400. And if you apply the formula that we have, that means that that average company without health care would pay as little as \$1 a day. The average employer who has health care would pay as little as \$2 a day.

Now, addressing your problem, if we don't do something about the rising cost of health care, if we don't go to some form of universal coverage, then it's going to continue to be shifted onto the backs of small business. You and I are the ones who are paying for it. It shifted on our backs. And that's why you're only able to offer your employees catastrophic coverage. What you're going to be able to offer them in the future is comprehensive, real insurance -- not just some kind of catastrophic coverage.

Q I want to thank you and Mr. Bowles both for taking the time to join us today. I own a small restaurant called the Santa Fe Cafe in Rosslyn. We have about 15 employees. By industry standards, I'm a successful operator. I've been there for five years. I make a middle to upper middle-income level salary. If I have to provide health care for my workers -- which I have a great staff; they need the help. So I do wish you both success in the project -- it could greatly reduce the percentage of salary that I make. I'm successful, but if you go to your home state of Arkansas, for instance, there's many small restauranteurs there who might make \$10,000, \$15,000, \$20,000 a year working 60 hours a week, both as

laborers as well as administrators to their business. If they have to take a perhaps 50 percent cut in salary, what incentive do they have to keep their businesses going? And, of course, if they don't, they close down. People are out of work.

THE PRESIDENT: First of all, they don't -- let's just take somebody -- let's just take somebody's running a family restaurant and they make \$20,000 a year. The following things will happen to them. First of all, they'll be capped at 3.5. Secondly, their expensing provision of the tax code went from \$10,000 to \$17,500. Thirdly, they're going to get a tax cut under the new tax bill because their income -- they're families working for a living and because of their low income.

So all -- those folks are going to do fine. The people that I'm concerned about here are people who have -- people like him -- people who make between -- who net between \$50,000 and \$100,000 income, have more than 50 employees, and aren't eligible for the cap the way the bill's now drawn. Anybody who is under 50 employees with anything like in the wage range we're talking about, I think will probably recover -- between the caps and the expensing provision, will probably be able to manage through this okay in the early years. But I'm very -- the people that I'm most worried about are the people in the category of this gentleman here who spoke.

Q Won't there still be a cash flow problem for these small businesses, though? And how will that be addressed? Is this a percentage of their salary that will be withdrawn every paycheck, or how will that work?

ADMINISTRATOR BOWLES: Really, as you look at the cash flow effect it should have on your business with -- I think, if I remember right, 15 employees, is that right? -- again, assuming that your payroll for those employees is around what I imagine most restaurants are -- your costs are not going to be increased appreciably. Again, if you think that -- if your average payroll is around \$7,400, for each one of your employees, then it's only going to cost you \$259 for the year. That's all it's going to cost for this. I believe that's probably something that you could absorb per employee.

THE PRESIDENT: One of you asked a question about the employees, too -- about how they could pay and whether they could pay. Don't forget that under this tax bill that just passed, most all families -- working people with children, with incomes of under \$27,000 a year are going to get a tax reduction, which will help them to deal -- if they have no health care costs now -- with the up-front cost of this. Most of them will have a tax reduction that exceeds what their 20 percent cost of the premium will be.

I think the real problem, by and large, there may be some -- I can conceive of economic circumstances under which these problems will occur that you talked about. But I think the real problem here in the way the plan is drawn now is the people in his category.

ADMINISTRATOR BOWLES: Can we close with one --

THE PRESIDENT: Well, let's take two more. These folks in the back and then our hosts ought to be able to close up.

Q We do health research, health education and health communications in Rockville, Maryland. I'd like to follow up on Marilyn's question, which I thought was very relevant on the long-term issues that we face in health care. If you look at the United States, we have a lot of behaviors in this country that make us use more health care, but also make our health care more expensive.

And as you answered Marilyn's question, you indicated much more toward individual prevention. But if we look at special populations - women, minorities, and the population as a whole, there are a lot of behaviors we need to change in the long-term to bring our health care costs down. Is this part of your program, and if so, how will it work?

THE PRESIDENT: Yes, --- well, let me first of all say -- let me sort of reinforce what she said. I'm going to back off one step and then I'll come right back to your question. If someone asks me, is there any conceivable way America could get its contribution, that is the percentage of our income we pay going to health care, down to Canada's or Germany's, I would say no. And I would say no for some good reasons and then no for some not so good reasons.

One good reason, though, that we probably all agree on is that we spend more money on medical research, advanced technology trying to break down barriers trying to help people live longer and better lives than any other country. And I don't think any of us would want to give that up. Let's just say that adds one or two percent to our contribution to health care, it also employs a lot of people, by the way, who make basically high incomes and make our economy strong. So I don't think any of us would want to give that up.

But here, to go back to your point, are the downsides. We have a lot of people who smoke, a lot of people who are overweight. We also have a higher percentage of teenage births which are far more likely to be low birth weight births, far likely to be very costly and far likely to lead to children with mental and physical limitations. We have the highest percentage of AIDS as any advanced nation, and that's extremely expensive. And as, thank God, we find drugs to keep people alive and their lives better longer, it will be more expensive. We have to have a preventive strategy there.

And perhaps most important of all -- and here in Washington I think I could say it and get a cheer from the Mayor -- this is the most violent advanced country on Earth. We have the highest percentage of our people behind bars of any country, which means that every weekend we've got more people showing up at the emergency room cut up or shot than any other country, and the rest of you are all paying for it.

So, yes, we need a strategy to change those behaviors. We could start by passing the Brady bill and taking semiautomatic weapons out of the hands of teenagers. (Applause.) It would change the environment. Nobody ever talks about it that way, but if you did something about this, it would lower health care costs. I mean, if you could get a spreadsheet on the cost of health care in Washington hospitals, you would see that an awful lot of it goes to the emergency room.

So the answer to that is, yes. One of the reasons I made the appoint I did to the Surgeon General's office is so that we could have a broad-based, aggressive, preventive strategy to change group behaviors as well as individual ones.

Q I have an aircraft maintenance management and information technology firm in Waldorf, Maryland. And I'd like to first say that Administrator Bowles's staff provided us with information about your plan. I read it, and I support it. I'd like to say, for me, it would result in a savings to my company, if it's implemented as it presently stands. I'd like to know, will you describe some of the hurdles that exist before the plan is implemented?

THE PRESIDENT: Well, there are a lot of hurdles that exist. But I think some of those hurdles are good hurdles. That is,

I have been working on this issue for three years -- over three years. Long before I ever thought of running for President, I agreed to head a project for the governors on health care. And I started off by interviewing 900 health care providers. I then interviewed -- in my own state. I then interviewed several hundred businesspeople and employees about their particular circumstances. This is the most complicated issue that the United States has had to face in a long time. It has a very human face when you deal with the human dimensions of it. But it's extremely complex.

So the first hurdle is to try to get everybody singing out of the same hymnal, as we say at home. For example, in the next few days, we're going to have a two-day -- Congress is going to sponsor a two-day health university for Republicans and Democrats just to try to get information and facts out. Just to try to get the evidence so people will get a feel for all of your different circumstances and what are the problems, and how does the system presently work, and what are the costs, and where are we out of line -- all things we've been talking about today. So getting the information out I think it's significant.

Then I think the next big hurdle will be trying to make sure that we make decisions based on the real issues and not illusory ones. I've not tried to mask the fact today, and I won't in the debate, that there are some tough choices to be made, and that in the short run we can't make 100 percent of the people winners.

For example, if you want to end job lock and preexisting conditions and really smooth out things for small business, you have to go to broad-based community rating. That is plainly the best for small business and plainly the best for most Americans. If you do that, young single super healthy people may pay slightly higher premiums, because what you do is you merge them in with middle-aged people who get cancer, but still can go back to work, for example. So there are tough choices to be made.

Then thirdly, if you really clean out the administrative waste in this system and you go to a more preventive base system, you will shift the way you are spending money. You will shift the dimensions of the health care system and you'll shift money drastically away from administration and insurance costs into the provision of basic health care. And so there will be people who won't favor that and will fight it.

You will also tend to favor either bigger providers of health care -- and these big alliances are people who have joined together and do it jointly to provide an alliance. So then we'll fight through the winners and losers. That's what -- that'll be the toughest part in the Congress.

But I think a big part of this -- there is a real spirit of cooperation, I think, in the Congress now. A willingness to try to face this terrible problem, do something sensible about, take our time and really listen to people, and do more good than harm. And I think that's very hopeful. We should all be very glad about that.

Q Mr. President, I'd first like to thank you for taking the time to come down here and listen to the concerns from the small business community. And also for choosing W.S. Jenks.

Most of my questions have been answered. But one thing that has me concerned is, given the government's past history with the funding of Social Security and Medicaid, how will your plan guarantee that this plan will not be underfunded as our population ages?

THE PRESIDENT: Well, the way you can -- arguably, Medicaid is under funded now, although the truth is that it's wrongly

funded. That is we're spending money on the wrong things. The Medicaid budget is still going up -- over the next five years is projected to go up somewhere between 16 percent next year and 11 percent in the fifth year. In other words, over four times the rate of inflation next year.

Social Security, believe it or not, is now overfunded. That is, it got underfunded 10 years ago. If people hadn't made the right projections for the -- it is now overfunded, but the overage is all being used to make the deficit look smaller. So we're going to have to stop spending Social Security on the deficit if you don't want the payroll tax for Social Security to bankrupt small business. Because when I, people my age -- I'm the oldest of the baby boomers, people born from '46 to '64 -- when we start retiring in the next century, we cannot at that moment still be using the Social Security tax to make the deficit look smaller, which is why it's -- another reason it's so important to get control of this deficit now. We just can't do it.

The answer to your question, sir, is Social Security is basically under control if we bring the deficit down. The problem with the Medicare and Medicaid system is that it can't control its membership since the system -- the private system is hemorrhaging. And it is based on a fee for service system where there is no regularization of benefits and where many of the beneficiaries don't assume any responsibility for themselves.

So what we're going to try to do is to increase the amount of personal responsibility in the system as well as put some cost controls. Then, instead of just paying a fee-for-service system, what we want to do is put Medicare and Medicaid -- starting with Medicaid because Medicare actually works pretty well; it's adequately funded and well administered -- but Medicaid, we want to put those folks in the same kind of health alliances so they'll be in competition -- to go back to what you guys said -- so there will be some competition for the services.

Florida has started to do that, and their preliminary indications are there's going to be a big reduction in the cost of Medicaid if we do it. In other words, I think the mistake has been not to have Medicaid subject to the same sort of competitive environment that the private sector -- the bigger private sector employers are. If you put small business and the Medicaid in where a lot of the bigger employers are now and the public employees, you're going to see a real modification of the cost trends in the outer years in ways that will help you all as taxpayers as well as employers.

Thank you very much. They say we've got to go. I wish we could stay. You were great. Thanks. (Applause.)

END

11:20 A.M. EDT

THE WHITE HOUSE

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PRESS BRIEFING

BY

ERSKINE BOWLES, ADMINISTRATOR,
SMALL BUSINESS ADMINISTRATION

AND

KEN THORPE, DEPUTY ASSISTANT SECRETARY,
HEALTH AND HUMAN SERVICES

The Briefing Room

3:55 P.M. EDT

MR. ANDERSON: This will be an on the record briefing featuring Erskine Bowles, Administrator of the Small Business Administration. The topic is health care reform and small business. Mr Bowles will be joined by Ken Thorpe, who is a Deputy Assistant Secretary at the Department of Health and Human Services. And Mr. Bowles will have a short opening statement. After that we will end sound and camera.

Q Excuse me, why?

MR. ANDERSON: Why?

Q Mr. Bowles was on the record this morning, why isn't he on the record this afternoon?

MR. ANDERSON: I don't know.

Q Dee Dee said it would be on the record.

MR. ANDERSON: The briefing is on the record.

Q Your just fighting for broadcast interest now and we appreciate it.

Q Well, in that case it's a -- (Laughter.)

MR. ANDERSON: Fair enough. I do apologize for the many delays. As you might imagine this is a scheduling meltdown of historic proportions -- this coming into this week before the President's speech. The problem principally is one of principles and them being torn apart in different directions. Mr. Bowles has just come from a meeting with the members of the Black Caucus. And we do apologize for the delay but we are ready. Erskine Bowles.

ADMINISTRATOR BOWLES: Good afternoon. I think we've had a -- at least for the small business community, an exciting and good day with the President. We had a chance this morning, as you know, for a number of people who had written the President to come visit with him and to read their letters and talk about their concerns about health care.

We also had an opportunity to go to a small business here in the District, and we had small businesses from throughout the country come and visit with the President and talk to him about their concerns and their thoughts about health care and the solution to our health care problems.

MORE

I think over and over again we heard small businesses talk about the absolutely skyrocketing increases of health care costs that they are experiencing -- health care costs that are growing by 20 to 50 percent a year. And we also heard these same small businesses talk about the abuses of a current health care system that are focused upon them. And I'm talking about things like exclusions for pre-existing conditions, things that I've experienced with a diabetic child.

Each one of these small businesses talked over and over again about how they had tried to control the cost of health care, how they had tried to do such things as to hold the cost of health care down by switching programs, by going to managed care, by trying self-insurance, by reducing benefits, by passing a bigger cost along to their employees, and how nothing had really helped. That the cost of health care continued to rise and rise rapidly and eat into their profits.

And the President had a chance to listen to them and talk about his plan. And he had a chance to talk to them about the plan he would present and how that plan would offer to them real insurance, rock solid comprehensive insurance, and insurance that they could afford.

He talked about the caps and subsidies that would hold down the cost of health care, and he talked about the mechanisms that would keep the cost of health care from increasing at too rapid a rate.

And he also had a chance to talk to them about something they brought up, which was workers' comp, and how workers' comp was the only item on most of these small businesses' income statement that was increasing at a more rapid rate than health care, and how we would hold that down.

And the last thing we talked about was offering 100 percent deduction for the self-employed instead of 25 percent that they have now to put them on a level playing field.

I think we had a good day. We had a large group of small businesses there representing lots of different markets, and I think we all had a chance to learn something. I know the President felt he benefitted from it greatly. Thank you, I'll take your questions.

Q Mr. Bowles, some of the small business owners there with more than 50 employees said that under the President's plan, their costs would go up -- double or triple what they are now. Some of them said they are now paying, in the case of Daryl Routzahn, only 2.9 percent of payroll. One other business owner said he talked to President Clinton after the formal session and he indicated some interest in looking into, or changing that 50 employee cut-off so that businesses -- small and mid-size businesses with more than 50 employees -- might also get some government subsidy. Is that under consideration now? Has that changed? Will businesses with 50 or more employees get a government subsidy?

ADMINISTRATOR BOWLES: Clearly, I can't say whether or not that will change. What -- I do think it's a mischaracterization to say a number of the small businesses would experience increased costs. I think a few of them will. But clearly, the vast majority would experience not only lower costs, but the availability to have real insurance coverage -- comprehensive, rock solid coverage.

Let me give you an example, okay? One of the people that was there today, Marilyn Hart of Design Plastics in Fort Worth, Texas -- today Ms. Hart, who has 65 employees so she doesn't fall

under the less than 50 cap -- she pays \$166,000 a year for coverage. That's for 100 percent of her employees. Okay, that's 15.4 percent of payroll. Under the plan, she would only have to pay about \$85,000, which is a savings of almost 50 percent. And the coverage she would be able to offer her employees would be better.

Now, if she chooses to cover not only the employer portion, but the employee portion too, she would still save 25 percent. So she's going to be far better off, and her employees are going to be far better off. And she's going to save money, and that will enable her to go out and hire more people.

Q If I could follow on Gene's question. When the President said that this was one of the things that he was most concerned about -- this 50 employee cut-off -- what was he talking about? What is he prepared to do to relieve that burden?

ADMINISTRATOR BOWLES: Well, as you well know, this President is focused on small business. And he has spent -- I can't tell you the countless hours -- making sure that we put together a health care plan that would help small business, that would be good for small business, that would hold down the costs for small businesses.

Now the cap is at 50 today, and it is probably one of the things that the President would like us to take a look at. But we are going -- you know, today for companies with less than 50 employees, clearly the vast majority of them -- if you call them up and ask them, just ask them -- you know, how are you going to be under this new plan? -- they'll tell you that we're going to have better coverage at a lower rate.

Q Do your surveys specifically quantify how many people who have employed between 50 and 100 would be affected adversely by this?

ADMINISTRATOR BOWLES: I don't know. I can tell you that I did read Ms. Staddler's article the other day, and she quoted five small businesses, and four out of those five would have reduced costs.

Q But you've done extensive surveys. You don't have any numbers that can tell us? When you say a vast majority would get lower cost, you don't know how many would get --

ADMINISTRATOR BOWLES: I just can't give you an exact percentage, I just don't know. I'm sorry.

Q The other side that NFIB and other people are saying is that not only might people have some increased cost, say in the 50 to 100 employee range, but some there will be substantial job loss. I know you all are starting to look at the question of what the job loss will be like. What types of small businesses are likely to not only have increased cost, but suffer job loss? What conditions --

ADMINISTRATOR BOWLES: Again, I think the vast majority of all small businesses will have lower costs. And therefore, with lower costs, they will clearly, clearly be able to go out and hire more employees.

Q But you know a lot about small business. What's the profile of --

ADMINISTRATOR BOWLES: I spent my entire career in small business -- (Laughter.)

Q Right. So what's the profile of a small business person who would be imperiled not with only increased costs, but maybe having to cut jobs or shut down.

ADMINISTRATOR BOWLES: Let me give you some statistics, okay, so you can live with this. National Small Business United came out today -- or just last week -- and they said the average small business that doesn't supply health care to their employees has an average payroll of about \$7,400. Well, you know what it's going to cost that small business that doesn't provide health care to provide health care to its employees? Less than a dollar a day.

They also said for the average small business that provides health care coverage to their employees, the average payroll is about \$15,600. It's going to cost that small business less than two dollars a day. And I dare say, that's going to be a significant savings for that small business, and they are going to be able to take those dollars and go out and hire new people and buy -- and -- go out and make new capital expenditures that will create jobs.

Q Could you answer the question please?

Q The President said today -- he conceded today, I believe for the first time, that there would be some gross job loss. That overall, if the current system stays in place, there will be more job loss. And that if your system passes, he says, there will be reduced job loss. But he did concede that there would be some job loss --

ADMINISTRATOR BOWLES: Every single company, you know, won't win. That's impossible, okay? But the vast majority will. And that's what I'm trying to drive home to you.

Q Do you think it's important for people to know which types of businesses the conditions that will exist, where they will have job loss?

ADMINISTRATOR BOWLES: I think what I have just told you is I believe that the vast majority of all small businesses will be able to offer their employees comprehensive, rock-solid, real insurance. Not some insurance that's going to be jerked away two years from now. Or not some insurance where the rate is going to skyrocket a year from now. Or not some kind of insurance where you're subjected to pre-existing conditions exclusions. But real insurance, and insurance at a lower rate.

I think what we have asked small businesses to do is to call a 1-800 number to the SBA, give us your numbers, okay, and we'll tell you exactly whether you are going to have increased costs or decreased costs. And we believe that the vast majority will find out the costs will go down.

Q Have you given out an 800 number?

ADMINISTRATOR BOWLES: No, but we will.

Q Mr. Bowles, what I want to follow up on is you're saying the vast majority will have lower costs. As you well know, the vast majority of small businesses, when you get to businesses that have five or fewer employees or very few employees, that is the vast majority. But when you get to this segment that has more employees, you are getting to more substantial businesses that are more the engine of the economy -- the small businesses that are really contributing more to the economy and --

ADMINISTRATOR BOWLES: -- the way their health care costs are increasing, the health care is going to end up being the

salary and your cash wages are going to be in the fringe benefits the way it's growing.

Q Indeed. But given that, you said that this group is something the President wants you to look into. Is that something that's going to be done now? Will --

ADMINISTRATOR BOWLES: Oh, we continually -- continue to take the input. The very purpose of having meetings like today is to listen to the small business community, to listen to others that will be affected by the plan, to go and take that information and come back and evaluate it and see how we can improve a plan. I mean, we always are looking for ways to improve a plan, and we'll do that up until the day it goes forward.

Q What are your projections on the job loss in the insurance industry?

ADMINISTRATOR BOWLES: I don't --

Q -- regardless of size?

ADMINISTRATOR BOWLES: I'm sorry. I don't know any numbers on those.

Q How about the projection of overall job loss in small businesses? I'm not disputing your point that the vast majority may end up saving money --

ADMINISTRATOR BOWLES: I believe that you will see job gains in the small business community. I think the example that I just gave you of Marilyn Hart is a perfect example of the kind of person who is going to have -- be able to go out and hire more people, not less. She's going to save money. She can use that money to hire additional people. She can use that money to go out and make capital expenditures to become more productive. I think she'll be able to have job gain, not job loss.

Q Do you have figures on gross jobs lost and gross jobs gained?

ADMINISTRATOR BOWLES: I'm sorry, I don't.

Q Do you have figures on -- you don't have -- there's been no study on this?

ADMINISTRATOR BOWLES: Yes, sir?

Q What arguments would you make to the NFIB and other groups for employer mandate? If you were sitting down with them now, what --

ADMINISTRATOR BOWLES: What I'm saying is today small business has the worst of all worlds. It can't be any worse. We have every abuse in the system today. The cost shifting that goes on is all shifted right onto the backs of small business. We have a skyrocketing cost increase. You know, those people who can afford to buy insurance -- you know, the costs are going out of the roof. Some people, because the costs are so bad or insurance is just not worth it anymore, you know, can't buy it.

So what I'm saying is this plan addresses the need. You know, NFIB has come out with some statistics that I saw themselves the other day. They did a survey back in -- let me see if I can find it -- that some -- Professor Charles Hall -- Temple did. And in that survey they said -- they found out that 92.4 percent of small business owners agree that the cost of health insurance is a serious business problem. Sixty-nine percent of small business owners agree

or strongly agree that every American has a right to basic health insurance. Sixty-four percent of all Americans should -- small businesses agree that all Americans should receive a minimum level of health care, regardless of their ability to pay. And probably the most important one is over 60 percent of small businesses in this NFIB survey felt that the government must play a more direct role in health care to bring the cost under control.

So what I would say -- we are doing exactly that. We are attacking the problems that are compounding on the backs of small businesses. We're going to reduce the cost. We're going to put mechanisms in to control the increase in cost. And we're going to provide rock-solid, comprehensive, real insurance. And I think if you call the members of the NFIB -- individual companies and ask them what it costs today and what it costs under the plan, you'll find that the vast majority will have better coverage at lower cost.

Q But the reality of the lobbying fight that you're facing on the Hill gives NFIB a lot of weight.

ADMINISTRATOR BOWLES: I'm just trying to get by the rhetoric and get to the facts.

Q I understand that --

ADMINISTRATOR BOWLES: And the facts are the plan will be really good for small business.

Q -- but I'm talking about political reality on Capitol Hill. A lot of people whose jobs depend on support from organizations like the NFIB will obviously be listening to their complaints about the plan. How are you prepared to counter that?

ADMINISTRATOR BOWLES: I'm not worried about politics. I'm here --

Q You're not?

ADMINISTRATOR BOWLES: -- as a business person. Okay? I spent my entire career in the business sector and the private sector, so I'm here to tell you the truth. And the truth is that I believe that the vast majority of all small businesses will be better off. That's why we're asking small businesses to call us -- tell us what it costs today and what your coverage is today, and we'll tell you what it'll cost tomorrow and what the coverage is tomorrow. And I think you will find out if you go and ask the businesses -- get by the rhetoric, okay? Look at the facts, and the facts will tell you that the vast majority of all small businesses will be better off.

Q The NFIB apparently made a case, though, with the administration to treat independent contractors the way they are currently treated under tax law. And I'd like to know the rationale behind why the administration decided to change the treatment on up to 10 million business owners?

ADMINISTRATOR BOWLES: I certainly wouldn't give any trade organization credit for that position. I think that's a position that we have and I think it's the right position.

Q But it wasn't a week ago. A week ago you were treating independent contractors as employees.

ADMINISTRATOR BOWLES: I think clearly, as we go through this process, we are looking at a plan that is still -- you know, the President hasn't even delivered the plan yet. I know you may have a bootleg copy of it. But this is a plan that's still being developed. That is a portion of a plan. It is one of the things we looked at, it's one of the things that's been in the discussion for a long

period of time. And a position has been taken, and that position is the one you just said.

Q Why did you change your position, is what I'm asking.

ADMINISTRATOR BOWLES: I don't know if the position was changed, to tell yo the truth.

Q Is was in the original ---

ADMINISTRATOR BOWLES: I could say that we've gone through lots of different times of looking at it.

Q You said you expected some net job gains out of this program in the small business sector. I mean, what do you base it on and how many do you expect?

ADMINISTRATOR BOWLES: Well, all I can do is base it on the ones that I have talked to -- okay? -- in the surveys that I have done myself. And I can tell you that we have called literally hundreds of small businesses, and we have found that the vast majority of those small businesses will have lower costs and be able to offer better coverage.

Q That's not the question I asked you. The question I asked you -- the question I asked -- Mr. Bowles, the question I asked was how many net job gains you expect from this and on what you based that job gain expectation? Do you have some, Gene?

MR. SPERLING: You know, we've just -- so far there has not been a study that has accurately portrayed our plan. The studies that the NFIB has assume no subsidies. They have no clue as our plan did not look at the lower administrative costs. So there has not -- there has not been a serious study in that regard.

The main point that Erskine is trying to say is if the overall majority of businesses you have are going to see their administrative costs go down, are going to see their -- those who are providing, see their health care costs go down, that is going to lower both their security in hiring more people, and it's going to lower their cost of hiring. And the chances -- for those small businesses, the net gain -- that their job gains will lead to a net job gain is very strong.

But, Gene, you asked about the 50 to 100, but you just asked as if the whole universe of those businesses don't provide health insurance. Those who do provide health insurance are clear winners. Those who provide full coverage are going to see their costs go down -- are going to see their costs go down dramatically. And even if there are some small businesses who see some of their costs go up, I say -- want to suggest there is very little evidence to suggest that that would in any way lead to a job effect. That people might -- that may be their theory, but the studies that have looked at the minimum wage lately have shown there have been far greater minimum wage increases, that there was no employment effect at all. And I think that's been reported by some of your papers. Those were talking about even when New Jersey increased from \$4.25 to \$5.05, which was an eight -- a substantial increase in cost that did not have any job effect at all.

So the overwhelming thing to keep in mind is most businesses and most small businesses provide health insurance, their costs will go down. Their administrative costs will go down. Their security in hiring more people will go down. So any logic that would lead you to say that some people have higher costs and that will have a job effect, that same logic should mean that there will be job -- there will be job gain. I don't know if there is a conclusive study

at this moment on what the effect is. But I will say that anything that's being put out there that's suggesting there is job loss is bogus. And that is pretty generous.

Q I think we're wondering, Gene, where the President got his information that would lead him to acknowledge that there might be a job loss involved here.

MR. SPERLING: The President said -- he said that's he's not going to tell you that everybody is going to be -- that every single person is going to immediately feel an immediate financial benefit in every single way. But that does not mean that there is not going to be a job gain -- I mean, this is part of an overall economic plan that is designed to bring the deficit down, to bring low interest rates down, to give people security that they can hire workers without having to fear an explosion in health care, or that if one of their workers were to get sick, their health care costs were to go out of control -- this is part of an overall plan that I don't think we have any question is going to be good for the economy and good for job growth.

But overwhelmingly -- and I mean, Erskine's heard this. We've heard this all through the campaign. The fear, the insecurity over health care costs is -- clearly has a deterrent affect on people -- on employers. And I don't know if there is a conclusive study. We have not even put out the final facts of our study. But I do suggest that one should look very, very skeptically to anything that one has heard on the negative side, and that the overwhelming -- that if you provide insurance, your costs are going down and that that will have a positive wage or employment affect. Either your current workers will likely receive a higher wage, or you will have more capacity to hire future workers.

THE PRESS: Thank you.

END

4:20 P.M. EDT

THE WHITE HOUSE

Office of the Press Secretary

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REMARKS BY THE PRESIDENT,
THE FIRST LADY,
THE VICE PRESIDENT AND MRS. GORE
IN HEALTH CARE LETTERS EVENT

The Rose Garden

8:10 A.M. EDT

THE PRESIDENT: Good morning. Please be seated. Welcome to the Rose Garden. I'm glad the rain has stopped, but we put up the tent just as a precaution.

Nine months ago, when I asked the American people to write to us to send their thoughts about the health care system and the need to reform, I had no idea what I was doing to our already overworked correspondence staff. Today, more than 700,000 letters later, I am happy to be able to join Hillary and Al and Tipper in welcoming a few of you here who wrote to us.

In the weeks and months ahead, health care will often be topic number one at dinner tables, at offices, at medical clinics, and in the halls of Congress. But before we launch into the debate I wanted to invite you here to remind everyone that, as Hillary says, there are 250 million health care experts in our nation and everyone has a different story.

If you read some of these letters as I have, the picture very quickly becomes clear. Even the millions of Americans who enjoy health care coverage are afraid it won't be there for them next month or next year. They want us to take action to give them the security that all Americans deserve. Let's start then with four people whose stories speak volumes about our health care system.

In order, they are Jermone Strong, Nelda Holley, Stacey Askew and Margie Silverman.

Q Mr. President, Mrs. Clinton, thank you very much for the opportunity to speak this morning -- Vice President Gore, Mrs. Gore. I really appreciate the opportunity to be with you this morning and share my experiences with the health care conditions within this country. And I'd like to take an opportunity to thank the University of Michigan Medical Center, who yesterday morning prepared me to come to this trip today so I could be with you today.

I am the beneficiary of the advance of medical technology. I received a liver transplant in August of 1991. This is a story, but not the story. Prior to my surgery, I had become very ill with liver disease and had to take a medical leave from my job in order to have the transplant.

Several weeks after surgery I received a registered letter from my employers at the Michigan Department of Management and Budget informing me that they could not extend my medical leave. Needless to say, I panicked. I was informed that the state would not let me take -- would let me take a special year leave, but if my condition was not to permit me to return to work at the end of that

MORE

year, I would be terminated. My only option was to take a nonduty disability retirement.

I am now 45 years old and unable to work in a taxpaying position. My wife has been forced to turn down several career advancements because I am covered by her insurance. The state policy will not allow both of us to have coverage. We're living primarily on my wife's salary. My Social Security income does not begin to cover the cost of my prescription and medical co-pay charges.

Q I'd like to thank the White House for the opportunity to be here today. My husband is a church minister in a mid-sized town in Mississippi. Until five years ago, I taught school, having 16 years of experience. We have two daughters and a 13-year-old son.

Five years ago my husband was on the staff of a large church in Atlanta. We lived in a church-owned house in an exclusive section of Atlanta. I taught school, we had our three children at home, and we were a normal family. I drove a new car. We sent our children to orthodontics, took them to the doctor when necessary, gave them allergy treatments or whatever else was required. We took those things for granted. After all, we had not one, but two family health insurance plans, one with each of our jobs. There was little that our insurance did not pay and we were glad to cover the difference.

Then I was diagnosed with lupus. I taught as long as I could manage, until I finally could work no longer. We moved to Florida and then to our present location. Our lives are very different now. We live in an apartment with no hope of owning a home. My husband drives what used to be our second car. And I drive a 20-year-old car we bought secondhand when we had to choose between keeping the family car and keeping my health insurance. We chose to keep the insurance.

Today I got a notice from Blue Cross that my policy is going up to \$558 a month. My husband and son have another policy which is \$300 a month. Because of the \$1,000 deductible on my own policy, I often delay buying medication that I need -- one in particular that my doctor told me to mortgage the house if I had to in order to get it -- in order to pay my insurance premiums.

My husband makes \$36,000 a year. This year's medical expenses were almost \$11,000 and would have been higher if I had taken all my medication. This family will hold on to its insurance coverage as long as possible, but the day may be coming sooner than we had feared that it will not be possible, because over the last two years the increases in our insurance premiums have reduced our standard of living even more.

I think you get the picture here. We are a middle class family, but we have no hope of living in our own home, no hope of getting ahead. We doubt we will be able to stay even. I have no retirement because of moving around. My husband is not able to pay into his own retirement right now.

I try not to dwell on this as there is nothing we can do to improve our situation. Choosing between medication and insurance premiums is a hard choice, but next year we might have to make tougher choices than that.

Q Good morning. My name is Stacey Askew. I live in Flushing, New York. I recently graduated from the State University of New York at Buffalo, and I'm currently seeking a full-time job. As a student I was covered by my mother's HMO and had on-campus insurance at a nominal charge. But I lost both of these when I

ceased to be a full-time student. I have been in New York City for the past two months, not only away from home, but also uninsured.

I cannot afford an individual policy with a health insurance carrier, and will have to wait until find employment to qualify for a group policy. I have been informed that the job search process can take from six months to a year. It seems like a long time to wait and worry that I might be in an accident or get taken to the hospital or that I might get sick and need attention. I don't mean to be overly emotional about my situation, but it's a terrifying prospect that I might be refused care.

Q My name is Margie Silverman. I'm from Miami, Florida. Dear President and Mrs. Clinton, two years ago my only daughter wanted a change in her life and moved from her hometown, Miami, Florida, to northern California. She was 28 years old at the time. She was successful in being hired as a junior high school teacher. She was content with her life and elated about teaching. She loves the kids. This past spring she began to have a medical problem and was diagnosed as having a large fibroid tumor. She was advised to have a hysterectomy. The fibroid was removed and she was then told by her doctor that the fibroid was malignant and that she must have a complete hysterectomy. This was done.

As you know, this makes her uninsurable by anyone other than her current provider of insurance, Kaiser Permanente. Their coverage can only be had at one of their own facilities. And they have no plant in Florida.

My beautiful daughter is alone in California. Her loving family is here in Miami. She wants to come home where she can have the support of many cousins, aunts, uncles and, above all, her parents. She really needs us and we need her to be near us. I stayed with her in California for five months and returned home only recently. We can't move there because of the expense. Both my husband and I are living on Social Security and whatever savings we accrued over the years.

Mr. and Mrs. Clinton, you have only one daughter, you understand. Please help my daughter to be able to get insurance wherever she goes so she will not have to be alone anymore. Thank you.

THE PRESIDENT: These letters are representative of tens of thousands that we received telling stories like the one you've heard -- people who can't go back to work, people who can't take job advancements, people who have no coverage because they're young and they're unemployed -- all the other things that you have heard here.

There is one particular problem in our health insurance system in America that I'd like to focus on by asking for two more people to read letters -- something that's a part of the everyday vocabulary now of most working men and women in this country: the preexisting condition, the thing which if you have it you either can't get health insurance or you can never leave the job you're in. So I'd like to hear from two people from California and Illinois -- Suzy Somers and Jean Kaczmarek.

Q President Clinton and Mrs. Clinton and the Gores. I'm Suzy Somers from California. Please help. Having breast cancer and a partial mastectomy was bad enough, but not horrible because I'm proud of my reconstruction and thrilled that my tummy is now looking much better as a breast. (Laughter.) Having had to endure chemotherapy for six months was bad enough, but not horrible because I gained the wisdom, strength and courage from the ordeal -- oh, yes, and a great collection of hats. Having to take Tomoxophin for an undetermined length of time is bad enough because it accelerates

menopause and causes hot flashes, but not horrible because I met and laughed with hundreds of women as I fanned myself in public.

But losing my health insurance and being unable to find full coverage at any price is horrible. I was insured by my ex-husband's company policy. When his company filed for bankruptcy, it enabled the insurance to immediately place me on a convergent policy. Twenty five thousand dollars will last me four years if I remain totally healthy, cancer free and only require testing and drugs.

In searching for coverage, I have been told: We will never cover you; or you must be cancer free for at least five years before we will consider your application; or you must be treatment-free for two years, at which time you may apply to have the waiver concerning preexisting conditions removed. After numerous questions I came to discover that treatment free meant no Tamoxifen, no oncologist's checkups, no bone scans and no other X rays except mammograms. This is incomprehensible.

I presently own my own company, and after 10 years am faced with giving it up in order to slip into the system of a large company. The other possibility is remarriage to a person working for such a company. Are these options? (Laughter.) I am a one-and-half-year cancer survivor who is doing everything medically, physically and mentally to remain cancer free. However, I need the peace of mind that I will be financially able to fight this disease if it should ever recur.

And there's a footnote. I would like you to know that my insurance situation remains the same, and last week I found another lump.

Q I'm Jean Kaczmarek from Glen Ellen, Illinois. Most people wouldn't look at us as needing or even thinking of health care reform. We live in a \$200,000 home in an upper middle class suburb of Chicago. We appear to be living the American Dream.

Last year I gave birth to our first child. It wasn't easy getting her here. Nearly seven weeks before her due date I developed preeclampsia. A nine-day hospital stay for me and some \$25,000 in bills later, we were blessed with a healthy, beautiful daughter. My delivery was normal. Our daughter required little post-natal hospital care, and I've learned that it's unlikely that I'll have preeclampsia again.

We didn't realize that we had a health insurance problem until recently when I lost my job. Because COBRA costs are very high, especially if you're unemployed, we began investigating other insurance plan options. So far companies are eager to do business with us as long as I have no more complications in pregnancy. This one illness seems to have excluded me from all other unrelated complications.

Now we find ourselves stuck. Do we continue with COBRA until the 18-month limit and try to give birth to a second child in the meantime? Or do we go with another insurance company later and gamble that nothing will go wrong? Or perhaps I would be wise to not consider having a much wanted second child. None of these options appeal to us.

MRS. CLINTON: Well, I want to thank all of you for having read those letters. You know, as the President said, we have been getting samples of those 700,000 letters every week to read, and I don't think there's been an issue that has come up with more frequency than this whole problem of people being eliminated from health insurance or being charged so much that they can't afford it, as the ones that we just heard about with the preexisting conditions. And it relates back to your daughter being locked into her job and

not able to move, and the problems you have with lupus, and the fact you can't go back to work, and all of the other issues that have already just been discussed.

I didn't know much about this when my husband asked me to start working on it, and I really did not believe that the kinds of life decisions that we've heard about -- whether to have a child, where to go to work, whether you can be with your daughter -- would be affected by health insurance. I have just been amazed by that. And it is so wrong to me that something that people try to do for themselves, to get their insurance so that they can insure against the possibility of being sick, would be taken away from them because they ever had been sick. I never could figure out why insurance companies only wanted to insure people who had never been sick or never would get sick. I think that eliminates everybody.

So what we hope is that we will come up with a plan for our country that guarantees health security, health insurance security, to every single American no matter who you are, or where you live, or who you work for, or whether you've ever been sick before. That seems to us what we ought to do if we're really going to have an insurance system in our country that works for everybody. (Applause.) And no matter what finally happens in all of this debate that going on in the country, we have to eliminate preexisting conditions and all that goes with it. That has to be done.

THE PRESIDENT: Let me just say one thing about this to try to hammer home what I think is a very important point. All the stories you've heard today have nothing to do with the quality of American health care, but everything to do with the system of insurance we have. And in the weeks and months ahead you may hear a lot of stories about that, but the bottom line is this: If you lived in any other advanced country in the world you wouldn't have this problem. None of these problems.

But it's not a reflection on our doctors, our nurses, our health care providers, it is the system by which we insure against risk. It can be different.

I want to go on now to the next issue, because every time I say this people say, well, how are you going to pay for this, this is going to cost a fortune. I have an answer to that, but I want you to -- I want to hear from people who are talking already about the exploding costs of health care in this country.

Next to the problem of security, we hear more about cost. And, of course, Miss Holley talked a little bit about costs, and some of the rest of you did, too. But we have some people hear who want to read letters. They're from Georgia, Pennsylvania, and California -- Karen Nangle, Mary Catherine Flyte, and Brigitte Burdine. Would you please read your letters to us, or say what you'd like to say?

Q I'm Karen Nangle, from Savannah, Georgia. Our daughter was diagnosed with clinical depression 11 years ago when she was 16 years old. Under the care of a psychiatrist in Connecticut, and clinical social workers in Massachusetts, where she was in school and now lives, she was able to complete high school and college successfully.

Until recently, we were able to pay for here psychotherapy, acupuncture and medications while giving her enough money so that she could live independently with the part-time job she holds. Her goal is to be able to support herself by herself.

During the past 11 years, when I was working, we paid her insurance premiums even though her insurance covered only a small fraction of her medical expenses. Now, I have lost my job and my

husband and I have moved to Georgia, where the cost of living is lower. And although we had hoped to be able to retire, we are both looking for jobs. Because we can no longer support our daughter, and because her clinical depression constitutes a disability, she applied for and was accepted for supplemental security income. Her psychiatrist in Connecticut and her psychotherapist in Massachusetts filled out the application on her behalf.

The hitch is that her coverage does not allow her to see out-of-state doctors or therapists without medical degrees -- the very people who wrote on her behalf and have been treating her all this time. They want her to find a new doctor, although switching to a new doctor is not cost-effective and would slow the progress she is making.

Her team of doctors has enabled her to finish schools and begin to work and live independently as an adult while slowly reducing her medication. Treatment by a new doctor would cost the system many thousands of dollars more a year than the treatment she is successfully receiving.

Our daughter is bright and motivated. She yearns to be part of the American Dream, to be medication free, have a self-supporting job, and save for a house. But her disease and the health care system she finds herself caught in prevent her from doing so. She wants to contribute to the system, not be a drain on it. There is no way to describe the anguish and heartbreak we have felt over the years, let alone the humiliation of having to apply for assistance only to find that it is hamstringing.

Q Mr. President, I'm Mary Flyte, from Pennsylvania. I'm a registered nurse with over 15 years of long-term care, home care, and nursing home care experience. When my mother was recently struggling with cancer, I took an extended leave of absence from my job to assist my father in her care. She had fought the disease for over three years, but became bedridden in October of 1991. My father at 73 could not care for her along. They lived in Romney, West Virginia, a small town with only limited home care and nursing home care.

I was very fortunate to have employers who were sympathetic and allowed the leave without jeopardizing my position. I was able to use my vacation, personal days and sick leave, but my paid days off were quickly dwindling. I needed to return to my home in Pennsylvania and to my job. I was a single mom with a daughter in college.

I looked into home care. We could find no services that would provide it for the length of time needed. I was becoming concerned about my father's health. I called nursing homes within 100 mile radius of their home; there were no beds available, even though we would have paid private for her care. My father and mother were living on Social Security and a small VA pension. My mother's treatments and medications were exhausting their small savings. Their savings made them ineligible for assistance, so they were willing to use their life savings for her care, but there was no care to be had.

Mom had to be admitted to the small local hospital for dehydration. Her physician was very caring and recognized our problems. After mom was stabilized, she could be transferred to their skilled long-term care unit under Medicare if she had a feeding tube put in; that would qualify her for coverage. We were faced with keeping her alive with a feeding tube and having part of her nursing home care stay covered by Medicare, or taking her home to die slowly by starvation. And I had to return home.

We decided to have the tube put in, and I went home. My mom died in January of 1992. I was fortunate enough to be with her. My father is now faced with having a potentially life-threatening operation. We have started to take care of some things. I have medical power of attorney. We went over his will and insurances. We even discussed his funeral. He refuses to go to any hospital other than a VA. He saw what mom's bills were. He wants to leave what little money they have left to my sister and me.

I understand there are no easy answers, but we must continue to give the decisions to the individual. And those decisions cannot be based on who will be paying for the care or if the care is available. Papa's lucky, he has the VA and a daughter who's a nurse, and a little savings to help her out with her bills when she takes her unpaid leave. There are many others who are not so lucky.

Last night I called home. My father in West Virginia will be transferred to a VA hospital here in Washington, DC. If they want to do it, the surgery will take place a week from today. And I live in Pennsylvania, but I want to be with him.

Q Good morning, I'm Brigitte Burdine, and I'm from Van Nuys, California. My 22-year-old sister, Heather, is a single mother who works in retail earning \$7.35 an hour. She and her two-year-old daughter, Chase, live at home with my parents in Maryland. After a year ago, Heather became ill and eight months later was diagnosed and being HIV positive.

She has since been diagnosed with full-blown AIDS. As soon as her insurance company was made aware of her diagnosis, they stopped paying her claims while the conducted an investigation that they hoped would prove she had a preexisting condition so they wouldn't have to pay anything.

Meanwhile, her bills are piling up. The cost of her doctor's appointments are as high as \$700 per visit. Medical tests are \$300 each, and the cost of prescriptions and nutritional supplements are astronomical. In addition, she has had to seek legal advice concerning the insurance issues and her daughter's future.

My parents have decided to adopt her daughter in case my sister loses her insurance. So far her employer has been very supportive. However, we fear that my sister will be fired or laid off because the insurance company will likely threaten her employer with higher insurance premiums.

Even if this does not happen, she will have to stop working in the near future due to health reasons. She shouldn't even be working now. However, if she quits, we're not sure how long she'll be able to hold onto her health insurance because of increased costs and lost income.

She's already had several HIV-related illnesses and, of course, more hospital and medical bills. How anyone making \$7.35 an hour, who also has other heavy financial obligations -- how is somebody supposed to pay those costs under those conditions.

To make matters worse, her two-year-old daughter is also HIV positive. While we were writing this letter she was hospitalized with pneumonia.

I have many friends who have found themselves in a similar situation to my family's. Caring for a person with serious illness takes time and enormous amount of money. I often get angry when I think of our health care system and how a person with insurance may be cancelled at any time or services disallowed.

My sister not only faces high medical and legal expenses, but the high cost of her prescriptions, which already run close to \$6,000 per year. I understand from my research that it could eventually reach \$36,500 per year.

When somebody becomes chronically ill with a life-threatening disease, there's no way that the average middle class family can afford proper medical care without seriously compromising their standard of living. My parents love Heather and Chase as much as any other parents in this country love their children and they would do anything to keep them alive, including being forced into poverty. This is not fair. No one should be refused topnotch medical care in this country because of financial reasons, and when someone becomes chronically ill it should not be allowed to wipe out their entire family financially.

I just wanted to say thank you for caring. Your efforts really are appreciated greatly. (Applause.)

THE PRESIDENT: Thank you.

Tipper?

MRS. GORE: Well, thank you for sharing those stories. You know, the one thing that you have in common and you represent for so many other Americans is that each of you women have been taking care of members of your families with the added burden of skyrocketing medical costs, worrying about how you're going to pay the bills. And as you said, Brigitte, that is absolutely not fair; it's not just. And that is something that the Clinton health care plan is going to address.

Now, Karen, as you know, I have a very personal interest in mental health care and I'm proud to say that this administration is going to include mental health benefits in the health care benefit package. And I think that it's going to help situations like yours and your daughter's, so that she will be able to receive treatment and care and live a happy and productive life. That is certainly her right, and it's the right of anyone afflicted with a mental disorder. And this administration is taking revolutionary steps in order to bring mental health care the justice that it deserves.

You're a nurse and, in fact, you are a part of the backbone of the medical profession that is a part of health care reform. I certainly admire you and what you do, and I know in the future we're going to be relying even more on what nurses can give those of us who are in need of health care.

You referred to the need for community health care and at-home services. That's something that Mrs. Clinton and the Health Care Task Force has heard about, and the Clinton plan is going to include more home-based health care. Because it's cost-effective, it makes sense to be able to care and treat people and allow people -- family members -- to help their own family members that are ill in their home. It's going to cost less and it's more humane, as you have pointed out.

And there's going to be cost-effective incentives built into the system in order to create even more community-based care. That's our hope.

And for you -- thank you for sharing the story of your sister. And I know it's very painful. Many American families are dealing with the tragedy of mental illness, of cancer, of AIDS and other health-related illnesses. One thing that could help your sister and others that are dealing with AIDS is simply the reduction in paperwork. One thing that the Clinton plan will include will be a standardized form and a reduction in the regulations that the doctors

and the nurses who want to be taking care of AIDS patients have to spend their time doing. So it may seem like a small thing, but it actually will take a -- make a big chunk of savings.

We wish you all well, and we want you to know that the Clinton health plan is going to be based on cost-effectiveness and consumer choice.

Thank you. (Applause.)

THE PRESIDENT: I wish I could say something to each of you, but I don't want to -- I want to hear the other letters. But let me just say one thing to you Karen. One of the things that really has upset me now that I am at least nominally in charge of the federal government -- I say nominally -- is how many programs, like the supplemental security income program, were designed with the best of intentions, but because we have this crazy little patchwork health care system, with a little done here, a little done there, a little done the other place, a system that was designed to help your family is actually wrecking your health care plan and one that works, and costing the taxpayers more money to boot. That's one of the things that we think, just by rationalizing the system, we can handle.

One other thing I want to say to you, Brigitte. I want to make it clear, there will be some difficult choices in this decision, but let's not kid ourselves there's a lot of waste in this system which we can squeeze out. But there will be some difficult choices, and your family represents one. And I want to just try to describe this to you.

Most countries that insure people, either directly by tax dollars or indirectly, as in Germany, through employers, and more and more American states that are looking at this are looking at something called community rating. Hawaii has had it since 1974 -- where 98 percent of the people in the work force are covered and they have lower than average overall premium, but it's because they put all people in big, big insurance pools.

Now consider this, in the case of your family, how much better off your family would have been if your sister could never lose her insurance, certainly as long as she was at work and then if she wasn't she'd be picked up under a general system; even though she got sick her employer would not have to worry about going broke by covering her under the insurance because he would be -- he or she and all the employees would be in a big, big pool, say, a couple of hundred thousand people -- so if one person gets AIDS it only adds marginally to the cost of this big pool. Same thing with you.

Now, I just want to tell you what the tough choice is. The tough choice is that someone like you in the same pool, because you're young and healthy and strong and unlikely to get sick, might have to pay a little bit more in insurance premiums so that everybody in the big pool could always be covered and no one would be kicked out. I think most young, healthy, single Americans would be willing to do that to avoid the kind of horror stories we've heard today. Same thing would have helped you.

But I do want to say, there will be -- there are a lot of things that can be done to this system, but I don't want to kid you, the American people will have to be willing to make some changes. And this is one change that we think most young Americans would like to make -- to know, because they are all presumably going to be older some day, or going to be sicker some day. And that is one thing that I think we've just got to do. If we were all in these big pools then you wouldn't have had half the problems you had and your family would be better off.

Let's go to the next issue that nobody in America understands this -- the crisis of American health care more than small businesses. Small business owners often have the worst of both worlds. They want very much to cover their employees, but they can't afford the coverage, again because they can't buy into large pools. Their premiums are much, much more expensive. So you have this situation where a lot of small businesses don't cover their employees. Then when they get sick they don't get care until they are real sick and they show up in the emergency room, or they provide coverage but the deductibles or the co-pays are astronomical -- often as much as \$2,500 a year.

So I thought we should hear from a couple of people who can share their stories. Mable Piley, from Kansas; and Karl Kregor, from Texas.

Q Good morning Mr. President and Mrs. Clinton, and Mr. Vice President and Mrs. Gore. My name is Mable Piley, and as the owner of a garden shop I am especially pleased to be here in the Rose Garden this morning. I was afraid the rain might drive us inside. It is my hope that all of you are able to come here alone from time to time to kind of escape the pressures of the day and enjoy the beauty and the aroma of the flowers here.

Now to my letter. I am 59 years old. My husband is 61 years old. We own a small retail garden shop in a small town in southeast Kansas. We've had Blue Cross/Blue Shield since 1989. Our monthly premium in 1989 was \$243. In 1990 it rose to \$433. In 1991 it was up to \$558, and last year it had more than tripled to \$900 a month.

The only hospital stay during this entire time was a two-day stay for minor surgery. There was some outpatient testing as I have a history of bladder tumors and my husband also had a cataract removed from his eye and did have some complications from that.

As our annual income is modest, it is needless to say when the premiums went up to \$900 a month we were financially forced to make some changes in our coverage. I have since found new coverage for myself which has a \$2,500 deductible per year. This has forced me to stop out-patient testing on an annual basis for my bladder tumors. I was unable to find another insurance company which would cover my husband because of his preexisting conditions, so he has had to stay with Blue Cross/Blue Shield with a larger deductible. Our combined coverage is still costing over \$500 a month, though. And on top of that we are both on prescription drugs which costs us \$95 a month.

At this time in my life I have decided that whatever happens to me that is health related is really up to God as I can no longer afford the medical profession. My concern now is for my children and my grandchildren and sincerely hope that our government can do something about this runaway nightmare of a problem. Thank you very much.

Q I'm Karl Kregor, from San Antonio, Texas. And I know people whose health needs are more immediate than mine, and whose physical and financial suffering are tangible. I'm not a dramatic human interest story, but I'm probably in the majority if we think about people whose lives are being hostage to a kind of a medical and medical insurance blackmail.

I separated from my past employer in 1992. My separation package includes health insurance which will expire in June, 1994. I'm 55 years old. Since May '92, I've been developing a consulting practice and my hope is that I'll be able to make enough to afford insurance until I'm eligible for Medicare.

Meanwhile, my wife is also an independent business person and has been covered by my policy. Even though we are in good health, our ages and the insurance industry's loose definition of preexisting conditions makes me fearful of being able to get or afford insurance until we reach retirement age. Ironically, we have this gnawing fear about how we can handle future health needs. And that fear reinforces the anxieties that weakens people's health.

Maybe language like hostage and blackmail doesn't seem fair. But the economic as well as psychological consequences are just as real. Without secure medical coverage, no uninsured person feels free to help out their children and grandchildren as they start their lives, or pay for new training and education, or take investment risks, or spend for anything much beyond basics.

And I want to take this moment to thank my wife for having the courage to support my career change.

THE PRESIDENT: I feel the same way about my wife.
(Laughter and applause.)

First, let me thank both of you for coming. And let me say that this is another one of these areas where I think a chance can offer enormous hope and deal with the problems that you have outlined, but where we'll also have to take some disciplined different action that will require some people to do more. And let me describe that.

Most small businesspeople, both employers and employees and people who are self-employed, do have some kind of health insurance. But it often provides inadequate coverage or has astronomical deductibles, or in any case, costs a fortune. You heard -- you said that your premiums, I think, quadrupled in three years, from '89 to '92. Now, during that time the cost of health care was going up at about two and a half times the rate of inflation. But that would not lead to the amount of increase you had. You had that increase because you owned your own business and you were probably in a very small pool of people -- probably 100, 200, 300, something like that.

Under our plan, two things would help you. You would be in a very large pool with a community rating -- the same thing that would help your sister and family -- and also as a self-employed person because you'd still have to pay relatively more, you'd get 100 percent tax deductibility for your premiums instead of 25 percent today.

So it is almost certain that your costs would go down. It is certain -- your costs would go down. Under our system, what would happen to you is if you developed your own consulting business, you would become like Mable -- you'd have 100 percent deductibility for your premium and you'd be able to buy into a very large pool, just as if you were an employee in a company that had 5,000 people insuring its own employees.

Now, the flip side of that is, the only way we can make that work is for the small businesspeople today who don't provide any insurance coverage at all to their employees to make some contribution to the health care system and for the employees to do it.

Now, it will be better than the present system because we're going to lower premiums for small businesses by putting them in big pools. I just explained that. We also propose to provide a subsidy to keep the premiums even lower for several years for the employers that have low-wage employees and, therefore, are very low-margin businesses.

So we're going to try to help there. But you have to understand that all the employers in the country who don't provide any insurance to their employees, they basically are getting a free ride in some ways from the rest of you because if their employees or they show up at the hospital, it's there. It's just like driving on the road without paying a gas tax. I mean, the infrastructure is there -- the clinics are there, the hospitals are there, the tests are there, the nurses are there. And until everyone is willing to make some contribution to his or her own health care, and until we get all the employers in the system even at a modest rate, we won't have a fair system where we can apportion the costs fairly and we can keep everybody else from being overcharged.

So that's why -- that's one of the most controversial parts of this program. But it is true that a lot of small businesses simply could not afford to get into the insurance market today without going broke. That's absolutely true. And since most jobs are being created by people like you who are starting small businesses, we know we can't afford to do that. But it's also true that a lot of big businesses can't afford to hire anybody else and always work their people overtime or hire part-time workers because they can't afford health insurance premiums because they're paying too much.

It's also true that a lot of people who work for employers that have health insurance never get a raise anymore because all of the money is going to the health insurance premiums. So I think it is a fair -- again, it's not -- I don't want to pretend that this is all going to be easy, but it seems to me that it is fair thing to say everyone in America should make some contribution to his or her own health insurance. And all employers should make some contribution, but if they have a very low margin, we're going to subsidize them for several years while we work into this system.

And if we do that and give you 100 percent deductibility and you 100 percent deductibility and put you in great big pools, then more Americans will live without the kind of blackmail that you just outlined. I think it is the only fair way to work it. It's the only way any other country has solved this problem. And I don't think we can reinvent this wheel. (Applause.)

You've heard a little about this already because of the so-called preexisting condition problem, but there are literally millions of Americans who are locked into the jobs they're in. This is a very tough thing in a country where job mobility is important, and the average young American going into the work force will change jobs eight times in a lifetime. To be locked into a job at a time when many people who've lost a job here can tell you, you don't get that same job back, you have to get a new job, is a very, very hazardous thing.

Judy Dion and Shelly Cermak are here to tell us about this problem with our health care system that's come to be known as job lock. They're from Maine and Maryland. Judy and Shelly.

Q Good morning. My name is Judy Dion, and I'm from Saco, Maine, and this is my daughter, Jessica. My daughter, Jessica, was diagnosed with a rare form of Leukemia. The year that followed threw our family into unimaginable stress and disruption. After four months in the hospital where she underwent a bone marrow transplant, she came near death on several occasions.

Shortly afterwards we were able to bring Jessica home and the transplant was a success. In the year that followed, my family's insurance premium went from \$250 to \$900 a month. I could not leave my employment because my daughter was now considered uninsurable. After being trapped in this position for four years with minimal pay increases, the state of Maine developed an

assistance program that enabled me to move jobs but be secure with our insurance. This program is now facing termination.

Although Jessica's transplant was a complete success, she still has related problems. Our biggest fear is without insurance, will she be turned away for a serious medical problem because she has no health insurance. I feel that my daughter has been through a lot since she was brought into this world eight years ago. I only pray that it will not all end because she could not get the proper care because her health insurance was cancelled. And I'm also happy to say it's been seven years since the transplant. So she's doing very well. Thank you. (Applause.)

THE PRESIDENT: She looks very well.

Q Hello, my name is Shelly Cermak, and I'm from Baltimore, Maryland. And thank you for inviting me.

Multiple sclerosis is the most common disabling neurological disorder of young adults. There is no known cause or cure. Most often its first symptoms are experienced between the ages of 20 and 40, and it is characterized by an unpredictable course of remissions and relapses. I have MS. I am currently in remission and for the most part I am symptom-free. On the surface, I'm not the most sympathetic of figures since I am not in a wheelchair and I am able to maintain a fairly active schedule. But I am severely affected by the health care crisis.

I have a masters degree in molecular pharmacology, which has led me to a successful beginning career. My problem is that I do not have the same choices and advantages that my colleagues have since, according to the insurance industry, I am disabled.

As I am sure you are aware, in any successful career path, job changes are usually necessary for advancement. I am at a point in my career where my current job is not satisfying and with my skills and experience, I have a decent resume. I have been pursued by headhunters, so I know that my skills are marketable. I am scared to pursue potential job opportunities for fear of losing my health insurance, so my career is at a standstill.

Although I face a 30 to 40 percent chance that I will be in a wheelchair within 10 to 20 years, I feel I have many productive years left, possibly my entire working lifetime. I should be afforded the opportunity and feel I should have the right to pursue the possibility of a rewarding and successful career just like the next person.

THE PRESIDENT: We agree. And we don't think taking care of your beautiful, young daughter should keep you from ever taking a better job, either.

The bottom line on this is that if we change the rules so that no one can be denied insurance coverage because of a preexisting condition, we also have to change the system so that no business goes broke for giving that insurance coverage. In other words, we can't afford to cut off our nose to spite our face. We have to make it possible.

So what we -- again, what we hope to do is to give you the protection of knowing you can always have health insurance; that if you change your jobs, you'll be able to get it; that no one will be able to turn you down; but that your employer won't go broke, either, because they will be in these large pools so that the risk will be fairly spread across a significant percentage of the American citizenry. And it seems so simple. You must wonder why it hasn't been done before. But it's wrong not to do.

And probably this will affect -- this and the cost issue will probably affect more Americans than any other single issue, because a lot of you, even who have talked about other problems, are indirectly affected by this whole job lock issue.

Also, it affects you -- it affects everybody in all kinds of different ways. So we must do this. We must do this. And let me also say that it's bad for the American economy. Every healthy person in America is disadvantaged if you two can't take a better job. Because when Americans with talents and gifts can't fulfill their God-given abilities to the maximum extent, then that makes our whole economy less productive, less competitive. It hurts everybody. So it's not just all the people who have your life stories. All the rest of us are really disadvantaged if you get locked into a job. Also, somebody coming along behind you who would get that job and that's a better job than they have -- those folks are disadvantaged, too.

Let me just say in introducing the last set of letters that there are a lot of people in this system who are very frustrated by the incredible bureaucracy of the American system. It is the most bureaucratic system -- health care system in the world of all the advanced countries. The expense is staggering. It probably costs at least a dime on the dollar more in sheer paperwork than all competing systems. And we have some people here who -- that not only has financial consequences, it has terrible personal consequences. We've found some people here who have been lost in that maze and I wanted you to hear their stories.

So let me ask now James Heffernan from Florida -- I'm going to try to pronounce this right -- Carol Oedegeest -- close enough? -- from California, to read their letters, and the Vice President will respond.

Q Mr. President, it is a real personal pleasure to be here. Thank you. I am Jim Heffernan, Venice, Florida. I retired to Florida after working the majority of my life as a civilian with the U.S. government, Washington, D.C. -- gravy train. As a result of this employment, my wife and I are covered under Medicare. We also have supplemental insurance coverage under Blue Cross and Blue Shield, as well as cancer and nursing home insurance.

Each of the above mentioned medical insurance policies require separate and different applications for reimbursement for medical expenditures, each of which has to be mailed to different addresses. Even a bill for a \$15 prescription requires the completion of a form, an envelope and postage stamp if you want to get partial reimbursement.

This mountain of paperwork places an undue burden on older Americans who do not fully understand the mechanics of the complicated medical claim forms.

I am a volunteer with Hospice of Southwest Florida, and my specialty is to provide assistance to hospice patients in the filing of medical claims to the insurance organizations that they have been paying monthly premiums for the majority of their lives.

As you are undoubtedly aware, Hospice does not accept patients until the attending doctor certifies that the patient is terminal and has six months or less to live. As a consequence, a lot of patients in this physical condition are unable to cope with the multitude of regulations and paperwork to apply for and receive the reimbursements they have been paying for throughout their lifetime.

I can recall one patient who was in tears and shaking because a hospital in her hometown had placed the balance of her medical charges in the hands of a collection agency, who wrote to her

and said she may be sent to jail for failure to pay her hospital bill. I think this kind of senseless action on an elderly terminally ill is unforgivable.

I also was in the hospital for two weeks last November for prostate cancer surgery. I wish you could see the medical insurance file which accumulated during my hospital stay. It is nearly two inches thick.

Q I'm Carol Oedegeest from Sunnyvale, California. I had knee surgery several years ago where the hospital billed me for an astronomical amount. I turned the bill into the insurance company, but at the same time asked for a detailed accounting of the charges from that hospital. It turned out they had billed me \$2,407 for a pair of crutches.

When I reported this to the insurance company, I was told the bill had already been paid. Not satisfied with that, I called the hospital accounting department and was told exactly the same thing: the bill had already been paid. Did someone pocket that money? I never found out. The decimal point had obviously been misplaced, but where had the difference gone? How did they balance their books?

THE VICE PRESIDENT: That's a pretty good question. (Laughter.) We've heard about the \$5 aspirin. Now we've heard about the \$2,700 crutches.

As I was listening to both you, Jim, and you, Carol, I was thinking that there are probably thousands and thousands of doctors and nurses who agree 100 percent with what you, as patients within the medical care system, are saying about the unnecessary paperwork, bureaucracy, regulations, and unnecessary complexity, which adds so much money and so much hassle to the practice of medicine and to the experience of receiving medical care. And we've got to fix that.

Now, it's crucial to understand that one of the reasons the First Lady's Health Care Task Force has focused on simplifying the system is that the present system does not work. And one reason it doesn't work is that all of the insurance companies that are trying to serve their patients and at the same time make money are competing with each other to exclude people, to exclude conditions, and to shift costs over to other people, wherever they can. And their weapon in doing that is paperwork.

And you've now got a situation where doctors and nurses and hospitals have to hire more and more accountants and clerks and specialists in all of the different health care plans that they have to deal with. They have to figure out who is covered and who's not covered according to a thousand different rules and all the different plans that they deal with. They have to figure out who is the primary company providing the coverage and who is secondary. And there's a whole paperwork war about that.

They have to figure out what codes to use. They have to figure out what particular kinds of care will be covered under which plan. And they have to document it all extremely thoroughly. And it amounts to so much paperwork that it is now almost a third of the cost our country pays for health care.

We pay 30 percent more for health care than the people of any other nation on the face of the Earth. And most of the extra unnecessary cost is simply in the form of paperwork and bureaucracy. By having a standardized -- and Tipper talked about this earlier -- by having a standardized package so that everybody knows what's covered and what's not, so you get rid of all the paperwork wars between companies that want to sluff off coverage to somebody else;

get rid of all this effort to document whether a condition was preexisting or not -- and you talked about what your sister has had to go through in fighting off the effort to put her in one category as opposed to another -- we get rid of most of that unnecessary paperwork and bureaucracy.

And we free up the doctors and the nurses to do what they want to do. They're working miracles. The bone marrow transplant, the liver transplant, the miracles that citizens all over this country can talk about where doctors and nurses and other health care providers have worked miracles. We need to concentrate on that. And we need to concentrate the forces of competition on delivering a higher quality of care, not on seeing who can do the best job of excluding care, and who can do the best job of building up a mountain of paperwork to make sure that somebody else pays the bill. That is one of the principle achievements of the Clinton Health care plan. (Applause.)

THE PRESIDENT: Let me say that I hope all of you are familiar with -- at least have heard about the Vice President's brilliant report on reinventing government, and he's given us suggestions that will save the taxpayers \$100 billion over the next five years if we can implement them all and free up that money to reduce the deficit or invest it in needed programs. But the health care system needs that, too. And our strongest allies in this, I think, will be doctors and nurses.

To illustrate what he said, let me just give you two statistics with this nurse sitting here. The average hospital in America has clerical workers at four times the rate of health care providers in the last 10 years. Think about it.

Another thing. In 1980, the average doctor took home 75 percent of the money that came into his or her clinic. They just took it home. By 1990, that figure had dropped from 75 to 53 cents on the dollar, the rest of it going to paperwork. You wonder why the bills are going up? So this is a huge deal.

I also want to thank publicly, I think -- I've not had a chance to do this -- I want to say a special word of thanks to Tipper Gore for being such an active member of the Health Care Task Force and being such a passionate advocate for the interests of the mentally ill and the interest that the rest of us have in dealing with it in a more sensible and humane fashion. (Applause.)

And I'd also like to thank the First Lady for the work this task force has done, not only for receiving 700,000 letters, but for meeting with literally 1,500 different interest groups and involving thousands and thousands of people in the health care system itself.

In the months ahead, as we debate health care reform, you will hear numbers and arguments fly across America. I hope that this beginning will help us to remember that fundamentally this is about people, about all of you that have read your letters, about all of you who wrote us letters who are out here today whose letters couldn't be read. I invite all of you to speak to the members of the press who are here about your stories.

I just want to thank you for coming, and for having, particularly these people, for having the courage to tell us their personal story and to tell America their personal stories. We can do this -- we can do this if we recognize that even though it's complicated, we can work through it if we will listen to the voices of the real people who know it has to be better and different.

Thank you very much. (Applause.)

Carol Rasco
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THE WHITE HOUSE

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PRESS BRIEFING
BY
THE PRESIDENT'S SENIOR ADVISOR FOR POLICY DEVELOPMENT
IRA MAGAZINER,
AND MEMBERS OF THE HEALTH CARE TASK FORCE

September 12, 1993

The Briefing Room

3:35 P.M. EDT

MR. GEARAN: We'll have an opening statement on camera by Ira Magaziner, and then he will be joined here with Ken Thorpe, who is the Deputy Assistant Secretary for Health Policy at HHS; Nancy Ann Min, the Associate Director for Health for the Office of Management and Budget. After Mr. Magaziner's statement there will be no televised coverage of the rest of it, although it will be an on-the-record briefing.

Mr. Magaziner is a senior advisor to the President. We have a sheet on it. You will be provided paper on this. Why don't we, with all deliberate decorum, have Mr. Magaziner join us.

MR. MAGAZINER: Good afternoon. I'd like to thank you all for coming to what will be the first in a series of briefings on health care as we head towards the President's speech on September 22nd.

First, I'm sorry to announce that we've already lost a serious source of health care revenues that we'd expected. If we'd only had the good sense to charge for all the copies of the draft plan that are all over town, we probably would have solved all the financing problems.

Q What did you expect? (Laughter.)

MR. MAGAZINER: In the coming days and months we're going to hear a lot about health care. But before we get into it, I want to make a couple of points very clear. First, the debate is, first and foremost, about the American people and their health security. People are going to disagree on a lot of details. But we are going to stand firm on what the American people need, and they need guaranteed health security, comprehensive benefits, affordable health insurance that increases their choices and improves the quality of care.

Second, the administration is proud of the unprecedented consultations that we initiated back in January and are continuing. The draft proposal that is circulating around town is just that, it is a draft. And we are ready and willing to work with everybody who is committed to comprehensive health care reform.

Now let's turn to the numbers. At the very beginning of this process the President asked for a commitment that we have fulfilled. It was a commitment to undertake an historical attempt to bring together the best minds in the country to help us design a financing package for health care reform, and we have fulfilled that commitment. The numbers and analysis that underline the President's

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proposed plan for health security represent months of rigorous analysis which brought together analysts from various federal agencies for the first time. We brought together actuaries from various branches of government. We had an outside group of private economists and actuaries who audited the work that was done by that team from within the government, and they've examined and validated the costs and savings projections.

The cost and savings projections in the draft document are solid and we stand firmly behind them. These projections are credible and conservative.

Everyone, both inside and outside the administration, knows two things for sure: we have to get health care costs under control before they bankrupt our families and our nation, and we are not getting good value for our health care dollar today. Too many working Americans are losing their coverage every day, and coverage is eroding for countless more. And all Americans pay too much for their health care, and will pay much more if we do nothing. No American, even with health insurance today, can be sure that they will have health insurance at this time next year.

There is some misinformation out there about what people will pay under the plan and what they will get. Let's be clear about this. Under the President's health care security proposal the vast majority of Americans will pay less for the same or better health benefits than they have today. And they will have two things they don't have today: Number one, a full package of preventive health care services, including things like immunizations, mammograms, and yearly physicals. And number two, the guarantee that your health insurance will never be taken away no matter what. If you lose your job, you're covered. If you move, you're covered. If your child gets sick, you're covered. And if you want to start a small business, you're covered.

The President believes, and he has said this since early in the campaign when he made his commitment to health reform, that it would be wrong to propose a broad new tax on the American people to pay for the waste and inefficiency that riddles our health care system. We must control the growth of health care costs, and that is exactly what our proposal will do.

Here's the bottom line: The government is going to set the standards, guarantee high-quality affordable care, and then get out of the way.

Today's system has too much insurance company red tape and government regulation. When somebody goes to the hospital, the bill is checked by checkers, and then by other checkers, and then by other checkers. It's wasteful and it doesn't do anything to improve the quality of care. Our plan will mean less regulation of doctors and hospitals, leaving them to concentrate on practicing good medicine instead of having to worry about filling out thousands of forms every day.

Is there some area of more government regulation in this plan? Sure. There is regulation of the insurance industry. The insurance industry has run roughshod over consumers for too long in this country. Our plan makes it illegal for insurance companies to refuse to cover people with preexisting conditions; illegal for insurance companies to raise your premium or drop you if someone in your family gets sick; and impossible for insurance companies to continue to charge small businesses 35 percent more than they charge large businesses.

Today there's no competition in the health care market. Insurance companies can charge you whatever they want for health care and you have to pay it. The President's health security proposal is

built around putting consumers in the driver's seat and forcing health plans to compete for customers by bringing costs down and improving the quality of care.

Finally, in response to stories that appeared today, let me make a few points. First -- and let me be very clear about this -- the administration is not considering a tax on hospitals in order to pay for this reform. There have been no discussions of such a thing since May when we were considering every idea that was presented to us. And any suggestion to the contrary is absolutely untrue. We feel that hospitals must remain the cornerstone of our health care system and our plan fully recognizes their critical role.

Second, one report today contained some misinformation about what individuals will pay under health reform. Employers can continue to cover 100 percent of the employee's premium if they so choose, and employees will not be required to pay more than 20 percent.

Third, there is misinformation about changes in Medicare. Medicare will remain the federally-run program for seniors and disabled that it is today. Medicare cost growth will be slowed. However, even with slower growth, Medicare spending will increase at roughly twice the rate of inflation over the decade, and Medicare recipients will get new benefits -- prescription drug benefit and help on long-term care.

Thank you very much. And now we'd be happy to answer any questions that you might have.

Q For my readers who live outside of Washington and don't understand policy wonk talk, can you explain to us how you're going to pay for this?

MR. MAGAZINER: Yes. We're paying for it, first, by savings as we bring the growth in health care costs under control. Secondly, we're going to be imposing some type of sin taxes on tobacco and perhaps something else.

Q What is that --

MR. MAGAZINER: We're not sure yet. And we also are going to ask that employers and individuals all make a contribution towards their health insurance and the health insurance of their employees. That's the fundamental funding mechanisms.

Q On the sin tax, can you talk about what range you're considering on cigarette taxes?

MR. MAGAZINER: That is one decision that is still not made yet -- is the final composition of the sin taxes.

Q But you have a range there.

MR. MAGAZINER: We have a range, but I'd rather not get into it until we have a specific formulation, which we'll have this week -- later this week.

Q Could you explain a bit about the Medicare situation? That seems to be one of the big concerns, that it's impossible to slow the rate of Medicare growth at the rate you're proposing without gutting the program certainly in terms of hospitals that are largely Medicare dependent. And some of the people who are really credible that have seen your numbers tell you that this is basically -- it's a joke. What's the answer?

MR. MAGAZINER: Well, I think, first of all, we've had hundreds of experts from around the country who have been working on

this plan and who have developed the Medicare piece of it in consultation with Medicare experts at HHS and in the Congress. I think the rate of growth that we are looking for in Medicare will still be twice the rate of inflation; that it will be accompanied by a slowing in the rate of growth in the private sector as well, so that there won't be the kind of cost-shifting problem that we often run into.

In addition to that, the slowing of the rate of growth actually benefits beneficiaries considerably because it slows the rate of growth of the premiums they have to pay. Further, for the hospitals that have a large share of Medicare and Medicaid people, there are a number of features in our program which divert new funds directly to those hospitals to support them.

There is what we call an essential provider provision that means that they will receive extra funds from the federal government. Also, those are the very hospitals often that are going to receive the best benefit from universal coverage because they tend to be hospitals that treat a high proportion of uninsured people -- hospitals in rural areas or in poor urban areas. So we have taken special recognition of those hospitals that would be affected in this program and there will be additional funds for those hospitals.

To say one other thing about the Medicare savings -- there are other proposals that have been made on health care reform in the Congress which actually would call for bringing the rates of Medicare and Medicaid growth to an even sharper reduction than what we're proposing. If you look at the McDermott-Wellstone bill, the single-payer bill, they actually bring the whole health care system to a growth rate of about GDP in '95 or '96. The Stark bill that's been proposed does it in '98. Our bill does it about '99. And even then, Medicare is still growing faster than GDP, although the private sector is a little bit slower. So we think that we've been conservative in estimating the slowdown in rate of growth.

DR. THORPE: I guess the only other thing I would say is to put the Medicare savings in some perspective. You've all seen the five-year summary numbers, which have been reported in various places at \$124 billion. And I think the thing to keep in context is that over the five-year period, that's off a base of over \$1.4 trillion in Medicare spending. So if you put it in a context of what these numbers are in terms of the Medicare program, summing them up over the five years, you'll see that this is something only on the order of about eight or nine percent.

Q -- in the real world, what is this going to mean to doctors and hospitals? Where are we going to -- what is the hospital of the year 2000 going to look like, or doctor's fees in relation to today? Where is this all going to come out of?

MR. MAGAZINER: Almost everybody that we have talked to this year who has had experience with the health care system, whether it's doctors, nurses, clerks, patients, all know that there's tremendous waste in this health care system. The paperwork is enormous; the unnecessary tests that take place; the fact that you can look at two different hospitals in the same state of Pennsylvania and one charges \$80,000 for the same operation that another charges \$20,000 for and there's no difference in outcome, as has been demonstrated in study after study.

Almost every study that's been done indicates tremendous waste in this system. And what we need to do is try to get that waste out, because it would be unfair to ask the American taxpayer to raise some type of broad-based tax to continue funding that type of inefficiency.

Q What happens to doctors' salaries, for example, or incomes and hospitals' margins which they say are already -- a lot of them taking --

MR. MAGAZINER: Well, hospital margins vary. Some of the hospitals that serve underserved areas and rural areas or urban areas do have profitability problems, and that's why we're taking special note in directing new funds their way. But there are also many hospitals in the country that are doing quite well and we think that as long as hospitals can become more efficient, they'll continue to do very well.

Q Doctors?

MR. MAGAZINER: Doctors the same way. Doctors' incomes have been going up much faster than everybody else's in the country for quite a few years. If they can become more efficient in the new system they'll continue to go up faster. But if they can't, then they might see a slowing in the rate of growth of their income.

MS. MIN: The level of spending on Medicare for physicians will still -- the level of spending on Medicare for physicians will still be growing at twice the rate of inflation. And the level of Medicare we'll be spending on providers will still be growing. We're just talking about reducing the rate of growth.

Q Will doctors want to see Medicare patients under the schedule that you're proposing?

DR. FEDER: What relates to that issue is some of the people -- when you look at Medicare in isolation and people have talked about constraining Medicare costs without constraining the rest of the system, Medicare faces a real problem. It's always playing catch-up and its patients are fighting for access with out patients. Now we're talking about doing this as part and parcel of a reform which creates greater equity as well as overall constraint.

Q Ira, one of the things that seems to have surprised some people is the number of new commissions and boards and the likely size of the staff underneath the national health board. Gradison, the former congressman who now represents the health insurance industry, said on TV today, he predicted that that staff for the national health board would create as many jobs as Vice President Gore's reinventing government effort would cut. (Laughter.) What do you think there's a need for a staff?

MR. MAGAZINER: Well, that's a good line, but it's inaccurate. We think that the national board is primarily going to be playing an oversight role. It's not playing a regulatory role. We don't anticipate that it will have much of any staff. The actual work that will be done on, for example, new research on quality and that type of thing, would be done in existing departments of the government, not in the national board.

Also, we are looking for a system that would be flexible at the state level and primarily a state system, not a federal system.

Q This is the board is going to negotiate with all the alliances and enforce the budget and is going to have very little staff?

MR. MAGAZINER: No, it doesn't -- I mean, initially, it will approve as a board of directors might the state plans. But it's not going to have a large staff that does that work. That work will be done elsewhere. It's basically like a board of directors type operation, not an operation with a lot of staff. It won't be involved in any kind of detailed negotiations. What it will do is to

do things like make recommendations on updating the national benefits package and that kind of thing.

Q What's your target date for universal coverage?

MR. MAGAZINER: It depends on the state. What we're looking for and expecting is that some states will be ready to come in to the new system in 1995; probably the bulk in 1996, and maybe some others in 1997. But we're saying that 1997 should be the outside date for all states.

Q The end of '97?

MR. MAGAZINER: That people should be enrolled by the end of '97, yes.

Q -- parity between states?

MR. MAGAZINER: Well, there's not parity today in terms of prices, if that's what you mean. Today the -- in fact, even within states, you can go to Miami, Florida, or Tallahassee, Florida, and see dramatic differences in the price of insurance premiums or the cost in hospitals. And across states, there's dramatic differences.

What we're going to try to do is over time -- we think as more information is made available, those costs will begin to come together. But initially we're going to start out where states are.

DR. FEDER: But the key is that with the exception of these couple of years, everybody is in. In that sense, there's parity; everybody has got universal coverage.

Q Ira, have you done any analysis on the overall impact on the economy -- I think medical care is about one-tenth of the overall economy. And how do you answer those critics who say this is going to be a major job loser when you force employers to pay for medical care?

MR. MAGAZINER: First of all, we have done economic analysis and we're completing some additional studies now that we're finalizing the plan. And health care costs now take over 14 percent of the GDP. And if we do nothing, they're reckoned to go up to almost 19 percent of GDP, even without insuring one more person. So they eat up over two-thirds of the increase in GDP per person, and over 120 percent of the increase in workers' wages if we do nothing.

There has been a hidden tax on American companies in this country for decades, and that hidden tax is the rapid rise in health care costs, going up twice or three times as fast as wages and eating up money for investment, eating up money for wages. What we are going to do is to bring the growth of those costs under control so that workers can have wage increases again and so that companies can have capital to invest.

On the jobs issue, let me be clear about this: If all we were to do was to impose a mandate for employers to pay health insurance tomorrow, it would cost jobs. But we would not propose that and that is not what we are going to do. What we are doing is changing a whole system so that, yes, employers that now don't contribute to health insurance will be asked to do so, although small firms will have a significant discount and it will be phased in. However, we're also slowing the rate of growth and lowering costs for many other firms, including the majority of small firms who do provide health insurance. And when you reduce the cost that a company has to spend on health insurance, that frees up money to create new jobs. And since most small companies now provide health insurance, and in the preliminary analysis we've done the fastest

growing small companies now provide health insurance, we think that there's going to be a net benefit.

Q The administration has said it's willing to revise this plan based on consultations with Congress. What are you willing to yield on? What are you not willing to yield on? Will you change the Medicare-Medicaid savings projections? Will you change the composition of the sin tax based on what you hear on the Hill?

MR. MAGAZINER: Well, there are many principles -- and I think the President will enunciate this in his speech more eloquently than I can do for you today -- but there are many principles upon which we won't compromise. We want health security for all Americans. We want affordable health care. We want to simplify the system and various other things.

However, we don't believe that we have all the answers. We're not coming down from the mountain with the tablets and expecting that we have all the answers. And so as people have better ideas on some of these things we're willing to be flexible on how to achieve the principles and the goals.

Q Including financing?

MR. MAGAZINER: Aspects of financing, potentially, yes.

Q When you said you were opposed to a broad-based tax, that that would be unfair to the American people now, would that be something you could compromise on with Congress?

MR. MAGAZINER: I wouldn't expect so.

Q How would you enforce the budget? What if California says to you we just can't live within your budget, what would you do?

MR. LEVITT: Hi, I'm Larry Levitt. We're not talking about saying to California that here's your budget and it's your problem to figure out how to do it. What we're saying to essentially the health insurance market in each alliance area is here's what your premiums are expected to go up by. And we expect in most cases that the market will, in fact, produce rates of increase in line with inflation and in line with the growth in the economy. If they don't, there is an assessment mechanism; essentially, a mandatory rebate mechanism so that health plans in an area, if premiums in that area went up too fast, health plans whose premiums were going up too fast would be required to rebate the difference to employers and to consumers. And in addition providers would, in effect, would be required to rebate their increases also.

Q Ira, how do you expect to recapture the savings without a tax, particularly on hospitals?

MR. MAGAZINER: Recapture --

Q Savings in the system.

MR. MAGAZINER: Well, we expect the savings in the system to go back primarily to those people who are doing the paying. The employers and the individuals who are paying for their own care.

Q Well, what happens if hospitals no longer have a problem of uncompensated care and suddenly have a windfall?

DR. FEDER: I was just saying, when we talk about the financing and the savings being a critical piece of financing the federal share or the subsidies, those savings are monies that the federal Treasury or state treasuries won't have to pay out anymore

because we've constrained rate of growth. So those are monies that we have in hand.

The other savings that Ira is talking about in the system are going to go back to employers and to consumers in general because their premiums will be lower because those are out of the system.

Q So you're not thinking about any other taxes besides sin taxes -- is that the only tax?

MR. MAGAZINER: The only thing, to be clear, there is a set-aside that we're looking at which would go to all premiums, both within the regional alliances and also the corporate alliances, to help pay for things like academic health centers and things -- research that's done in academic health centers and teaching hospitals, because that's infrastructure that everybody in the health system benefits from.

I'd like to say one thing about the budget, and this I want to emphasize from what Larry said. We don't believe that the budget is the main mechanism, that the insurance regulation is the main mechanism in controlling costs. We think the setting up of the competitive marketplace is what's going to control the growth of costs.

The insurance caps are really a backup mechanism so that if in certain parts of the country the competition is not working well enough at any given point in time, then the caps are there as a discipline. But that's not the main mechanism.

Q What happens to unions who have negotiated contracts to health benefits that would exceed the benefit package?

MR. MAGAZINER: They can continue to have them. We're not going to make people worse off for what they've negotiated. They continue to have them.

Q Ira, just so we have a sense of order of magnitude, besides the national subsidy pool, you've talked just now about what sounds like two other pools for essential providers and the one you just -- the set-aside you just talked about. When this thing is up and running, what are those two pools going to have in them and where is that money going to come from?

MR. MAGAZINER: That's defined in the draft, which I assume you have. (Laughter.) But basically, we are looking for a pool that would increase what's currently in the graduate medical education accounts and so on. That would come off of an assessment of the premiums. It's actually built into the premium number. And it's not anything new; it's built into today's premiums as well.

The issue is that when you set up a pure competition, that teaching hospitals and academic health centers often have a higher cost because they have those research and teaching functions in them. Today that's sort of averaged out in the system. When you move to a competitive system those institutions might be at a disadvantage unless you had a set-aside like this.

There was one other source -- the essential provider is going to be a direct federal contribution that will come out of some of the savings we gain, and also initially out of some of the sin taxes.

Q What's the order of magnitude of that?

MR. MAGAZINER: A couple of billion dollars.

Q Can I ask you about the caps again? You've got a limit on money coming into the system, but you really are not controlling the other aspects -- for example, high tech, older people getting sick. The costs will continue to go up, won't they, even though you're limiting the dollars going in? So sooner or later, aren't the higher costs and limited dollars going to blow up on you?

MR. MAGAZINER: Well, I think the most important thing to remember in this is that we're spending over 14 percent of our economy on health care. Other nations spend 7 percent, 8 percent, the Germans, the Japanese. They use high technology as well. They have actually more old people who live longer than our people do. They insure everybody. They have a more comprehensive set of benefits that we have. And yet, they spend less.

Almost every study that's been done has documented the tremendous amount of fat and waste in this system. There is no reason to believe that slowing the rate of growth in cost cannot be taken out of that waste and has to lead somehow to poorer care. There's going to be a lot of scare tactics used by people who are essentially trying to almost blackmail us into saying if we don't keep paying for all this waste and for all the fat, that everything is going to be terrible and there are going to be long lines and your mother won't be treated, and so forth and so on. That's nonsense. There is a tremendous amount of waste in the system and we have to have high quality standards to protect the consumer, but then also go after that waste with controlling costs.

MR. KRONICK: I'd just like to amplify on that. Only in health care do we expect that new technology is going to add to the cost of producing output. In most of the rest of the economy we assume that new technology will save money, and there are many possibilities for that in health care as well.

More importantly, I think that Ira mentioned earlier the comparison of Boston of New Haven; that if you look at what happens to Medicare beneficiaries in Boston, the expenditures are almost twice as high per person as in New Haven. And nobody says that we're rationing care to people in New Haven or that beneficiaries in New Haven aren't receiving all the care that the need.

So we take this kind of what we're spending now for granted and that we have to be spending that, and if we spend -- if the rate of increase isn't as large as what we're projecting, that something terrible is going to happen to us. And there is every reason to believe that if we give physicians and hospitals the incentives and the opportunities to use the resources that are available more effectively, that they can figure out how to do that. We have examples of that all over the country. And this plan is intended to change the environment in which hospitals and physicians function so that they have the opportunities and the incentives to use those resources better. There's no reason to believe it won't happen.

MR. ZELMAN: I just wanted to add to something Rick was suggesting. This health care proposal is not a one-time fix in which we expect to put a few things in place which will immediately wring out the inefficiencies and waste that virtually everybody agrees are in the system. It is a structured mechanism of setting health plans competing against each other so that they will, over time, for the next five, 10, 15 years, constantly be encouraged to compete with each other to produce savings and to produce lower costs to consumers. So it's a long-term kind of fix that we think will enable the system to continue saving money over time, as opposed to a lot of other proposals that suggest that the only way you're going to save money is by just paying your doctors and hospitals in a regulatory way less and less and less. So we think we've built in some long-term efficiencies here.

MR. MAGAZINER: At the risk of overdoing some personal stories here, the first time I went into the hospital for a hernia operation I had to stay in for three days. And then the last time I went in it was an out-patient procedure because of new technology. I had my knee operated on about 20 years ago; it was a two-week deal. That same thing with orthoscopic surgery could be done now in a couple of days stay in the hospital. So technology cuts both ways.

DR. FEDER: Didn't know you were such a mess.

(Laughter.)

Q I have two questions. As a result of the consultations you had this week on the Hill, are you looking, for whatever reason -- because of politics or whatever -- are you looking for new sources of revenue now? And secondly, the tax that was described in The Times today, maybe you wouldn't call it a tax, but you have talked in the past about recouping the savings from hospitals through an assessment, which we all translate into taxes.

MR. MAGAZINER: Let me be clear about this. We talked, as you know, about a million ideas in the past and in late April, early May discarded that particular idea. And we have not talked about it since. So what I think might have been inaccurate in some of the reporting today is that we have not been having discussions about new health reform sources of revenue and we have not had any discussions at all about resurrecting any kind of hospital tax. That went off the table in early May.

Q So the answer to the first question is as a result of these consultations, are you looking for other --

MR. MAGAZINER: No. The consultations basically could affect -- I mean, what you have now in those numbers tables are a draft. Through our own internal processes we intend to revise that draft a couple of different times with the consultations.

You'll see some numbers move around in there -- the deficit number may go up a little bit and down a little bit, the sin tax number up or down a little bit, the Medicare number up or down a little bit -- but we're not looking for new sources of revenue.

Q Surely, when you went up on the Hill, one of the things I would imagine you got the most concern about was the slowing of the rate of growth in Medicare and Medicaid, which is something they've never been able to do up until now.

MR. MAGAZINER: I think, first of all, discussions about the slowing of the rate of growth of Medicare and Medicaid have never been talked about in the context of comprehensive health care reform. They've been talked about solely going for the deficit reduction.

For example, on Medicare, a very important point is that the savings we're looking for in Medicare is smaller than the investment we're looking to make in the Medicare drug benefit and in long-term care. So the discussions in the past have not been slow the rate of growth of Medicare so you can give a drug benefit and long-term care. It's a very different discussion.

To your other question, I will honestly admit that we have heard from numerous people on the Hill about every one of our revenue sources. There are people up there who are not wild about the tobacco tax. There are people who don't like the Medicare and Medicaid cuts -- savings that we're looking for. There are people who don't like the deficit numbers. There are people who don't like different pieces of things, and that's natural. People have different views.

Q Are you saying that in early May you ruled out a broad-based tax -- in late April, early May -- and you simply haven't gone back to any kind of consideration of a broad-based tax since then?

MR. MAGAZINER: That's accurate -- hospital tax, yes.

Q To any broad-based tax?

MR. MAGAZINER: Well, it was around that time that we ruled out a broad-based tax as well, yes. We had done -- we started January 25th with our financial analysis. And by early May we had already run about 75 different runs of every different alternative we could think of. And we took a lot of things off the table during numerous discussions we had with the President in May. And the idea of using a broad-based tax, whether it's an income tax or a VAT or a hospital tax or whatever, was all taken off the table in May and has not been discussed. It was at that point that we decided to go to the employer-individual responsibility route.

Q There was some talk of placing an assessment on a corporate alliance, a one percent surcharge, or something like that. Are you going to do that?

MR. MAGAZINER: That's in relation to what I was talking about earlier about the set-asides for the academic health alliances and that type of thing. Whether it would be one percent or less is being looked at. But it was always designed -- see, in some of the ways we originally modeled the numbers, the regional alliances were essentially paying for the whole set-asides for the academic health centers, paying for things that were done for the underserved populations and so on. And then we went back and said, well, wait a second, because the corporate alliances are going to be on the same footing as the regional alliances, shouldn't they also have to make a contribution in their premiums as are going to be in the regional premiums? That's the context in which we've looked at that.

We're still looking at that in relation to a trade-off with the sin taxes within that amount of money, but no decision is made.

Q So you could not do anything or you could have some, or you haven't made the decision yet --

MR. MAGAZINER: That's right. That piece that's labeled in your non-handout -- (laughter) -- that sin tax-corporate assessment, we're playing with that total pool of money and deciding the mix of that money. And that's still not decided.

Q And is alcohol still included in the sin tax or have you ruled out alcohol?

MR. MAGAZINER: I'll let you figure out what you think sins are and then make the list.

Q What other kinds of tax revenue are available then if you're only going for a sin tax?

MR. MAGAZINER: Just what we've put in here. I mean, I don't --

Q There is no other kind of tax, as liquor tax?

MR. MAGAZINER: Well, as I say, I think you need to come up with your own definitions of sin. I'm not sure --

Q I wasn't talking sin. You brought it up.

MR. MAGAZINER: We're looking at a number of things that could be broadly considered sin taxes, excise taxes on various things that have traditionally been called that.

THE PRESS: Thank you.

END

4:10 P.M. EDT

Hanna

Please copy the letter to Carol
and the memo to Marina

Send copy of the letter and original
memo to Marina and keep copies
for us.

Roz

Marina Weiss
U.S. Dept. of Treasury
15th Pennsylvania Ave, NW
Wash, DC 20520

THE WHITE HOUSE

WASHINGTON

January 12, 1994

TO: Marina Weiss

FROM: Carol H. Rasco *CHR*

SUBJ: Student loans for primary care practitioners

Attached is the letter I mentioned to you on the phone recently. If you can give me any guidance in answering the gentleman's concerns I would appreciate it very much.

Thanks...and it was good to talk with you!



MEDINA COMMUNITY HOSPITAL

3100 AVE. E • HONDO, TEXAS 78861 • (210) 426-5363

Carol Rasco
 Assistant to the President
 for Domestic Policy
 The White House
 Washington, D.C., 20500

November 3, 1993

Dear Ms. Rasco,

I appreciated your comments during the Texas Tech Teleconference call on Monday, November 1, 1993, concerning the President's Healthcare Reform Plan. I brought to your attention that the incentive to forgive student loans for primary care practitioners moving to medically underserved areas is a sound approach. I feel it as counter productive, when under existing IRS code, the IRS taxes the forgiven loan as real income and at the time taken. I would hope the Administration will correct this inconsistency and do it immediately.

I further mentioned the need to preserve the integrity of the Rural Health Clinics and the Rural Health Clinic Act. It is true Healthcare Reform classifies Rural Health Clinics as "Essential Community Providers" as it does Federally Qualified Health Centers and Migrant Health Centers. Rural Health Clinics do not receive direct federal subsidy and are reimbursed only on a cost basis under the Medicare/Medicaid programs. I implore you to preserve the cost based reimbursement structure of Rural Health Clinics. Rural Health Clinics have grown from 489 (1989) to 1138 (1993) and in Texas from 1 (1989) to 159 (1993). Without the five Rural Health Clinics operated by this hospital, this hospital would be closed! In addition, eight physicians, three P.A.s and one NP (providing 32,000 outpatient visits yearly) would not be practicing in this Rural Texas county.

I commend the President for his foresight in providing for Universal Health Insurance. It is the answer in Rural America. I urge him to insure that whatever structure that comes out of Healthcare Reform that it protect and enhance the integrity of the Rural Health Care delivery system.

Sincerely,

Ernie Parisi
 Administrator

Chairman (Elect)
 Texas Organization
 Rural Community Hospitals

EP/kr

November 22, 1993

MEMORANDUM TO CABINET MEMBERS AND SENIOR STAFF

FROM: MARLA ROMASH
BOB BOORSTIN

RE: Health Care Information Package

Enclosed please find our most current health care briefing materials. They include a summary of the Health Security Act, frequently asked questions and answers, talking points on different issues, and a comparison of the competing health care reform proposals.

We hope that you find these materials useful in doing interviews and talking to groups as we move into the next phase of the health care reform debate. Thank you for your continued support in helping to promote the Health Security Act.

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Clinton Administration and AIDS

The National Task Force on AIDS Drug Development, whose purpose is to expedite the search for new therapies against AIDS and HIV, is the latest initiative by the Clinton Administration to combat the epidemic. Previous Administration efforts include:

Funding: The Clinton Administration proposed and guided through Congress significant increases in discretionary AIDS spending at all levels:

	FY	1994	1993	Change
NIH (Research)		\$1.301 billion	\$1.073 billion	+21.2%
Ryan White (Services)		\$579.4 million	\$348 million	+66.5%
CDC (Prevention)		\$543.3 million	\$498.3 million	+9%

Disability: The Clinton Administration enacted new regulations streamlining and updating the process for determining eligibility for disability and Supplemental Security Income benefits for people with AIDS. The new criteria include symptoms and diagnoses specifically affecting women and children.

National AIDS Policy Coordinator: The Clinton Administration created the White House Office of AIDS Policy, headed by Kristine Gebbie, to coordinate the government's overall response to the epidemic.

NIH Office of AIDS Research: The Clinton Administration supported legislation expanding the Office of AIDS Research, which oversees the AIDS research effort at the National Institutes of Health.

Health Security Act: The Clinton Administration has proposed comprehensive health care reform. The Clinton plan would outlaw denial of coverage based on pre-existing conditions and guarantee health-care coverage, including prescription drug benefits, to all Americans. It would also provide a long-term care benefit to people with disabilities. Some 27% of people with AIDS currently lack health insurance coverage.

AIDS in the Workplace: The Clinton Administration introduced a new policy to educate all federal workers on the need to treat coworkers who have AIDS and HIV with dignity and compassion.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Tuesday, Nov. 30, 1993

Contact: Victor Zonana
(202) 690-6343

HHS Secretary Donna E. Shalala today announced the formation of a National Task Force on AIDS Drug Development to expedite the search for new therapies against AIDS and the underlying human immunodeficiency virus (HIV).

The expert panel will be highly focused, seeking new and innovative approaches to the development of AIDS drugs.

"The task force has a clear and critical mission: to identify, and remove, any barriers or obstacles to developing effective treatments," Shalala said.

The 15-member panel will be drawn from government, the pharmaceutical industry, academia, medicine and the AIDS-affected communities. "This represents unprecedented high-level collaboration among leaders in the field," Shalala said.

"It is time to refocus and re-energize our best minds for a concerted attack on this killer," Shalala said.

"None of us can guarantee success," Shalala added. "HIV is a vicious and cunning adversary. But history will judge us harshly if we fail to give it our best shot."

Shalala was joined at the announcement by Assistant Secretary for Health Dr. Philip Lee, who will chair the panel; Dr. P. Roy Vagelos, chairman and chief executive officer of Merck & Co., Inc.; Kristine M. Gebbie, national AIDS policy coordinator; and Moises

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Agosto, research and treatment advocacy manager at the National Minority AIDS Council.

Also attending the National Institutes of Health press conference were Dr. David Kessler, commissioner of food and drugs; Dr. Harold Varmus, newly sworn in as director of the National Institutes of Health; and Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases.

"The FDA has made great strides in streamlining the approval process for drugs to treat life-threatening conditions, and the NIH has contributed mightily to our understanding of AIDS and HIV," Shalala said.

"In addition, the Clinton administration and Congress have raised the NIH AIDS research budget 21 percent this year, to \$1.3 billion," she added.

"But the sad fact remains that not a single New Drug Application for an antiretroviral drug is currently before the FDA. No matter how much we shorten the pipeline, we cannot achieve our goal unless we start filling that pipeline with promising compounds," Shalala said.

At least one million U.S. citizens are infected with HIV. Some 340,000 have been reported to the CDC with full-blown AIDS, and over 200,000 have died.

"Unfortunately, none of the drugs we have today are curative," Dr. Lee said.

"The task force, which will be appointed by and report to the secretary, will bring together many of the top people in the field.

- more -

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It will raise the level and intensity of collaboration," Dr. Lee continued.

"The group we envision will be constantly evaluating the process -- identifying obstacles, charting strategy, and asking: 'What are our options? Is anything falling through the cracks? Are we doing everything we possibly can?'" Lee said.

"We're not just talking about antivirals," Dr. Lee added. "We need an across-the-board strategy to develop drugs to treat all aspects of HIV disease. We need immune modulators, anticancer compounds, and agents to treat and prevent opportunistic infections."

"The Centers for Disease Control and Prevention inform me that AIDS and HIV, on average, kill 92 people in this country every day," Shalala said. "With so many people being held hostage by this virus, we must explore all possible options."

Shalala said she expects to begin receiving nominations for task force membership immediately.

Said Gebbie: "The mere creation of a new task force does not halt an epidemic, and if this new group were allowed to become a mere bureaucratic space-filler, it could even become counterproductive. I am confident, however, that neither of these things will occur."

Added Shalala: "This is is not just another government panel appointed to study an issue and write a report that gathers dust.

"I expect the task force to report to me personally, rapidly and regularly, and I pledge to work with all its members to eliminate any obstacles to finding effective treatments," she said.

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THE WHITE HOUSE

WASHINGTON

Statement of
Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator
at
Press Conference Announcing
National Task Force on AIDS Drug Development

AS the National AIDS Policy Coordinator, I am charged with promoting the highest levels of coordination and collaboration in the nation's response to the effect of the HIV/AIDS pandemic on individuals, families, and private and government institutions. The focal point of my efforts include, research, prevention and care.

Over the past several months, representatives of the Department of Health and Human Services (DHHS) have participated in forums with academicians, AIDS advocacy groups, and the pharmaceutical industry on AIDS research improvement. Out of those sessions have come several ideas on public-private partnerships for information sharing and research that can speed the pace of discovery in our effort to find a cure for AIDS. The establishment of this new Drug Development Task Force is one example of the type of improvement anticipated by many of us.

By bringing together those conducting research on drugs to combat HIV infection from the pharmaceutical industry, the academic community, individuals with HIV infection and those advocating on their behalf, and key agencies of the federal

government, DHHS formalizes channels of communication among the partners who must be involved to successfully bring new drugs into use. Working together, these partners can identify barriers to quick action or clear communication, and can act in common to eliminate those barriers.

The mere creation of a new task force does not halt an epidemic, and if this new group were allowed to become a mere bureaucratic space-filler, it could even become counter-productive. I am confident, however, that neither of those things will occur. Instead, the steadily strengthening collaboration among all parties concerned about AIDS gives me great confidence that this is one more important step toward our collective goal of stopping AIDS.

THE HEALTH SECURITY ACT OF 1993: A SUMMARY

The Clinton plan offers a system of guaranteed private insurance. It proposes to build on the current system of private insurance with two critical changes: first, the guarantee of comprehensive health benefits that can never be taken away; and second, greater consumer power for people and small businesses to choose quality health insurance at lower cost.

Our national goal is health security for every American -- comprehensive health benefits that can never be taken away. No limit on benefits over your lifetime. No refusal of insurance if you have a pre-existing condition. No losing your insurance if you get sick or lose your job. And no rate increases if you get sick.

Our principles are clear and distinguish our approach: Security -- comprehensive benefits that can never be taken away. Simplicity -- creating a single claim form to reduce paperwork and bureaucracy. Savings -- controlling health care costs. Quality -- making the worlds' best care better. Choice -- preserving your right to choose your doctor and expanding choice of private insurance plans. Responsibility -- every American assumes responsibility to bring an out-of-control system under control and put funding on a fair and responsible basis.

Real reform and real savings are possible only if health care benefits are guaranteed to every American. Without universal coverage, there's no guarantee we will be able to control costs and provide comprehensive benefits. For example, today, everyone of us pays a part of the \$25 billion bill for health care for the uninsured; and a single claim form doesn't save money unless everyone is using it.

Comprehensive benefits include preventive care, prescription drugs, doctor visits, hospital services, home health care, hospice care, emergency care and ambulance services, mental health care, vision care, and dental care for children and eventually, for adults.

For seniors, the protection of Medicare remains with improvements -- new prescription drug coverage and a new long-term care program. Our health security plan will achieve real savings in Medicare and re-invest those savings to improve benefits.

For small business, our plan provides insurance discounts to help them afford comprehensive benefits for their employees. Most small businesses already provide health insurance to their employees but they're forced to pay as much as 50% more than larger companies. Our plan helps assure them the best benefits, controlling costs and expanding coverage.

HOW THE PLAN WORKS

How Health Care Reform Will Affect You

- *Our national goal is health security -- comprehensive health benefits guaranteed for every American.*
- *How will the President's plan work? The Clinton plan offers a system of guaranteed private insurance. It proposes to build on the current system of private insurance with two critical changes: first, the guarantee of comprehensive health benefits that can never be taken away; and second, greater consumer power (for people and small businesses) to choose quality health insurance at lower cost.*
- *How will you get health insurance? The way most Americans do today, through your employer. If you're employed, you'll choose your health plan, and your employer will make a contribution to help pay. If you're unemployed or self-employed, you'll sign up by mail or telephone. Every American citizen and legal resident will receive a Health Security card that will protect you from ever losing your coverage -- no matter what.*
- *Your Health Security card guarantees you comprehensive benefits that can never be taken away -- benefits as comprehensive as those most Fortune 500 companies offer: doctor and hospital care, prescription drugs, and something rarely found in today's insurance plans -- preventive care, including prenatal care, immunizations, and disease screening for adults, such as mammograms, Pap smears, and cholesterol tests. And there will be no lifetime limits on benefits.*
- *You choose your doctor and your health plan. Every American will have a choice of health plans -- and plans will enroll everyone who applies, regardless of age, occupation or medical history. You will be able to follow your doctor into a traditional fee-for-service plan, a network of doctors and hospitals, or a health maintenance organization (HMO). For older Americans, Medicare will be preserved and strengthened with new coverage of prescription drugs. And there will be expanded options for home and community-based long-term care.*
- *Informed choices strengthen consumers. Easy-to-understand "report cards" on health plans -- the doctors and hospitals involved, the quality of care, consumer satisfaction, prices, and other factors -- will help you make smart choices. Once a year, consumers will have a chance to choose a new plan, something most people can't do today.*
- *It's easy to get care. Once you've picked a plan, if you need to go to the doctor for a check-up or if you get sick, you'll simply take your Health Security card, show it at the doctor's office, and they'll take care of you. Then you'll fill out one standard form, and you're done. So when you get sick, you won't be buried in forms -- and neither will your doctor or hospital.*

PRINCIPLES OF REFORM

Health Security is built on six principles: security, simplicity, savings, quality, choice, and responsibility.

Security: Guaranteeing comprehensive benefits to all Americans

The Health Security Act guarantees all Americans comprehensive health benefits, including preventive care and prescription drugs, and ensures they can never be taken away. Insurers will not be able to deny anyone coverage or impose a "lifetime limit" on benefits for people who are seriously ill. And the plan outlaws charging older people more than younger people, or sick people more than healthy people. The plan also sets limits on how much insurance premiums can rise.

Simplicity: Simplifying the system and cutting red tape.

The Health Security Act reduces paperwork by giving everyone a Health Security card and requiring all health plans to adopt a single claim form to replace the hundreds that exist today. The plan cuts insurance company red tape by creating a uniform comprehensive benefits package, standardizing billing and coding, and eliminating fine print.

Savings: Controlling health care costs.

The Health Security Act increases competition, forcing health plans to compete on price and quality. Health plans will have an incentive to provide high-quality care and control costs to attract more patients. As consumers and business band together in health alliances, they will have more buying clout and receive better prices on their health coverage.

Quality: Making the world's best care better.

The Health Security Act gives doctors and hospitals the best information and latest technology. And it provides consumers information on quality -- forcing health plans to compete on quality in order to attract patients. The plan also invests in new research initiatives -- into new ways to make prevention work, new treatments, and new cures for diseases.

Choice: Preserving and increasing the options you have today.

The Health Security Act ensures that you can follow your doctor and his or her team into any plan they choose to join. In addition, all Americans will be able to choose from a number of plans -- no matter where they work. And anyone can switch plans at the end of the year if they are not satisfied.

Responsibility: Making everyone responsible for health care.

Everybody -- employers and employees alike -- will be asked to pay something for health coverage, even if the contribution is small. Low-wage businesses and workers will get substantial discounts, but everyone must pay something. And those who profit from the current system must join in getting it under control.

For the majority of insured Americans -- nearly 7 out of 10 -- our plan means paying the same or less for health care benefits that are the same or better -- on average, saving \$61 a month on premiums, co-payments, and deductibles.

Of the insured population, about 3 in 10 will pay more, on average about \$24 per month, but they'll receive benefits that can never be taken away, and for many, better benefits.

If we fail to act:

- Every American -- 100% -- can expect to pay higher insurance premiums nearly every year, with no guarantee of security, no guaranteed benefits, and no guarantee that insurance will be there when they need it.
- One of every four Americans will lose their insurance at some point in the next two years.
- Almost \$1 out of every \$5 Americans spend will go to health care.
- By the end of the decade, just to keep their benefits, American workers will sacrifice almost \$600 in wages every year.
- Millions of Americans will find that rising costs will force their firms to cut back on benefits and limit choices of doctors and health plans.

Our plan for health security is the most comprehensive and responsible, building on what works in our current system and fixing what doesn't. We maintain and essentially private system, streamlined and less bureaucratic than what we face today. And, we're demonstrating how that system will work -- from details on the benefit package and premiums to a firm explanation of the most responsible financing possible.

GENERAL Q&A

1.) **Doesn't the Clinton plan add more layers of government bureaucracy?**

No. The President specifically rejected a government-run system in favor of a system rooted in the private sector, and based on what we have today. People will choose their own private insurance policy from among those offered in their area. The plan will free doctors and consumers from today's avalanche of paperwork, and streamline the system. It will require insurance companies to use a single claim form, which will replace the hundreds of different forms from the 1500 different insurance companies. And it will give every American a Health Security card which will lead to electronic billing and less paperwork.

2.) **I've watched those TV ads where the couple at the kitchen table asks: "What happens if the money runs out?" What does happen?**

Let's get one thing straight. Their ad says that the government will limit health spending under the President's plan. Well, that's wrong -- the limit they don't like is on how much insurance companies can charge on premiums. Insurance companies that say they have to jack up rates aren't playing straight with you.

The President's plan relies on the most responsible financing possible and it includes safeguards to ensure that health care will always be there for every American. If a health plan were to literally run out of money, and that's unlikely because of the way the President's plan is designed, consumers would simply join another plan. Unlike today, though, benefits would be guaranteed.

3.) **How do you pay for this whole reform plan anyway? Isn't it just "smoke and mirrors?"**

Not at all. Here's how we pay for reform. All the employers and individuals that don't pay anything today for the cost of their health care will be asked to contribute. We will raise the tax on tobacco and ask large corporations that decide to cover their own employees to help pay for the cost of health care for everyone. At the same time, we're going to slow the skyrocketing growth of federal health programs and crack down on health care fraud with new penalties.

Many leading, private-sector economists -- even those who disagree with the policy the President decided on -- have looked at the financing of the plan and said that the numbers add up. The plan uses very conservative assumptions and includes a 15% cushion in case costs grow significantly more than expected. Although the plan raises some additional revenue, it avoids a broad-based tax because the President feels that we can get better value for the dollars we currently spend on health care.

4.) **One of those TV ads says that the President's plan will limit my choice of doctor. Is that true?**

No, it's not. You will be able to choose your own doctor. What you pay will depend on which plans your doctor joins. There will be a range of plans available at a range of prices and your doctor will be free to join a number of plans -- so the choice will always be yours.

In fact, our plan actually increases the choices most consumers will have. Every American will be able to choose from several different kinds of health plans, no matter where they work. And the choice will be theirs, not their employer's. And, every American will be able to switch plans every year if they're not satisfied with their care or service.

Remember, this is an ad paid for by the insurance companies -- who are trying to scare you and preserve their profits.

5.) **Won't this plan mean that I'll pay more and get less?**

No. For the majority of insured Americans -- nearly seven out of ten -- our plan will mean you will pay the same or less for health care benefits that are the same or better -- on average, saving \$61 a month on premiums, co-payments, and deductibles. About three out of ten will pay more, on average about \$24 per month, but they'll receive benefits that can never be taken away, and for many, better benefits.

6.) **Won't your plan cause massive job loss, driving thousands of small businesses into bankruptcy?**

Absolutely not. You're listening to a scare tactic from some of the lobbyists trying to guard the status quo.

These studies don't take into account the significant discounts that the President's plan offers small businesses. The very lobbyist who paid for the most commonly cited job loss study calls it "outdated" and not relevant to the President's plan. And an independent expert calls it "way off base." (CNN, 10/22/93, about an Employment Policies Institute study predicting 3.1 million jobs lost, cited in a GOP ad) The Wall Street Journal called the Clinton plan "an unexpected windfall" for small business.

There will, in fact, be some job gains as a result of the plan. Manufacturers will see their costs go down, and one study from the Economic Policy Institute predicts that means 258,000 manufacturing jobs created over the next decade.

There will also be health care jobs created, with one health economist at the Brookings Institution predicting that the plan will create 750,000 home health care jobs. And the Employee Benefit Research Institute predicts that the President's proposal could produce as many as 660,000 jobs.

7.) **I've got good insurance. What's in this plan for me?**

People who like their insurance today have a lot to gain from the Health Security Act. First -- and most important -- you'll get something that no amount of money can buy in today's insurance market: **security -- the guarantee that your benefits will never be taken away.** You'll also get more choices of doctors and plans than many people have today, and you'll finally stop losing wages just to keep the same health benefits. And you'll probably pay less for high-quality care. **The bottom line is this: you can't guarantee that the benefits you have today will still be there tomorrow. The Health Security Act provides you with that guarantee.**

8.) **When you try to cut costs and limit the amount premiums can rise, won't that just lead to worse care and waiting on lines?**

Not at all. Costs will be controlled by eliminating the waste and fraud in the current system -- not by cutting corners on consumers. Doctors, nurses, and hospitals tell us they can save a lot and give better care if the insurance company red tape will get out of their way. The main reason plans won't cut corners is because they know patients will be free to choose a new plan and leave them if they don't provide quality care.

9.) **Won't the Clinton plan raise taxes on the middle class?**

No. The President specifically rejected a broad-based tax because he thinks that middle class Americans are already paying too much for their health care. There is already plenty of money in the system -- the problem is that much of it is wasted. The money saved by eliminating the waste, fraud, and inefficiency that exists today will help all of us get better value for our health care dollar.

10.) What's this I hear about Medicare benefits being cut?

That's not true. Older Americans who receive Medicare will continue to receive all the benefits they do today. In addition, Medicare will be strengthened by adding prescription drug coverage. If you're on Medicare, you'll actually have more choices after reform. You can continue to receive care like you do today, or choose among different health plans that may offer fuller benefit packages and lower payments. Older Americans will also benefit from new long-term care options in their homes and communities, where they want to receive care.

The growth of Medicare costs can be slowed, however, with comprehensive health care reform. Medicare will no longer have to reimburse doctors and hospitals for the cost of caring for the uninsured, saving billions of dollars per year. With all employers contributing to health care, Medicare will also save on workers now covered by those programs. Upper-income people will pay a larger share of their Medicare Part B premium, and there will be a crackdown on the fraud and overcharges that drive up Medicare costs. These reforms will slow the growth of Medicare costs from three to two times the rate of inflation, and the savings will be rechannelled into new benefits for older Americans, like prescription drugs and long-term care.

Every Democratic and Republican proposal recognizes that with national health care reform, we can save money in the rate of growth in Medicare and Medicaid.