in, hopefully, as good or better than the ones they're losing. We're going to do the very best we can on that.

Mayor Riley. It's going to be a huge help, and we are going to make Charleston a model, one that you can proudly point to.

The President. You can do it. I know you can. We'll do whatever we can to work with you.

Mayor Riley. Well, thank you. Thanks for everything.

The President. Tell everybody in Charleston I said hello. I always love coming there, and I hope I get to come again soon.

Mayor Riley. Well, I will. Somebody just a couple of weeks ago gave me a picture of you and I talking on January the 1st, 1992.

The President. The first stop I made in the new year, 1992.

Mayor Riley. That's right. Well, I've got to—it's been marvelous chatting. I was doing the talking, and they subtitled it, "Low country advice." [*Laughter*]

The President. Well, it was pretty highbrow advice from the low country, I'll tell you that.

Mayor Riley. Well, it was heartfelt, and we're very proud of you.

The President. Good luck to you.

Mayor Riley. Thanks for all your help.

The President. Bye.

NOTE: The teleconference began at 10:44 a.m. The President spoke from the Oval Office at the White House. A tape was not available for verification of the content of these remarks.

Teleconference With the California Medical Association

March 23, 1994

The President. Thank you very much. Thank you, Dr. Holley for that kind introduction and for your good work and the good work of all the physicians whom you represent now in dealing with these very difficult and complex and profoundly important issues. I regret not being able to join you in person today, but I am glad that Ira Magaziner is able to be there with you. I'm glad I had a chance to visit with you, Dr. Holley, and your past president, Dr. Richard Corlin, in Washington recently, following another health care forum. And I'm grateful for many reasons for your continued good counsel and for this invitation to address you.

Each of you has, in the most personal way, been part of the excellence in American medicine simply by caring for the families in your communities. And I'm grateful that you understand that our health care system needs dramatic reform. You know costs are rising too fast, that paperwork is mounting too much, that every day more constraints are placed on your patients and your ability to practice medicine the way you know it should be practiced.

But unlike so many others in the debate who will only tell us what they don't want to change, long ago you left the sidelines and became advocates for responsible, comprehensive reforms. I appreciate the early and continued support you have shown for the objectives we are trying to achieve: providing Americans guaranteed private insurance, preserving the right of everyone to choose his or her own doctor and their own health care plans, outlawing unfair insurance practices, protecting and strengthening Medicare, and linking these health benefits to the workplace, where most people get their insurance today.

These reforms are entirely consistent with many of the things that you have tried to do in California. Your health care providers have been innovators in improving quality and controlling costs and, judging from today's headlines, the new California purchasing pool is certainly a step in the right direction, offering consumers a wide choice of plans, a comprehensive benefit package, and lower rates. That kind of competition between insurers, combined with more choices for consumers, is what my plan is all about.

At a national level, I think the first step we must take is clear. The best way to preserve what's right about our health care system is to guarantee private insurance to every American. That's the foundation of our health reform plan. We'll provide every American with a health security card that will guarantee them a comprehensive package of benefits that can never be taken away. The benefits will include for the first time for many Americans prescription drugs and preventive care. All of you know that the best

way to keep people healthy is to promote wellness in addition to treating sickness. Retaining choice of doctors and health plans is also critically important to Americans and to American medicine. And this, too, is central to our approach.

Today, only about half of American employers offer their employees more than two choices of insurance plans; 90 percent of the businesses that have 25 workers or less offer no choice at all. And even for those who have some choice today, there's no guarantee they'll have it tomorrow if they change jobs or lose their job or if their employer has difficulty meeting the costs. This is a tremendous restraint on most Americans.

My proposal will guarantee the great majority of Americans far more choice of both doctors and insurance plans than they have now. Under this approach, people will be able to join a traditional fee-for-service plan, a network plan, or a plan sponsored by a health maintenance organization. But in all cases it will be families, not employers or insurance companies, that make the health care choices.

The people who are telling you we don't offer enough choice, which is clearly not so on its face, are the same who for decades have been pushing you out of the way and limiting your choices. You don't believe their arguments and neither do we.

That's why, among other things, we're going to insist upon different insurance practices: no more preexisting conditions, no more lifetime limits, no more higher rates for those who have had someone in their family sick or those who are older, no more overcharging of small employers or dropping them because one person in the workplace has a medical problem, no more avoiding people that might cost some money.

The fact is, increasingly insurance companies set your fees. They second-guess your clinical decisions. More and more they make you get prior approval from someone who's thousands of miles away who's never seen your patient and doesn't have a clue about what really ought to be done. They all pay according to their own fee schedules, requiring different forms for different people under different circumstances. The forms are drowning the health care system in paper.

I have a doctor friend who calls me about every 3 months to tell me another horror story. Recently he told me, "We've got all these people doing paperwork. Now we've hired somebody who doesn't even fill out forms, just spends all day on the telephone beating up on the insurance companies about the forms we've already sent in." He's told me, he said, "I went to medical school to practice medicine, but I'm getting lost in the fun house instead." Well, he's right, and I know a lot of you agree with him and identify with that story. But this year we can escape that fun house.

The fourth element of our approach is to preserve and protect Medicare. Older Americans will continue to choose their doctor and their plan. And in addition, we want to cover prescription drugs under Medicare and provide new options for long-term care in the home and community, which most people prefer and which will become increasingly important as our population continues to age rapidly.

Finally, let me say again, we should guarantee these health benefits at work; that's how most people are insured now. And 8 of 10 uninsured Americans have a family member who works. This is the fairest and most efficient approach to covering everyone. And so no one gets hurt by the needed reforms, we'll provide discounts for small businesses and breaks for self-employed people and their families.

This is the proposal; it's pretty straightforward. All Americans will get a card that guarantees with it the security of private insurance and comprehensive benefits, then they can pick the doctor they want. They'll know that they're always covered by what is said to be covered, and it won't be subject to change by anyone.

Before taking your questions now, let me again just express my deep thanks for your continued support and encouragement. After 60 years, I think this is the year we're going to provide every American health security that can't be taken away. I'm optimistic because of what's already been done. This Congress has been willing to act and to work with me to pass an economic plan that's helped

to produce low interest rates and high [low] [1] inflation and more than 2 million new jobs. After 7 years, this Congress passed and I signed the Brady bill and the family and medical leave bill, things that people had given up on getting done.

The point is not that we have been able to do so much but that is evidence that we can still do what we have to do. The American people have demanded that we make a great deal happen. They want their dreams back, and they want this problem fixed. A big part of the American dream has always been knowing that you can care for your children or your family if they become sick; that's what you do. You're a part of every American family's dream. I've seen the magic you perform all over the country. You care, and the American people know it. And our challenge now is to do everything possible to keep and protect the bond that you've worked a lifetime to establish. Our challenge is to provide every American health care that's always there. With your help, we can do that and we can make history.

I thank you for the leadership you've already shown. And if you have questions, I'll be glad to try to answer them. Thank you very much.

Q. Thank you, Mr. President. I wonder if you have a contract with Coca-Cola. [*Laughter*]

The President. I forgot to put it in a cup. There goes my Pepsi voters. [*Laughter*]

Q. Well, Mr. President, as you acknowledged, the California Medical Association has been deeply involved working for health system reform. You know, I think you have to realize that we had Harry and Louise opposing us when they were only engaged. [*Laughter*]

The members of this house, representing 40,000 practicing California physicians, are vitally concerned about what is contained in any proposal for health system reform. We will, after all, be caring for our patients within whatever structure is created by those changes. We want to be as certain as possible that it's going to work. We have some questions for you that will address some of those physician concerns. And I'm going to take the opportunity to ask the first one.

Mr. President, in your State of the Union Address, you said that you would sign a health reform bill if it met the test of universal coverage. In addition to universal coverage, what other elements do you believe critical to a reform package, and what must be included to secure your signature?

The President. Well, I want to be very careful about how I answer that because I don't want to be throwing down gauntlets that may mean more than I wish to say. But let me say, to have a system that works, you not only have to have universal coverage, but it seems to me that the benefits ought to include primary and preventive care. There ought to be a comprehensive set of benefits.

Then there ought to be a clear outlawing of insurance practices which have caused so much misery and caused so many Americans to fall between the cracks. I think there should be an end to lifetime limits. I think there should be an end to preexisting conditions. I think there ought to be an end to discriminatory rate-setting based on age.

In order to do this, I think we have to find some way of not only legislating community rating but actually having community rating. And we need a device that guarantees that small businesses and self-employed people will have access to insurance at competitive rates with people who are insured through big business and Government. I think that's very, very important. So these are the things that I think are critical.

Now, if you're going to cover everybody, you have to either do it through a tax or through some device by which people pay into an insurance pool. I think the employer mandate, so-called, is the best way to do it by providing guaranteed private insurance at the workplace because that's the way most Americans get their insurance today.

I know there are some small businesses for whom this would create difficulties, so we developed a system of small business discounts paid for from tax proceeds. And the taxpayers would pay to cover those who are unemployed and uninsured. That's basically the way I think the system would have to work.

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[1] White House correction.

There are lots of other things I think ought to be in it, but I think it's very important for the President, in the middle of a congressional process that is just not getting its sea legs and getting underway, not to be too specific in talking about vetoes.

If we can begin with a good comprehensive system of universal coverage, we can go a long way to dealing with a lot of the other problems. As you know, my plan does deal with a number of your concerns, and I know you have more questions on that, so maybe we should get to the other questions.

Q. Well, thank you very much, Mr. President. You're now going to have an opportunity to field questions from a group of pretty nervous California physicians.

Q. Thank you. Good morning, Mr. President. I'm a family physician in San Bernardino. I have a unique opportunity here to ask you a question, particularly because I was a graduate from the University of Arkansas for medical sciences.

The President. Good for you.

Q. Thank you very much. And I had an opportunity to campaign for you in 1982 when you made your comeback election for the Governorship. So what I would like to ask you, Mr. President, is that physicians are concerned that in the current marketplace and under your proposed model, insurers and businesses are encouraged to collectively purchase health care services. However, antitrust laws prohibit physicians from collectively selling their services. It's like requiring individual autoworkers to negotiate their salaries separately with General Motors.

In light of the strong opposition of the Federal Trade Commission to any changes in antitrust laws, what would you propose to provide a more balanced and fair environment in which these negotiations can occur between physicians and insurers?

The President. I think we have to change the antitrust laws to allow you to organize to provide your services and more comprehensive professional groups. And let me say that one of the things that has concerned me most about this is that there is a development in American health care which I like, which has a consequence that I don't like. What I like: the fact that people are getting together in competitive buying groups and trying to get a better deal and trying to squeeze some of the excess cost out of our system. I think we all agree there are some there. I don't like the fact that an inevitable consequence of that has been that so many Americans have lost the right to choose their own doctor. We try to address this in two ways, one of which directly addresses your question. But let me try to put the two ways together so they'll fit.

Under our plan, each American consumer, once a year, would have the right to choose from at least three plans, including a fee-for-service plan, an HMO, and hopefully some sort of provider plan that will be provided by providers who get together and who may allow all doctors in a State, for example, to participate if they agree to observe the fee schedule that the plan bargains for. So, I think you ought to be able to do that. We also think that the HMO's should have to have a fee-for-service option that would allow people who are covered under the HMO the option to choose another doctor if it seemed appropriate. And if the fee-for-service option were elected at the beginning of the year, the HMO would have to contribute to that.

So I think that this will help. But I agree that there must be some changes in the antitrust laws so that you can clearly get together without fear of legal repercussions. Otherwise, you are consigned to dealing with a middleman that will only add to the cost of your providing your services and undermine the choice that the consumer gets.

Q. Thank you, Mr. President.

Q. Good morning, Mr. President. I'm an oncologist practicing in Redwood City in northern California. My question is about budgets and living within our means for health care. We recognize the need for controlling health care costs, there's no debate about that. However, we are concerned that your proposal and others may limit the rise of the health care budget to the cost of living or other artificial indexes that may have little to do with actual health care costs. Rising health care costs may be more related to human factors such as our aging population, tobacco consumption, new technologies, new diseases such as AIDS. How can these factors be taken into account when arriving at or when developing a health care budget?

The President. Well, first let me say that I basically agree with you on that. I have tried not without complete success—or not with complete success—but I've really tried hard since I started thinking about this issue seriously 4 or 5 years ago, when I was still a Governor, to identify the elements of disparity between, let's say, the 14.5 percent of their GDP that Americans spend on health care, the 10 percent that Canadians spend, the 9 percent or less that the Germans and the Japanese spend. There's no question that a lot of it is due to good factors like we invest more in medical research and technology, and that's good. And there's no question that some of it is due to bad factors that you can't do anything about, at least in your role as a doctor, which is higher AIDS rates, higher rates of violence which lead to enormous medical costs.

What we believe is that in the beginning, at least, there are many, many savings which can accrue from a rational system, far, far lower administrative and bureaucratic paperwork costs, significant reductions in unnecessary costs that are in the system and that after that, in the years ahead, when we measure how much costs can increase, we're not only—consider population growth and inflation, we will also have to consider the burdens of the American system if the rate of AIDS, for example, continues to go up instead of going down, if the rate of violence goes up instead of going down, if the aging population imposes greater burdens rather than fewer because we don't succeed in doing a lot of the preventive things that we're going to do.

Those things will all have to be calculated in the rate at which medical costs go up. We can't ignore real-world factors that make the CPI and health care different from the overall rate of inflation. And I think those things should be taken into account.

Q. Thank you, Mr. President.

Q. Good morning, Mr. President.

The President. Good morning, sir.

Q. I'm a pediatrician from San Luis Obispo. My question to you this morning relates to the power of insurance companies. Yourself, Mrs. Clinton, and Mr. Magaziner have repeatedly stated that one of your goals is to return the control of medical practice back to physicians and hospitals. We obviously agree with that. Unfortunately, however, many of the current managed care plans in California are moving away from that goal. Mr. President, does your plan contain features which would achieve that goal?

The President. It does. I think there are some that would help indirectly and one or two that would help directly. Let me just mention them.

First, giving every consumer three choices will make a big difference, saying that every consumer has to have at least three choices and that one of those choices must always be fee-for-service. We'll put all these plans in competition with one another, and that will make a difference.

Secondly, making it easier for physicians to provide these services directly will dramatically minimize the ability of the insurance companies to add to the cost and delay and undermine the quality of health care by second-guessing everything the doctors want to do in the HMO's that they're promoting—[*inaudible*]—in our plan that the insurance companies disclose what's in their utilization review protocol in advance so people can evaluate that and know what's going on and argue against it. And competing plans, including competing physicians groups can say, here's why this is a bad deal for you and why you shouldn't take it and why it is going to add to the cost and undermine the quality of health care.

Now, all these are things, I think, that will really make a difference. Most doctors I know recognize that from time to time, there are certain things that ought to be subject to some kind of review. But basically, it's gone crazy now. It's become an instrument of denying service when it's needed. So what we've tried to do is strike the right balance here, and I hope we have.

Q. Thank you, Mr. President.

The President. I must say that Bravo is a wonderful name for a pediatrician to have. A lot of times you can just say that to your kids and they'll get better. [*Laughter*]

Q. Mr. President, I think the medical profession really believes that that issue is so important that if we win everything else but lose on that one, none of the other matters.

The President. It's absolutely clear to me that the whole HMO movement has taken the utilization review to an extreme and that it has to be backed off of. Forget about the HMO, just the whole insurance—it's the insurance companies that are driving this. And I think the more we can put doctors into the management decisions of the HMO and the more choice we can give to the people who themselves will be patients, who have personal contact with their doctors—keep in mind, this is a huge deal, letting the employees themselves make this choice instead of their employers, means that somebody will be choosing, every plan will be chosen by someone who has had a personal relationship with a physician who has doubtless discussed this with him or her. I mean, that's going to make a big difference in this. And I agree with you, it's a very important issue.

Q. Good morning, Mr. President. I am a trauma surgeon in San Bernardino, California. Medical malpractice concerns and the practice of defensive medicine are serious issues associated with the—[*inaudible*]—of care to the trauma patient. Mr. President, we are very pleased that you believe that the tort reform should be an essential part of the health care reform and have adopted some of—[*inaudible*]—provisions in your plan. But sir, would you be willing to add to your plan the most essential part of the—[*inaudible*]—that is, a $250,000 cap on noneconomic damages? And sir, if you just say yes, I would be happy.

The President. As you might imagine, we debated that thing for a long time before we presented our plan to the Congress, because we didn't want the whole health care plan to come a cropper on a debate over tort reform. We thought there had to be some. We knew that the States were taking up this issue to some extent, but we thought we ought to do something nationally, even though tort law historically has been completely within the purview of State government, not the National Government. So we agreed that there ought to be a limitation on lawyer fees, contingency fees. And we did some other things that were recommended by you and were in the model work that was done in California.

Something else we did that I think has been insufficiently noticed is we agreed to include medical practice guidelines developed by professional groups as raising a presumption that there was no negligence on the part of doctors. This offers an enormous opportunity to dramatically reduce the number of medical malpractice suits, the number of recoveries, and therefore the malpractice rates.

My own view is that based on the research I've seen in a couple of places where this has been tried on a limited basis, is it may offer the best hope of all of protecting doctors from frivolous lawsuits by simply raising a presumption that the doctor was not negligent if the practice guidelines developed by the professional groups themselves were in fact followed. So I think that that has been not sufficiently noticed. That is a very, very big step, in addition to the other things I mentioned.

My own judgment is that we will not include the national cap because there will be so much difference among the various congressional delegations from different States about what the caps should be and whether it should change with inflation over time. And in fact you might wind up in California with a situation different from the one you have now if it were to be done. For example, if there were a debate on the national cap, then the immediate thing would be, what should the cap be, and if States have a lower one, should it be required to be raised? Because all those things were involved, we decided that we would leave the cap issue itself to State law and deal with these other matters.

I urge you to look at what we have done, because I think we've taken a long step toward trying to relieve doctors of the burden of frivolous lawsuits and trying to control the cost of malpractice insurance.

Q. Thank you, sir.

Q. Good morning, Mr. President. I'm a practicing family physician in Modesto, California. I'm also the current California Academy of Family Physicians president and past president of the Stanislaus County Medical Society.

Mr. President, when I entered medical school, I was led to believe that I would spend my career practicing health care. I find that an enormous part of my day is spent

battling with health insurance clerks to get authorization for my patients to have some of the even most basic of health care. Obviously, it would be better for me to spend that time seeing patients. What will your plan do to prevent or to limit the use of these managed health care organizations from providing these, or throwing up these artificial barriers in the name of managed care, but in reality these things prevent us from providing that care?

The President. Let me try to restate what I said before. I believe that the micromanagement of medicine by insurance companies has reached an excessive point. And what we have tried to do to reduce it, since we can't—you don't want the Federal Government exactly passing laws saying what decisions can or cannot be made by physicians and others working with them. What we've tried to do is to change the whole system so that it would be much less likely.

And I will mention two things again. Number one, we make it easier for people like you to join with like-minded physicians in providing services directly or to join together and to tell people if you're going to work with them, you don't want those kinds of utilization reviews. And we require the insurance companies to disclose their utilization review protocols in advance. And they will be under much more pressure than they are now because now they won't have the same shot at business XYZ's employees because the employees themselves will be deciding whether they want an HMO, do they want a PPO, do they want some other kind of organization, or do they want to have fee-for-service medicine. Under each case the employer's liability is the same—responsibility is the same. So I think that we are changing the environment in ways that will really permit you, working with your fellow physicians and your patients, to cut down dramatically on the number of these abuses.

I also want to point out that if there is a single card which we envision which entitles a person to health care and which enables them to hook into a computer which says that they are covered and all of that, and if there is a single form related to the comprehensive benefit package which can be filled out in every doctor's office and hospital in the country and then processed by every insurance company in the country, then that is going to dramatically reduce the paperwork burden, too. I have many, many doctors complain to me that the time they have to spend and the money they have to spend in their clinics on post facto paperwork has exploded in recent years. And I think that is also very important, cutting down on that burden, not only the time, but the money is critically important. So I believe that we will make it better.

If you have further suggestions, I'd be glad to hear them. But this is an area in which it is difficult to legislate directly and in which many physicians are reluctant to have us legislate directly. It seems to me if you change the economics and change the distribution of the power of decisionmaking in this whole process, giving more to the doctors and to patients through the workplace and less to the insurance companies, that the practices will inevitably change because the shift of decisionmaking has occurred.

Q. Thank you very much. Mr. President, we know that your time is very tight. If you could spare us a few minutes, we have some other questions that we would hope to be able to put before you.

The President. Please do, because I know we've got one or two other issues that I think should be dealt with.

Q. Thank you, sir.

Q. Mr. President, I practice anesthesiology in San Diego. And I want to thank you for the opportunity to ask you a question today. Two years ago, right here in California, in this State, with the support of this organization, we passed a law that created voluntary health insurance purchasing cooperatives. In fact, you just alluded to them a few moments ago. And as you said, they so far have been enormously successful, both in extending access and in eliminating costs.

My concern is that there are some reform proposals that would cause these purchasing pools or alliances to become so large and thus so inflexible that they would in fact limit rather than enhance the competition that you yourself state, and I agree with you, that we want to see in the marketplace. So to make these entities work the way I think we both wish them to, the alliances and the purchas-

ing pools, I believe that we need to limit their size. So my question for you this morning is what would you propose to control the size of the purchasing pools and alliances so that they would fulfill their primary purpose of providing affordable, accessible care and not become a large, inflexible bureaucracy?

The President. Well, let me first say that I agree that we shouldn't have them become large, inflexible bureaucracies. Under our plan, the alliances would be much larger and the membership would be mandatory. But that's because we're trying to achieve something with our plan that is beyond what the alliances do. I think it will all be debated in the Congress, and I'm certainly flexible on it.

But let me explain why we recommended larger alliances and offer you, not just you individually, sir, but your group there the opportunity to suggest to me—either to Ira Magaziner who's there or to us through a letter later—how we could achieve the same objective. Because I know a lot of people say, "Well these alliances are too big or the work units—you don't—people with several thousand employees in them." And at one level, I think that's right, but at another level, I'm not sure, and let me explain why.

The purchasing co-op that you have in California, which has worked real well, is designed primarily to give small businesses bargaining power so that they can, in effect, have the same access to health care at the same cost that people in large units like big corporations and Government do. You can do that with smaller alliances, let's say with people with a few hundred employees or 100 or whatever it is in California, 50 and down, you can do that. The same thing is now happening in Florida where they're seeing these results.

What we wanted to do with the alliances were three other things that it still seems have to be done somehow under the plan. First of all, through the alliances, we were going to distribute the small business discounts. We can find another way to do that, but that was going to be done.

Secondly, we were going to provide certain handling services basically to bring together and reduce the paperwork burdens of the physicians, the employers, and the insurance companies. We were going to do a lot of the paperwork there. That can probably be done some other place.

The other thing, though, which I think is very important, and which all of you clapped when I mentioned earlier, is the alliances as large units were going to be used to make it financially possible for the insurance companies to observe community ratings. And I'd like to talk about that a minute.

There are two issues here on discriminatory rates. One is, how do you get small businesses and self-employed people access to the same rate structure presently available to big business and Government? The other is, how do you, as a practical matter, eliminate unfair billing practices without bankrupting the insurance companies that are still in the market? That is, how do you eliminate preexisting conditions? How can you afford to do away with lifetime limits? How can you eliminate rate discrimination against people with preexisting conditions in their families or against workers who are older at a time when older workers are having to change jobs a lot in their life, too?

Now, you can pass a law and say, we'll have community rating. But New York did that, and yet they still don't have it. And the reason is, they don't have any mechanism within which community rating can be practically made to work in a State where you have a lot of different insurance companies. And the insurance companies simply cannot solvently—can't stay solvent and do that unless people are insured in very large pools where insurance companies can make money the way grocery stores do, a little bit of money on a lot of people.

So the fundamental difference in what California has done, which is very good, and what we are seeking to achieve is that I'm not sure that, unless we have everybody below a certain substantial size in one of these alliances, we can achieve community rating. We can get better breaks within the present system for small businesses, but I am not sure we can get community rating. That's the rub. If we can solve that, I'm very flexible on the rest of this. I mean, I'm just trying to achieve an objective that we all agree is necessary.

Q. Mr. President, I practice emergency medicine in inner-city Los Angeles. Every day I see the impact of undocumented immigrants on our health care system. Mr. President, I'm grateful to you for making health system reform a top national priority. Your proposal provides health security for all citizens and $1 billion to cover noncitizens.

However, in some of California's largest counties, up to 25 percent of the population are noncitizens, both legal and undocumented. Currently, Federal law and our own ethics as physicians require that we provide care. But the reality is that these costs are putting an enormous strain on our State's health care delivery system and the entire California economy. We are spending close to $1 billion in Los Angeles County alone to deliver health care to undocumented immigrants. How do you feel we can better address this problem?

The President. It's a difficult one, as you know. Let me make a couple of observations, and then say where I think we are practically.

Obviously, no State or local government should be required to shoulder the cost of immigration or the lack of an immigration policy or the inability to enforce the policy we have now at the national levels. But as a practical matter, as we all know, it happens all the time. Now, in my last two budgets, I have tried to provide more funds to California, especially in the areas of health and education, for dealing with the extra costs of immigration because I think it's not your fault.

Now, in this health care plan, we provide a billion dollars in extra money. Is it enough? Of course it's not but it's a good step in the right direction. Let me say that if you look at the States with the big immigrant health care burden, California, Florida, Texas, New York, although there are five or six others with substantial burdens as well, our plan will save the States enormous amounts of money that they would have paid otherwise in out-of-pocket Medicaid match costs, long-term care costs, and other health-related costs related to running public health facilities, for example. In other words, our plan—we estimate that California will save, if our plan goes into effect in 1996 or we begin to put it into effect in 1996, phasing it in, we estimate California will save about $6 billion or more between that year and the end of the decade, new money that would not have been there otherwise in this budget. That will also allow the State to divert some of those resources to health care as well as to dealing with some of your long-deferred education and other problems out there.

So I believe that, between the savings that will occur from the State of California and the funds that we can put into immigrant health care—migrant health care—directly, I think that will make a big difference. Now, let me say, this fund will start at a billion dollars, but obviously, based on the evidence and based on our ability to secure savings in other aspects of the system, Congress will be free to supplement this fund every year from now on. That's where we're going to start.

I realize it doesn't solve the whole problem. I think it's frankly all we can afford to do at the moment. And I think the savings which will flow to the State from passing this plan will be so great that they in turn will be able to do more and still have money left over to address other needs of Californians. So I hope they'll stick with it, because I think it's the best we can do right now.

Q. Mr. President, you really need to know that over half the hospitals in California are currently operating in the red. It is an urgent problem, and I hope that the solution to the problem would not be tied to the whole health system reform.

Thank you.

The President. I certainly agree with that. Let me just say one other thing. I agree that we cannot hold this problem hostage to health care. We're just trying to use the health care reform which will free up billions of dollars to put more into medical research, more into undocumented alien health care, and other things. But I agree that we have to deal with it.

Q. Thank you, Mr. President. Do you have time for one last question?

The President. Sure.

Q. Thank you very much, Mr. President. I practice internal medicine in Los Angeles. I also drink Diet Coke. And I'm delighted to be here this morning as president of the California Hispanic-American Medical Association. Mr. President, in California, our

managed care system has evolved from what started as a not-for-profit market into one which today is dominated by large for-profit publicly traded HMO's. This evolution has also caused the profits and administrative costs of these HMO's to soar, while health care services to patients has plummeted. While the CEO's of these corporations make millions, I have to argue with these same companies who insure my patients to approve immunizations, pap smears, and mammograms. The CMA is sponsoring legislation in California to limit the administrative costs and profits of these companies. How do you feel about this situation, and how would your plan protect other States from this trend?

The President. In two or three ways. First of all, under our plan those plans will have to offer pap smears, mammograms, and other preventive and primary services. They won't be able to cut them out. Secondly, these companies will be under much more pressure to provide quality service and to siphon less money off to bureaucracy and profits than they are now because they won't be able to make a deal with employers which can then be enforced on employees. Every employee—that is, every patient you see will be able to make a new choice of plan every year. So if they get abused in year one, then in year two, the next year, they'll be able to make the same choice they made last year all over again and choose a different plan or fee-for-service medicine or a group of physicians who are providing health care.

So this will fundamentally change the whole incentives of the system. They simply will not be able to use the fact that they have a preexisting relationship with an employer to undermine the delivery of quality of care between the doctor and the patient, because the patient will be making a decision and every year can make another decision. And that will have a profound impact on it. And they will not be able to eliminate primary and preventive services from their package. That has to be involved. So that's going to change it.

Then we will make—when we make some of the changes in the antitrust laws, which will make it even easier for physicians to get together and deliver health care directly. So these HMO's are going to be under a whole different kind of competition. It won't be competition from somebody else providing less service at lower costs, it will be competition from somebody else providing more services and higher quality with more choices for the same costs or sometimes less.

So I think this will really change things and put you and your patients much more in the driver's seat than you are now. That's perhaps the most critical element of my plan that has not been really noted. We are not restricting choice, we're expanding it. And we're putting the decision—we're moving the decision from the employer to the employee about who makes the choice, which means you're moving it to the patient. And that should be, I think, something that will make a profound difference, particularly after you all get through talking to all of them.

Q. Mr. President, everyone in this room and all the people we represent would like to thank you for taking the time from your busy schedule to meet with us today. We want you to know that we're with you in this fight and we'll join with you in working with Congress in a joint effort to guarantee all Americans private health insurance that can never be taken away.

The President. Thank you. And let me just say in closing, if I could ask you one thing, it would be to impress upon the Congress the importance of acting and acting this year. This is a very complex issue. No one has all the answers. We'll be improving on what we do from now until kingdom come. But you know, more uniquely than most people do, what the consequences of not doing anything are, and that's more restricted managed care, more people without any insurance at all, more of the headaches that you have already complained about today. So you are in a unique position to embrace the fundamental principles here, work with me on the details, and impress upon your very large congressional delegation that the time to act is now, not next year, not 5 years from now, but now.

Thank you very much.

NOTE: The teleconference began at 11:47 a.m. The President spoke from Room 459 of the Old Executive Office Building. In his remarks, he referred to Dr. David Holley, president, California

Medical Association. A tape was not available for verification of the content of these remarks.

Remarks to Health Care Providers

March 23, 1994

Thank you very much. It's a great honor for the Vice President and Mrs. Gore and for Hillary and me to have all of you here today. I want to especially thank Dr. Haggerty for his moving account, and Marva Wade for having the courage not only to tell us the story of her work but the story of her family, and Sister Bernice Coreil for her stout-hearted defense of our continuing efforts.

I was sitting there thinking when she was speaking, I wonder how many nuns have ever given a speech and quoted Machiavelli? Well, I suppose he was a Catholic. [*Laughter*] And he certainly was right about a lot of things.

I want to say to all of you how important it is for us to have you here to validate our common efforts because of your work, your life, and your experience. We've been seeking out a lot of that lately. Hillary and I went to Florida the first of the week and met with thousands of senior citizens, some of whom have been frightened by claims that we were trying to do something to Medicare instead of to protect Medicare and to extend its benefits to prescription medicine and to long-term care options in the home and in the community.

I met yesterday with a very, very moving group of a couple of hundred small business people, and 12 or 13 of them talked. About half of them, by the way, in endorsing our program, acknowledged that they would pay more if our plan passed, but for the first time they'd be able to insure all their employees instead of just a few of them and insure them with good benefits. And for a change their competitors would be on an even field with them because they would have to do the same thing, and they'd all make out all right.

This morning I met by teleconference with the California Medical Association, the biggest affiliate of the AMA in the country, and they were extremely supportive of this plan and what we are trying to do.

And of course, now I'm meeting with you. And along the way, I have had encounters with people that we didn't plan that have made the same points all of you have made. I was in Florida and as I often do when I'm traveling, I agree to meet with children who are part of the Make-A-Wish network around the country, desperately ill children. And I met a family with two boys with a rare form of cancer which they believe must be genetically related because both their sons have it, and they have a daughter who is the youngest child and who has not yet been diagnosed. And we all hope she won't be.

But this family was living in mortal terror because they had a lifetime limit on their insurance policy, and they thought, well, maybe one of their sons would become an adult. They're both surviving and maintaining it, but if they have good success with the treatment and both the boys are able to live and go on and do well, they'll certainly outrun their lifetime limits while the younger son is still at home and needing care.

I was in Columbus, Ohio, the other day campaigning for our crime bill, and I stopped in a delicatessen where the owner of the delicatessen, who wound up being one of our small business people here yesterday by the way, came to me and said, ''I am in the worst of all worlds. I have 20 employees that are full-time, 20 that are part-time. I had cancer 5 years ago. I'm about to be declared cancer free. Because of my preexisting conditions, our deductibles went up, our copay went up, our premium went up. But I still cover my 20 employees. I'm proud of that because it's the right thing to do, but I'm at a competitive disadvantage to everybody who doesn't, and I feel guilty that I don't cover my part-time employees.''

So I hear these stories always. And those of you who are on the frontlines of medical care must wonder from time to time when you hear people make these speeches or you see these television ads, what planet they came from—[*laughter*]—because it's so inconsistent with the personal experience you've had.

Hillary and I have gone to extraordinary lengths to try to get people to look at this anew. We even made our own Harry and Louise ad for the national press the other