Antitrust

The Book and Pricing

DEPARTMENT OF JUSTICE

PRESS CONFERENCE

ATTORNEY GENERAL JANET RENO

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PRESS CONFERENCE

(10:35 a.m.)

ATTORNEY GENERAL JANET RENO

GENERAL RENO: We would like to welcome the First Lady to the Department of Justice. She is helping -- this is her first visit here, and I think it is wonderful that you as a lawyer have a chance to see where justice gets done in this district.

I would like to introduce Anne Bingaman, who is the Assistant Attorney General in charge of the Antitrust Division, who has been doing a wonderful job, and it is a special privilege to introduce the Chairman of the Federal Trade Commission, Janet Steiger. It is truly a pleasure to have her here, and it has been a pleasure to work with you.

We have Senator Howard Metzenbaum, who was the first person to talk to me about antitrust when I arrived in Washington back in those earlier days, and the first person I met in Congress, Chairman Jack Brooks. It is a privilege to have you here, Senator.

Americans want quality health care. Everywhere I have gone throughout this Nation in these last 6 months, the refrain was the same from people in every walk of life. To achieve that goal, to assist the President and Mrs. Clinton in this effort, we must make sure that we do

our part in the Department of Justice to eliminate excessive costs and delay in setting up an efficient, effective health care system.

We have been asked by health care providers, where would we stand under the antitrust laws? What can we do, what can't we do? We are here today to announce an antitrust policy statement to provide clear guidance to health care providers. The policy statements issued jointly by the Justice Department and the Federal Trade Commission include a commitment for expedited business review, the first time this has been done.

Requesters can expect an answer within 90 days after submitting the necessary information as to their particular situation and what can be done under the antitrust laws. This will be important.

Take some of these examples. Three small hospitals in Maine want to share the cost of a mobile CAT scan machine. They have not done it, because they cannot find out quickly whether the agreement would violate antitrust laws. We want to give them the answer up front so that they know where they stand.

Hospitals in another city want to know whether they can get together to buy a medivac helicopter. Hospitals in Ohio want to buy furniture together. We want to let them know whether they can or can't under the

antitrust laws in an expedited way that is fair to all concerned.

Doctors in another State want to know whether they can form a preferred provider organization to contract directly with insurance companies. An accounting firm in Atlanta isn't sure whether it can set up a deal for acute care services.

The speed and extent to which health care reform is carried out will depend on how quickly and how well the Government is prepared to answer those questions, and that is the reason we are here today, but that is not the only effort we are undertaking in health care reform. The President has asked for a larger review of health care issues.

The Justice Department is currently evaluating measures to increase the Federal power to fight fraud and abuse, for example by strengthening anti-kick-back laws and making heavy penalties against defrauding the Government applicable to those who defraud the private health care system as well. Those of us in law enforcement plan to be an important part in the President and Mrs. Clinton's effort to make sure that health care is available and affordable for all Americans.

The First Lady and I are going to have to leave early, so I want to make sure that she has an opportunity

to be heard first.

It is a great privilege to have her here today. I met her a little over a year ago, and to watch this lady in action has been one of the great opportunities. She is a person who is dedicated to this whole Nation and day-in and day-out through these first months of this first year she has truly demonstrated her commitment to America and to health care reform. It is wonderful to have you here, Mrs. Clinton.

(Applause.)

FIRST LADY HILLARY RODHAM CLINTON

MRS. CLINTON: Well, as Attorney General Reno said, this is my first visit to the Justice Department, a place that has always had a lot of personal and professional meaning for me, an with whom I have had a relationship through the years with various lawyers who have had the privilege of serving here.

It is a particularly special occasion for me to be here, and to know that Attorney General Reno is at the helm, and to know how faithful and committed the many, many people in this Department are to what the words above the entry say.

I particularly want to thank Attorney General Reno and her Department for their participation in our health care reform effort. From the very beginning,

lawyers from the Justice Department have been involved in the work that has gone on to try to analyze the many, many issues surrounding health care and come forward with workable solutions.

I want to applaud the actions taken today by the Department and the Federal Trade Commission in issuing these guidelines. They are the result of a lot of hard work by Anne Bingaman and Janet Steiger, by Senator Metzenbaum and Congressman Jack Brooks, and their very dedicated staffs.

These guidelines represent an important first step for an industry that is facing rapid change. They are a good example of what health care reform is all about. They will help lower costs, maintain high quality, and knock down the barriers to collaboration that unfortunately are too common in our present system.

The Attorney General has spelled out what the problem is. We have a complex and inefficient system that keeps doctors and hospitals from spending their money wisely and drives up the prices that consumers and the Government have to pay. Over time, the actions we take will turn this system the right side up.

Instead of requiring every hospital or doctor's office to buy the same expensive piece of equipment, these guidelines will allow them to share that equipment. They

allow physicians to get together to control costs, and they allow mergers that are competitive and save consumers money.

I have learned many, many things about our health care system in the past months, but one of the first lessons that I learned came to me from traveling around the country, when a member of a hospital board or a physician or a hospital administrator would come and, with real poignancy say, we want to help, but we cannot even have a meeting to talk about how we could have one piece of expensive equipment in our community instead of all of us feeling compelled to buy one for ourselves because our lawyers tell us we cannot cooperate.

This is not a problem that comes from the Justice Department or the Federal Trade Commission or the Senate or the House. This is a problem that comes from the grassroots of people trying to do a better job to deliver quality health care.

These actions are pro-competition, pro-collaboration, and pro-consumer. The results over time will achieve the following positive results: consumers will pay less, equipment will not stand idle, it will be used more frequently, hospitals will save money, the pressure on physicians to order tests to pay for the machinery that they bought in order to be competitive will

stop, and the highest quality tests and the latest technology will still be available, and I would argue more readily available, to those who need them.

I also want to thank the Attorney General and the Justice Department for their ongoing and accelerating efforts to crack down on the problem of health care fraud and abuse. As the Nation's health care bills have mounted, consumers and businesses have paid a high price. The crimes have grown more sophisticated and more outrageous, and every time someone rips off the health insurance system, the public, the private insurers, all of us pay more.

Settlements like the ones the Department has recently achieved on the West Coast, and the strong measures that we will have more to say about next week send a strong warning to those who would steal from the American taxpayers and permit the kind of health care fraud that has a damaging impact on all of us, no matter who we are.

We intend to make it very clear, health care fraud will not go unpunished. In a reformed health care system there will no longer be any room for the kind of games that for too long have permitted the kind of fraud and abuse that we are cracking down on now.

This is a message we must send to every American

who has health insurance and pays too much, and to every American who does not know if they will be able to afford their coverage next month or next year.

It's a great pleasure for me to stand here in this department with this team that has been assembled to take these steps on the road to getting health care costs under control and providing health care security for every American.

This is the kind of example of thoughtful, careful work that leads to a positive result that will translate into better health care for Americans in the years to come.

Thank you very much.

(Applause.)

GENERAL RENO: The leader of the Antitrust Division is Anne Bingaman, one of the most dedicated and vigorous lawyers that I have met in Washington. It is a true pleasure to have her on this team in the Department of Justice.

She has been working with the really dedicated people in that division, people who care so much about antitrust enforcement. She is going to remain to answer questions, but she might have a few words for us now. Anne.

(Applause.)

ASSISTANT ATTORNEY GENERAL ANNE K. BINGAMAN
IN CHARGE OF THE DEPARTMENT OF JUSTICE'S ANTITRUST DIVISION

MS. BINGAMAN: Let me just speak to you briefly, because Chairman Steiger and I will remain to answer detailed questions on the guidelines.

Let me just emphasize the extraordinary cooperation and coordination and consultation that went on jointly between the Federal Trade Commission and the Department of Justice in developing and issuing its guidelines. It is, I believe, almost unprecedented. It has been a wonderful experience.

It is exactly the kind of responsible and responsive Government that we need to have, because we recognize -- the Federal Trade Commission recognizes and the Department of Justice recognizes there is a problem out there. People in small communities honestly didn't know what the rules were.

As the First Lady said, you hear it over and over again. The rules were there, but they were in speeches and letters and business review advisories going back over a 10-year period, so that if you were a partner in a major New York or Washington law firm, you knew the letter issued February 18, 1985 covered such-and-such, but if you were somebody in Santa Fe, New Mexico, my home town, you may not know there were such letters, and yet

you had to give advice to your local hospital or your local group of physicians as a lawyer, or if you're on a hospital board, or a doctor trying to comply, you had to understand what the rules were.

So this is an effort to clarify, to state in one simple place what those rules are, and to commit to ongoing review in order to provide responsible help to the health care community throughout this country in a time of enormous change which needs to occur, and we want to do our part.

I want to thank Chairman Steiger and the Federal Trade Commission so sincerely for their enormous help. It has been a great pleasure working with them, and we look forward to many months and years of cooperation.

Thank you.

(Applause.)

ATTORNEY GENERAL RENO: Chairman Steiger has set an example for us all in terms of cooperative effort between Government agencies that are concerned with the same jurisdiction and the same subject matter. It has been a wonderful opportunity for us to work with the Commission and with Chairman Steiger, and it is a great privilege to have her here today.

(Applause.)

FEDERAL TRADE COMMISSION CHAIRMAN JANET D. STEIGER

CHAIRMAN STEIGER: Thank you. I also will be brief, since we are going to take 20 questions afterwards. But our thanks at the Commission for the leadership of the First Lady, and the Attorney General, and, of course, Anne Bingaman, for their assistance to us in this effort. And we cannot leave out the Senator and the Chairman, who were always resources for us in these efforts.

I just want to stress that the policy statements do represent a collaborative effort by the two Federal agencies who are entrusted with the responsibility for antitrust enforcement. They also represent a bipartisan effort. Sound antitrust laws is not a partisan matter.

The First Lady has noted that guidance is needed in how the antitrust laws do apply to the field of health care. Health care is vital not only to our physical wellbeing as people, but to our economic wellbeing as a county. And antitrust enforcement has historically played a very important role in protecting competition in the health-care markets, and in lowering the cost of health care for consumers.

But antitrust is, as Anne Bingaman said, a very complicated area of the law, particularly as it applies to the field of health care. This complexity has given rise, we believe, to the need to tell people with clarity what kinds of activities are and are not permissible, so that

legitimate conduct is not deterred, conduct that is beneficial to consumers. That that conduct is not deterred by a fear of antitrust enforcement that is not in order.

We at FTC are very proud of our record in the health-care area, of our record of challenging barriers to the development of HMO's and other innovative health-care delivery systems. And we are proud of our record of attacking conspiracies to raise prices to consumers. Sound antitrust enforcement efforts of this type should and will continue. But at the same time it is important to attest there are such as those we took today, to better explain our enforcement intentions so that misunderstandings about those intentions do not inhibit activities that benefit consumers.

I owe a special debt of thanks to my colleagues at the Federal Trade Commission, Commissioners Azcuenaga, Starek, and Yao. And I must add a real special thanks are due to Commissioners Yao, who is here with us today, and Starek. They took the very heavy work in the organization and coordination of our efforts at the FTC.

Thank you.

(Applause.)

ATTORNEY GENERAL RENO: Senator Howard Metzenbaum is the distinguished Chairman of the Senate

Judiciary Committee's subcommittee which deals with antitrust issues. No person in Washington is more concerned with the vigorous enforcement and fair enforcement of the antitrust laws of this Nation, and we are delighted that he cut short a meeting on the Hill to be with us today.

Senator, welcome.

(Applause.)

SENATOR HOWARD METZENBAUM, DEMOCRAT, OHIO

SENATOR METZENBAUM: Jack, I hope you get the message. Because it is a tremendous sense of excitement that I feel that here are we two males, we, while these four wonderful women provided leadership. Government has changed in Washington and I am all for it, and I couldn't be more pleased about it.

(Applause.)

SENATOR METZENBAUM: I am also excited about the fact that we are going to solve a problem in the antitrust field without changing one word, one comma, or one semi-colon of the antitrust laws. And there is no need. Our antitrust laws are not to blame for the high cost of health care. They have protected consumers from price fixing and gouging. In fact, the antitrust laws have never blocked a pro-competitive health care deal.

We are here today to clear up confusion among

doctors and hospitals about how these laws apply to them. We want to end their uncertainty. If legitimate confusion about antitrust has slowed down even one cost-cutting merger or joint venture, that is one too many. These policy guidelines are proof positive that we can make our laws work to accommodate businesses when their concerns have logic and merit.

I became convinced that the hospitals were looking for clarity, not loopholes, when I chaired a hearing on the subject last March. And I also attended a hearing conducted by Senator Rockefeller where a half-dozen Senators indicated their concerns about the hospitals trying to work together in their local communities, and saying what a great problem it was, that we had to change the antitrust laws.

At that time I said we don't have to change the antitrust laws; we can work this out. And this is the culmination of those efforts, because it has been brought about without changing the antitrust laws by bringing about changed guidelines that spell out what can and can't be done.

Together, we began to look for resolution after those meetings. And thanks to the help of the American Hospital Association, they took the extraordinary step of writing the First Lady to win her support for antitrust

guidelines for hospitals. I promised the AHA that I would work with the Justice Department and the Federal Trade Commission to come up with guidelines.

Today's announcement is a victory for consumers that will speed health-care reform. These measures will help end uncertainty about how the antitrust laws will apply to hospital and physician deals, without creating costly loopholes in those laws that could hurt consumers. They will also help hospitals and doctors to understand the difference between a joint ventures that cuts costs and also benefits the public and a joint venture that is likely to eliminate competition and drive up prices.

I hope that we will hear from others in the medical profession who have voiced similar concerns and fears. We can work these problems out together. And thanks to the magnificent leadership of the First Lady, the Attorney General, Janet Reno, and Anne Bingaman and Janet Steiger, we are here today, and this is a victory for the people of this country and I am so pleased to participate in it.

Thank you.

(Applause.)

ATTORNEY GENERAL RENO: You all know Jack Brooks as Chairman of the House Judiciary Committee. He is also one of the most vigorous and most committed people to

efforts of full and fair law enforcement at all levels of anybody I have met in Washington, and it is a pleasure to be with him here today.

Mr. Chairman.

(Applause.)

CONGRESSMAN JACK BROOKS, DEMOCRAT, TEXAS

REPRESENTATIVE BROOKS: Thank you very much. I am the last speaker, you'll be happy to know.

(Laughter.)

REPRESENTATIVE BROOKS: With the appointed of Attorney General Reno, and Assistant Attorney General Bingaman to head up the antitrust division, I have great expectations for competition policy. For 12 years antitrust has languished and was viewed by those in authority as the enemy, not as a guarantor of the small business community and the American consumer.

But in the past few months this administration, with the leadership of Anne Bingaman -- I call her Saint Anne or the Coppertone Kid -- has reaffirmed its commitment to our national competition policy, and today is no exception.

As the Health-Care Task Force began its work in earnest this spring, a number of health-care entities, position groups, hospitals, pharmaceutical companies, came seeking relief on the Hill from the antitrust laws. That

is, to speak plainly, they came seeking antitrust exemptions. At the Judiciary Committee we are used to hearing such requests. Frankly, we don't believe in many of them and use every effort we have to end the few exemptions that exist now on the books. They are unnecessary. They are harmful even to those who come seeking.

At the same time, we must acknowledge that in the health-care area antitrust uncertainties do exist and need to be addressed in a cooperative manner between enforcers and private parties. There is no substitute for such cooperation. Adversarial legislation and litigation should always be the last resort.

And very early in the health-care review process, I met with Mrs. Hillary Rodham Clinton, our First Lady, and discussed my deep-felt view that it was imperative to avoid extreme steps in the antitrust area because of the many unintended consequences that could result in both the short and long term. She listened carefully. She was well versed in the history of importance of a strong antitrust policy in this country. Hers was a nearly overwhelming task, and few would have been up to it. She was.

I am very pleased today that the Clinton administration has unveiled a plan, has chosen to reject

the exemption route in favor of the clarification route. Already in place, already working now, we are seeing the benefits of such an approach in other critical and strategic industries that are taking advantage of prenotification and consultation for a variety of research and development activities, and now for production joint ventures.

I intend to do my share in moving the antitrust section of the health package forward in the coming months. What we are witnessing today as the unveiling of health-care antitrust guidelines is simply good medical technique, opting for preventive medicine rather than radical surgery. And I would say that the two ladies we've got here, these women are not tough -- they are not tough. They are highly intelligent. They are dedicated. They are compassionate. And for that we, in this country, have a lot to be grateful.

I want to say I salute the First Lady and the wonderful work of you, Janet, and your organization, and the Justice Department. Thank you.

(Applause.)

ATTORNEY GENERAL RENO: Ms. Bingaman and Chairman Steiger will now be available to answer your questions.

QUESTION: I know that Senator Metzenbaum said

that this does not change the antitrust law, but it is my understanding that the White House says this is the first piece of the antitrust package and that legislation is to follow.

What legislation will be coming out after this?

MS. BINGAMAN: It is not my understanding that there will be antitrust legislation as such. The President's package is not part of what I call this package -- at least in the guidelines. But it is my understanding that there will not be antitrust exemptions as legislation in the health care package. These guidelines and policy statements and the very important business review procedure which we commit to there on an ongoing expedited basis. It is certainly, for everyone who has a question, it is my understanding that that is our approach.

QUESTION: It is my understanding that Magaziner was saying that --

MS. BINGAMAN: About a week ago I heard people say -- I can't address that. I just can't. And I told you what I know, and I am doing the best I can at this point.

QUESTION: Does this mean that the petition by the drug industry will probably be rejected? And have they asked for any exemptions?

QUESTION: Can we have her repeat the question, Anne?

MS. BINGAMAN: She said does this mean that the exemption for the drug industry -- this is the pharmaceutical manufacturers' request -- will be rejected?

QUESTION: Yes.

MS. BINGAMAN: We have that under advisement and we expect to act it in the near future. But I would not want to pinpoint it. It does not touch on it actually as such. There is nothing in these policy statements that directly address this -- any issue on that.

QUESTION: And can you say in what way -- can you tell us in what way we are going to crack down or beef up your efforts to go after fraud?

MS. BINGAMAN: The Civil Division is in charge of fraud. We are the Antitrust Division. And the FTC and the Bureau of Competition does antitrust enforcement.

QUESTION: I understand that, but they said, in concert with this policy, these policy guidelines, there would be a crackdown on fraud.

MS. BINGAMAN: I think you are aware of the San Diego case and the very massive settlement involving fraud. I think what is expected is more emphasis, more looking for cases like that, and more focus on that, in order to prevent high cost due to fraud. That is my

understanding. But it is not my direct responsibility.

QUESTION: Ms. Bingaman, I have observed in the past a lot of complaints in Washington about that the Antitrust Division in the last 12 years has largely ignored big corporations and big cases, and gone after the small ones. I trust you are going to change that policy?

MS. BINGAMAN: Oh, I tell you the truth, we are going to enforce the laws as best we can on the facts, as they come before us, period. That is what we are going to do.

CHAIRMAN STEIGER: I think we are all committed, and I certainly have been and our Commission has been, in the past four years, to vigorous enforcement of the antitrust laws. And our record will speak for itself on that point.

QUESTION: Can you tell us what happened to the plan on the McCarren-Ferguson exemption for health insurers?

MS. BINGAMAN: My understanding -- again, this is not my bailiwick as such, and I think it is in the health care plan, the draft of which is circulating -- is that McCarren-Ferguson will be modified and limited for health care insurers. As some of you may be aware, I testified before Chairman Brooks' committee about June or July on behalf of the administration. We favor limiting

the scope of McCarren-Ferguson.

We did not testify on the particulars or a particular bill, but we said that we believed the McCarren-Ferguson exemption should be narrowed.

QUESTION: May I follow up? But you would need legislation, would you not?

MS. BINGAMAN: Yes, yes. Oh, definitely. There would have to be legislation for this. It is just that the particular language -- the particular terms we have not worked through yet.

QUESTION: Is that the only legislation involving this? Or have you tried to answer that before? Other than McCarren-Ferguson, are there any other aspects of this that require legislation?

MS. BINGAMAN: To my understanding, McCarren-Ferguson is what is affected in the antitrust area. If there is anyone in the room here who has a different understanding, I am not aware of that.

QUESTION: You have a 90-day review process. What is it currently, or is there no system for review?

CHAIRMAN STEIGER: The Justice Department has, in the past years, promised business review letters that would be finished in 90 days. The Commission, until this policy statement, has not had such a deadline system. And we are now committed to 120 days, depending upon the

subject matter response. And this is a new commitment for the FTC.

MS. BINGAMAN: I might add, it is a new commitment for the Justice Department, too, in that the previous policy was best efforts to answer in 90 days. It was not a binding, flat commitment. Secondly, the previous policy, which still applies to all other industries, is to answer such questions as we believe need to be answered. We retain the discretion, if we think a question is trivial, unimportant and simply not worthy of our limited resources to invest the time, to simply say to the lawyer asking: Take your best shot. We are not doing that in health care.

So, for the Justice Department also, this is a new commitment for the health care industry in that we commit absolutely to answer any question within 90 days, and we retain no discretion to not answer any request. We will answer all requests in the interest of certainty and clarity in this area.

QUESTION: What about retroactive cases? If there is a merger pending, what are the guidelines? When do they take effect? And what happens to mergers that are now underway with regard to the FTC or Justice Department, or any other agency?

CHAIRMAN STEIGER: They do not apply to pending

cases.

QUESTION: If they are pending as of today?

CHAIRMAN STEIGER: That is right.

QUESTION: So all of these cases that are now in the courts, will those have to be worked out?

CHAIRMAN STEIGER: If they are in litigation, this does not apply.

MS. BINGAMAN: As a practical matter, though, I might just amplify. I do not think either one of the agencies views these statements as a change from current policy. They are simply a synthesis of the multitude of business review letters, consent decrees and so forth, that it is an effort to simplify.

So, as a practical matter, although clearly the chairman is exactly right, these are effective today, and from this day forward. I am not aware that there would be any practical significance to that.

CHAIRMAN STEIGER: I think that is an important point, and I agree with it.

QUESTION: Just to clarify. You just said that the 90-day review was new. Is that the only new thing? Is that the only new provision?

MS. BINGAMAN: What else is new is the whole concept. There are several new things here.

Number one, neither Agency has ever issued a set

of guidelines in a specific industry. That alone is -- in the antitrust world, somewhat earthshaking. We are doing it because of the extreme change, the small markets and what we view as the need for responsiveness. So that is one change.

Second, there has never been a policy statement -- certainly not by both Agencies. We have had the business review procedure to particular instances to state the Agency's enforcement intentions and to say this particular transaction, on these facts, would not be challenged by this Agency at this point. What we have never had before is a statement applicable to an industry of what we call antitrust safety zones in these guidelines.

These guidelines set up -- they are in fact current enforcement policy, so they are not a change, but it has never been stated this way before. And for many thousands of lawyers and health care professionals out there, enforcement policy can seem like a black box. And so the mere fact that setting out in so many words -- and we call it an antitrust safety zone -- if you meet these criteria, absent extraordinary circumstances, neither Agency will challenge your conduct. And so that is new.

And then the third -- the time for the commitment.

CHAIRMAN STEIGER: I think it is important to stress, as Anne did earlier, that people across this country, hospital administrators and others who face questions of a changing health care landscape, have a place to go. They do not have to go back to see what happened in the 1985 advisory panel from X or Y. We have put it together for them. But it is a synthesis of current enforcement policy. The very existence of this document is new.

QUESTION: Just to follow up on that. In taking this different approach here, didn't you say to yourselves at some point in your policy formulation, Gee, we are going down a new road here, and this might set a precedent in other industries? And what bearing did that have on your final decision?

MS. BINGAMAN: Certainly that is a concern. Because everybody wants guidelines, and we have got real work to do and we cannot write guidelines for every single industry in America. We cannot spend all our time doing that. It is an enormous devotion to resources to turn out this document, to feel comfortable with it, and to state publicly this is it. This is what we will and will not do.

So, certainly, it was a major issue as to the advisability of issuing industry-specific policy

statements. But it was our judgment that in the extraordinary circumstances the health care community faces today, with massive restructuring, changes that are being proposed, the crisis in cost for health care, the enormous uncertainty that small local markets, thousands of them with legitimate questions about what is and is not permissible, all of those factors we thought made this situation unique and worthy of special attention.

CHAIRMAN STEIGER: We do not see these particulars anywhere else in the landscape that we are looking at now.

QUESTION: Doesn't this legislation put at risk those smaller fringe outfits like MRI's? Won't they end up going out of business if bigger operators in town are allowed to collaborate?

MS. BINGAMAN: I do not understand your question. Could you repeat that?

QUESTION: What is the effect going to be on some of the smaller operators in town that may not be able to collaborate with a bigger hospital?

MS. BINGAMAN: All this does is state what competition policy allows. And competition policy right now, the matter of sharing of expensive equipment, allows hospitals jointly to purchase a piece of equipment if they could not utilize it effectively themselves. In other

words, if there is no need in a town for two CAT scan machines, there is only half demand by each hospital for one CAT scan machine in a particular town, the fact is, right now, it is permissible for hospitals to jointly purchase a CAT scan machine and to jointly use it, because it reduces the cost per transaction. And that is pro-competitive and efficient.

But people do not understand that. They think that it is an antitrust violation to even speak about purchasing jointly a CAT scan or some other piece of equipment, a helicopter or whatever you want to talk about. And the purpose of these is to clarify the instances in which it is permissible.

Now there are also instances in which it is not permissible. So we have a safety zone, and then we have the rule of reason analysis for instances that do not fall into the safety zone, and then we have the backup business review procedure for anyone in the country who wants to ask us -- Here is my situation, can I or can I not do this? -- and we will respond.

CHAIRMAN STEIGER: I would add that neither Agency has ever challenged a joint venture on the purchase of high-tech or expensive hospital machinery. It is clearly within the -- as the guidelines indicate -- a permissible activity and we do lay that out. But, in

spite of the fact that there has never been a challenge, we have been told there is this lingering uncertainty that was chilling effective pro-competitive, pro-consumer choices. And this is what is in the root of the policy.

QUESTION: Chairman Steiger, one of your commissioners, Deborah Owen, dissented, and contended that this is special interest antitrust exemption and that you should do it, if you do it at all, through legislation, not through unilateral actions such as this. Could you speak to that point?

CHAIRMAN STEIGER: Well, I think Howard Metzenbaum said it very clearly, these are not exemptions. These are statements of current enforcement policy. They are the type of guidance that I believe we do in this particular extremely dynamic and very fractionalized -- in the sense of markets -- industry. I do not think legislation is needed. I do not think there are any exemptions that we are talking about.

We are talking about laying out groundwork so that people out across this country know what is clearly permissible. So my answer is no.

MR. STERN: There are about three or four hands. I think we will cut it off before we get too heated.

Over here.

QUESTION: You said that these are not legal

exemptions. However, you noted that the PTC case which started in 1989 is still in litigation would fall into the safety zone created here. In light of that, would a case like that be brought again? And, if not, will these after-the-fact, de facto exemptions be antitrust?

CHAIRMAN STEIGER: I would note that -- you are correct -- that publicly they indicate that the statistical parameters on that fall in the safety zone. I would only add that, were a case like that to come to bat, we might still look at it to see if there were extraordinary circumstances in an area in a case where we would normally not or very rarely take an enforcement area.

I cannot comment as to whether such circumstances exist. We will decide it under section 7 of the Clayton Act. But those challenges have been so rare. And the rarity of them I think confirms our high degree of comfort with this safety zone.

QUESTION: I am still not exactly clear. Are these safety zones new or have they already existed but there just never was a general statement explaining that?

CHAIRMAN STEIGER: They are a synthesis of our experience -- the economic literature and our own experience over time. There are two problems: a census of 40 patients per day over a three-year period. Our

experience reflect our experiences that these are probably not competitive situations. They are not competitive hospitals. They are not realizing the efficiencies, and probably a merger -- most probably a merger in these areas would not pose consumer injury or an antitrust problem.

QUESTION: So you are saying, I think, that you are not creating any new safe harbors here, you are just lighting them better and letting them come in faster?

CHAIRMAN STEIGER: We are basically synthesizing what we know in this area to the best of our ability. And there might be other measures that could be used.

QUESTION: In the example the assistant secretary used about two hospitals sharing a CAT scan or buying a CAT scan jointly, if those two hospitals then decide to move to set price to use that CAT scan, would you then challenge that?

MS. BINGAMAN: If the two hospitals do what?

QUESTION: Decide jointly to set the price for the use of that CAT scan. Would that run afoul of the antitrust laws?

MS. BINGAMAN: Under my understanding is that under these guidelines they can jointly market. And I believe that means they can jointly price. And so the answer is no.

QUESTION: Well, how does that enhance

competition if they can jointly market?

MS. BINGAMAN: That is what is going on right now. It enhances competition this light. It keeps each of them from separately buying a CAT scan. And it keeps each of them from having to price it double, because in order to recover fully on half as many procedures of a given piece of extremely expensive equipment, honestly the price has to be much, much higher than it would be if you could cut it by usage.

And so if those two hospitals have the equipment, there may be a hospital across town that has a different piece of equipment that competes with it. In other words, you can't look at these two hospitals in a vacuum. In most metropolitan areas there are many, many hospitals, and there can be many of these arrangements going on. And you can have a joint venture here competing with a joint venture there, or with a single hospital that has a lot of procedures on its equipment.

QUESTION: Well, can't you separate joint purchasing of equipment from joint pricing of the service?

MS. BINGAMAN: That could have been done. It could have been done, but it was not.

CHAIRMAN STEIGER: I think the guides make it clear that the same violations remain. Price fixing is price fixing. I think that if you read the specific

policy statement on this joint venture in purchasing it does answer the question.

MR. STERN: We will take a last question from the lady in orange.

QUESTION: What is the impact of these guidelines on the HHS safe harbor provisions, or is there any impact?

MS. BINGAMAN: I honestly cannot answer that. I do not know. I am not aware of any. I would give you an answer if I knew the answer, but I do not. I honestly cannot.

MR. STERN: Thank you for coming.

(Whereupon, at 11:18 a.m., the press conference was concluded.)

Business council
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THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript May 7, 1993

REMARKS OF THE FIRST LADY
TO THE BUSINESS COUNCIL

Williamsburg, Virginia

MRS. CLINTON: Thank you very much. I am delighted to be here and have this opportunity to visit with you. I know you've already had a number of very substantive and useful presentations about health care. And I'm looking forward to the opportunity to hear your questions and be able to do my best to try to describe where the administration is in this process.

I wanted to say just a key word about the process and -- (inaudible) -- especially to this group. The process that the President put into motion in order to seek out and find the best possible approaches to dealing with our health care crisis, because it is a crisis, has been unprecedented. It struck the President as a bit odd that it would be viewed in Washington and somewhat unusual to try to bring together in one effort people who cross all kinds of bureaucratic and other lines to work on behalf of a common agenda.

But apparently, as I was told the other day, there hasn't been anything quite like this effort since the planning of the invasion of Normandy. And I think that's a sad commentary to some extent on our domestic agenda in which we have allowed ourselves to be viewing these problems that are national problems through the prism of various bureaucratic agencies, various special interests, and losing sight of what the national common interest should be.

To that end the process has, first of all, tried to pull together from within the federal government itself those people with expertise, and then to go out and seek advice from some of the people you've already heard this morning, but many many others who have brought particular points of view to bear.

I'd like to give you just one idea of how difficult this has been and why it is so imperative that we follow through on what we have started. When I began this process, I learned very quickly that within the federal government itself there were at least five major agencies using different economic models based on different economic assumptions to drive different kinds of cost projections with respect to health care. And there were many other less important agencies who had pieces of health care who themselves were engaged in comparable effort; with the result that if one turns to the federal government and says, what would this proposed benefit package cost? One would receive, as I did, answers that varied in cost between $500 and $600, which on aggregate when one is looking at an entire nation, is an extraordinary amount of money.

We therefore concluded before we could go forward with the kind of intensive policy debate that this issue required, we first had to do everything we could to get the numbers right. Now, that may sound like an elementary conclusion to you, but it apparently was rather revolutionary in Washington.

And we put into place a process that has now been going on for three months, where we got for the very first time all of the actuaries and all of the economists from within the federal

government who have influenced health care policy over the last 30 years, but who had never been convened together. And we began forcing them as best we could to deal with one another, to examine each other's economic models and assumptions, and to go through a process that would give us the best possible numbers.

In addition, we convened a panel of nongovernmental, outside actuaries and economists who deal with health care and some of whom have been consultants to or in the employ of some of the businesses in this room, to second-guess and double-check the federal process. I cannot tell you how complicated it has been to reach some consensus among the government employees themselves about this issue. But I have said from the very beginning we would not go forward with policy proposals until we had agreements on numbers. And we will have the best numbers that the government has ever had before we do so. And we are close to a revolution of this, because we are now running various iterations based on the agreed-upon model.

But I wanted to start by giving you some sense of what the President has been up against in trying to harness even the resources of the federal government to speak with one voice about what the health care crisis is costing us, what the projected costs will be for the kind of policy recommendations that he favors, and what these savings will be to try to reach some net figures that we could consider credible.

In addition to the kind of hard work that underlies this process, there has been an extraordinary amount of consultation. Many of you in this room either through your individual capacity or through your corporation or through associations with which your corporations is associated, have been part of the more than 1,000 meetings that have been held between interested parties and persons and members of this health care task force.

That process of consultation will not only continue but intensify over the next weeks as we get to the point of hammering out the policy recommendations based upon what we believe will be the best available numbers to share with you.

In addition to the analytical and evaluative and consultative process that has gone on within the task force, we have also worked very hard to begin a substantial public education effort; because one of the principal difficulties we face is that the American public is aware in a personal way of their health care situation, but is not aware in the aggregate of what our health care choices have meant to our economy, to our quality of life, to our future stability. And so we are working very hard to reach out to enable people to be participants in a very broad conversation about what is the state of health care today; what is the real cost; and what future policy changes will mean for them personally.

I think that it is also a real difficulty for us is that even sophisticated decision-makers in their own areas often have overlooked the real impact that the rising and in some respects uncontrolled health care costs have had on their business interests and on the long-term growth prospects for -- (inaudible).

Many of you have had an occasion to hear presentations about the impact that health care costs have had on the deficit. But I want to underline this, because particularly important to this group, that we have worked very hard in the last several months to put together a credible deficit reduction proposal -- the first that our country has really undertaken seriously in several decades. But it is also clear that given the growth of health care costs in the federal budget that even were we to adopt the President's proposals, which, of course, I hope we will, it will create $500 million of savings in the deficit over the next years; that within five years the deficit will continue to rise because we will failed to deal with the principal driver of the rising deficit, which is health care costs.

And I think that the interrelationship between our economic fortune and the deficit reduction that is necessary for us to regain economic and financial stability for the long-term must always be talked about in the same breath as health care reform. We have to make it clear to businesses of all sizes as well as to individual citizens what is at stake in this health care reform effort.

So we are attempting then to do a number of things at once. We're attempting to educate ourselves, educate the American public, come up with a credible set of cost and savings projections, and create a policy that will reassure the American people that they will continue to have access to the best possible health care. They will be secure in their access, but there will be changes in the way health care is delivered so that we can begin to try to discipline the health care system and its costs that will eventually benefit all of us.

So those are the kinds of multiple goals often times difficult to describe but always -- (inaudible) -- that are driving this process.

And my final word on an introductory basis is this: There are many good ideas about how to reform the health care system. And you have heard from two of the leading advocates for the need for change. You just heard from Dr. *Dreyheart and *Entopin. What the process the President has begun, is attempting to do, is to put together a workable solution that draws from a number of recommended proposals that will be understandable to the American people and will result in the changes we are seeking.

There will be plenty of opportunities for people to argue over the details. But I hope that as we argue over the details, we keep in mind the overriding imperative to change what we are doing now and to do so with the goals of controlling costs; providing universal access, because access and cost containment are inseparable; and to retain and improve quality.

If we keep those overriding objectives in mind, I'm confident that we can work out the details. We want you to be involved in helping us work out these details, because there are a number of issues on which your experience, both in the corporate world and as reluctant but necessary managers of health care, can be extremely beneficial.

But there is not any -- (inaudible) -- way to do this. There is not any easy to do this. There is not any universally acceptable way to do this that is real. There are lots of folks on the sidelines who are promising to be able to deliver on health care reform with no pain and no change. This amounts to one of the most important restructurings that you will ever be part of. If done right, which I'm confident it can be, it will also be the most important role that any of us will play in ensuring the long-term economic and social well-being of this country.

Thank you all very much. (Applause.)

I would love to be able to answer your questions or to describe further what we are thinking about, if any of you want to pose a question. And I would appreciate it if you identify yourselves, if that would be all right.

Q On the premise that disease prevention is one way to improve the cost efficiency of the system, do you have any encouragement in terms of your deliberation that delivery system as it relates, for example, to immunization or to delivery of services

to rural areas can be improved under the auspices of the plan that you're working on?

MRS. CLINTON: Yes, sir. Let me tell you where we believe we can make a big difference, because we are not just changing the way we finance health care, because the changes there are not going to be all that significant; we are mostly concerned with changing how we deliver health care, because we think for both quality and cost reasons that is the key.

We are looking to have the kind of standard uniform benefit package that Dr. *Entopin referred to at the end of his remarks, which will heavily emphasize primary and preventive health care; because we have had it backwards for so long now. We will pay for your hospitalization for cancer, and we will not pay for your pap smear or mammogram. We will pay for your being the victim of the increasing number of measles epidemic in our country, be we won't in our insurance system pay for much of the well child care and the immunizations that would hopefully prevent that more costly experience.

So in the benefit package that will be proposed by the President, primary and preventive health care will be a part of it. We think if we can begin to provide that primary care and begin to encourage more people to utilize it, because it is now reimbursable, we will in that way alone begin to lower a lot of the costs of acute care.

In addition, in rural areas, we believe that the kind of integrated delivery network of care that will be the result of the proposal that the President will make, will benefit rural areas particularly. There are many people in rural areas who do not have adequate access to health care at this time. We need to provide that access in two ways: We need to increase the number of practitioners and facilities; we need to change a lot of the rules that will enable us to do that; and we need to hook in rural providers into integrated delivery systems so that they are part of providing care on a continuum to residents of rural areas.

Let me just give you a few examples. We have had for the last year a system through Medicare, which has subsidized the graduate medical education of specialists. It is not, therefore, surprising that the specialists are now outnumbering by a substantial majority primary and preventive health care physicians. We need to change those incentives so that we can provide more of the kind of personnel that are required not just in rural areas but across the nation.

We also need to encourage the use of other medical care professionals, like nurse practitioners and physicians assistants. They are particularly important in rural areas, but there is also a role for them elsewhere. In order to do that, we have to do things like change the anticompetitive statutes of a number of states that have tried to keep many practices and procedures for the sole -- (inaudible) -- of physicians; or even if given the opportunity, to people who are under the direct control of physicians. We have to change the way we think about who can deliver primary and preventive health care.

We need to make better use of technology. We are now running from good experiments around the country where you have small hospitals in rural areas hooked up with interactive video in more sophisticated medical centers that provide better health care.

So there are a number of ways that we think by changing the delivery system so that rural areas are part of the same system and the physicians and other practitioners in those areas are not out there on their own, and the reimbursement for services is not heavily

skewed against rural areas as it is in many ways now, that we will create a better supply of medical care in those rural areas and begin to deal with a lot of the access problems that currently exist.

Q -- (inaudible) --

MRS. CLINTON: Yes, sir. In fact, regulatory reform and administrative reform are at the key of the cost savings that we think are within the system. I believe that it is a fair estimate to say that 20 to 25 percent of the costs that we currently have within the system could be better allocated, as well as eliminated.

Much of that is because of the point you make. We have over the last years, but particularly within the last 10 years, particularly within the Medicare and Medicaid system, have created a regulatory model in which checkers checked checkers, in which there is constant second-guessing about decisions that are made which have no value added to the delivery of health care or as the outcome of that delivery.

We believe that we will have to do two things simultaneously -- well, actually a million things simultaneously -- but two big things simultaneously. As we move on cost containment and universal access, we will be moving on eliminating a lot of the unnecessary regulation and paperwork and administrative bureaucracy that is now eating up a large portion of our health care dollars. There is no doubt that if we move, for example, as we intend to do, to a streamlined reimbursement system, that fuses, we hope, one form, but certainly very few forms, that we will save an enormous amount of doctor and other practitioner time as well as money.

The average physician is actually spending somewhere between 30 and 50 percent, depending upon the nature of his practice, on his income, on the kind of support services that consist of filling out forms, arguing with insurance companies over who pays for what, making sure that the proper kind of reimbursement protocols are met -- from the both private and the public third payers. That has to be gone. And it is one of our most important goals.

Now, the cost savings that that will generate will come over time. It will not be immediate. But we really believe that if we focus on that, we will be successful in saving billions of dollars.

And the other point I would make about the regulatory reform issue is that part of the reason we have -- engage in so much regulation over the past years is because there is this sense among all of us, whether we are private payers or public payers to the health care system, that there is a lot of unnecessary costs and flaws and abuses going on.

And there is now a growing realization as for the reasons why. And one can see it anytime one looks at a hospital bill. I saw it graphically illustrated the other day when someone sent me a bill for a relative's stay in the hospital and showed me the comparable cost in the marketplace of some of the items that were being billed for. And we all know about the $50 Tylenol. Well, we also know about the latex gloves, which you can go and -- (inaudible) -- wholesale and buy for $28. But if they're used when you're a patient in the hospital you'll be billed for maybe $100. Or for the foam rubber mattress that you can go and buy at some outlet for maybe $100, but you'll be billed $1,100.

Why is that happening? Is every hospital administrator in America a crook? No, of course, not. The reason it is happening is because we have so much uncompensated and undercompensated care being delivered in hospitals that you and I and our insurance companies are therefore billed, and the Medicare system is therefore

billed, to be able to pick up the slack. That difference between the $100 and the $1,100 for the foam mattress pays for somebody showing up who is uninsured at the emergency room and being treated for something they should have been treated for all along at much less cost to the primary and preventive health care system.

So we have to begin to rid ourselves of the regulation that has attempted to try to control this unsuccessfully and move toward much more administrative simplification, which I think is going to be the primary goal -- (inaudible) -- administrate the changes -- (inaudible).

Q -- (inaudible) --

MRS. CLINTON: My answer is yes, I believe more is necessary. And I don't know whether it will have as significant an impact as some people argue it will. We have looked exhaustively at every study that has been engaged in. And as Robert Reischauer, the head of the Congressional Budget Office, testified in Congress recently, the -- (inaudible) -- for saving are in the ballpark. I mean, you've got a low of $2 billion, which are studies that are obviously favored by -- (inaudible); and you have a high of $40 billion, which are studies obviously favored by physicians.

The truth is somewhere in the middle. I don't know that we will ever know where it is. But the facts are that for whatever reason and for whatever combination of factors, the medical malpractice system has had an impact, an adverse impact, on the cost of practicing certain kinds of medicine, absolutely. Obstetricians are often viewed as the primary victims of this, and have had an impact -- again, incalculable -- on the proliferation of checks and procedures.

There is, however, a much more important reason for the proliferation of tests and procedures, and that is the whole fee-for-service system where we pay on the basis of tests and procedures. When you are in the Medicare system, you get paid on the basis of how many tests and procedures you run, not on how well you treat this single human being and what kind of outcome you get.

So what role the malpractice system plays in increasing defensive medicine is -- again, I cannot tell you exactly. But we do need malpractice reform in order to weed out whatever that cost is. And we intend to come forward with that.

Q I'd like to ask a question about a more narrow area, specifically the diseases of alcoholism and chemical dependency. In the last three years as a result of the application of -- or maybe misapplication of managed care -- people are being denied the ability to go for treatment for these diseases. The net result is 40 percent of the rehabilitation beds in this country have been closed in the last -- months. How does your benefit package deal with these important diseases?

MRS. CLINTON: That's an excellent question. And I have to say, this is a prefatory remark. Alcohol and drug abuse are not only problems in and of themselves, they are contributing in underlying cost problems within the entire system. I became interested in this when I began to look at lengths of stay in hospitals and compare like kinds of injuries among the same kind of people -- a, you have two four-year-old white males had been burned severely, go into the hospital; where there is an underlying alcohol problem it takes 10 to 12 days longer for the treatment to be effectual. So we are therefore, in effect, paying more for the underlying alcohol problem, even though we're treating a burn problem.

So this issue is not just an alcohol, drug issue, it is a much deeper and more -- (inaudible) -- health care problem. We intend in the comprehensive benefit package to provide for mental health treatments and substance abuse treatment. We are very conscious of the experience that a number of the corporations in this room have had in trying to monitor effective mental health and substance abuse treatment. But we believe that providing it as a comprehensive benefit will create a bigger and more effective market than we have currently have.

When Mrs. Betty Ford came to visit me recently to talk about the Betty Ford Clinic, she brought with her documentation showing that the cost of the Betty Ford Clinic, which is generally acknowledged as a very successful treatment center, is substantially less than many other treatment centers that don't have the same kind of positive outcome. And yet many people because of the celebrity connotations associated with that, would assume otherwise. And there has been very little base information on which to make good management decisions about the kinds of programs that really work effectively.

And I would just throw in an additional point here. We also need to be looking at ways that we can deal with some of the hard-core problems represented by the severely addicted and severely mentally ill. And here is a perfect example of why it is important for us to move in a comprehensive way at once, if one looks at the mentally ill community.

Twenty-five or more years ago, actually in the late 1960s; I think it was a combination of a Johnson-Nixon policy -- we made the decision to deinstitutionalize the severely mentally ill. And we were going to have home-based and community-based care for them. We did the first part of this, and we never did the second. The results are lying on the streets and in the parks of every one of our cities.

We, therefore, need to think clearly about how to deal with these severe problems in an effective way. And we are looking at the creative ideas of such things as treatment with conditions, so that people who receive treatment and then fail to follow through, we will have to look at more -- perhaps more restricted confinement, where if they are a danger to themselves and others, or where they could possibly are public health dangers, such as the growing tuberculosis epidemic.

So I hope that if we move forward in this policy debate, substance abuse and the mentally ill will be seen as part of the comprehensive problem that needs to be resolved.

Q Mrs. Clinton, building on that, you mentioned that there's -- (inaudible). How much is the President's proposal going to cost? What do your models say, and how do you propose or how will he propose to allocate those funds?

MRS. CLINTON: Well, I assume since I'm talking to a group of business executives and off the record, unlike talking to people on Capitol Hill and off the record -- (laughter) -- and what I say to you will not be immediately told to the press because I want to be as straightforward as I can in this process. I am learning that that is a very difficult matter. (Laughter.)

And -- (inaudible) -- to my experience, because the other day in a bipartisan meeting that was an exceptionally good meeting where there was a lot of good give and take and a great deal of honesty on all sides, I explained where we are in this cost issue, and one participant in the minority, but with his own agenda -- (inaudible) -- contact and carried off his particular point into the sunset. It's a real shame. I just -- (inaudible) -- as I come from

a primarily private sector experience, I wish you all would just take a minute and imagine what it is like to try to make important decisions with people peering over your shoulders who are running their own agendas, and may therefore not keep in confidence whatever you tell them from minute to minute. It makes public life very challenging.

So what I would like to say, given those ground rules is that we don't have a final number, as I said in my very opening remarks. And I'm not going public with any numbers until I can absolutely defend them and not be ticked off by somebody saying you forgot assumption 942, which throws you off by $10 billion.

We see two things happening simultaneously. If you look at how we achieve universal access and cost containment at the same time, there are very few options available to us. We can either move towards an entirely government-funded system -- and I know there are some among you that advocated a large VAT in order to achieve that government-funded system, in part because you believed that you would be better off competitively if you were out of the health care business. But if you look at what it would cost to replace all of the dollars currently spent in the private sector to support health care in this country, the amount of a VAT would be extremely large. There is some variation as to how large. Some people say a 17 percent progressive VAT that would eliminate food and rent and utilities would be required. Others say if it were progressive, it would have to be 22 percent -- within 17 to 22 percent range. A regressive VAT that included food, rent, and utilities would perhaps be in the 8 to 10 percent range.

That is one alternative. There is another alternative which is a government-financed system that keeps some private base, but adds a VAT. And people have come forward with a proposal for that, which is approximately a 7 percent employer-paid roll with a 7 percent VAT to try to get the equivalent dollars.

The President has rejected both of those for policy reasons, for substantive reasons and for political reasons. It just seems that it is very difficult to describe to the American people why we would need a huge general tax increase to fund our health care system in a more effective way when we believe there is a tremendous amount of money within it that can be better utilized in ways which can be eliminated.

So if we're not going to move toward a general government-financed tax-based system, then we have the various alternatives that fall under the broad rubric of a premium approach, whether it is a pure premium in which there is some kind of mandate for insurance obligation on the individual and the employer, whether it is a premium as a percentage of payroll, there are a number of possibilities there.

And then there -- our third alternative, which we do not believe will solve our problems, which talk in terms of mandating the individual, either through a medical IRA or some other means, to go out and get his or her own insurance. We do not believe that will adequately address cost shifting and achieve universal access which will therefore further exacerbate the kind of cost shifting that is currently going on.

If you look at the kind of benefit package that we think is reasonable, it is not the top-dollar benefit package, but it is equivalent to what most Americans now have in their insurance packages. We think that if you had a combination -- not new taxes, but a combination of public and private sector investments and the private sector would be both employer and employee, and the public sector would be both significant front-end savings and some additional revenues, most likely from a cigarette-alcohol tax

combination, because of their direction relation to health care costs -- that the whole package of investments would be about $100 billion. And that is not $100 billion in new taxes, but it is $100 billion in new funding that would go into the system.

At the same time, we believe there is approximately $100 billion in public and private savings that would be -- (inaudible) -- realized almost immediately. So what we are attempting to be able to do to show you and to show your colleagues around the country is that for most of the businesses in this room, and maybe all of the businesses in this room, we believe that within a relatively short period of time, your real costs of health care would decrease. We believe we would stop your escalating costs and begin to decrease the costs that you currently pay.

One model that we are looking at is a model in which we do require all employers of whatever size to participate through an employer contribution and the acquisition of health care for all their employees and require all employees to make a contribution.

If we phase in what we believe will be the decreases that many of you will realize with the new requirements on the smaller businesses, we think we would get to a level of -- (inaudible) -- in terms of a premium-based payroll percentage that would be about 7 to 8 percent of payroll. I bet there are not many of you in this room that are paying only 7 or 8 percent of payroll for health care right now. We know that some of the car companies are at 20 percent of payroll. And we know that some of the older manufacturing industries are at 15, 16 percent of payroll. And many of the rest of you are at 10 to 12 percent of payroll.

There are large sectors of the economy that utilize large numbers of first-time workers that are not at 7 percent of payroll; as well as small businesses that currently do not make a contribution.

In addition to health care reform, however, we think you will not only get savings because everyone will finally be contributing, which will stop the cost shifting, stop requiring you to run health care businesses on the side to try to keep your costs down, but we also intend to fold into health care reform the health care portion of workers compensation and automobile insurance. If you add to what you are currently paying for health care, your workers comp -- (inaudible) -- your auto insurance-health care costs, I think we will be able to show you that it will be greatly to your economic advantage to support the kind of plan we are putting together.

Most small businesses currently provide some kind of insurance. The number is about two-thirds. And one of the points we have begun to make to the small business community is that the small business that is currently providing health care, it sits on some main street in Norfolk or Newport News, next door to a small business that does not. It's subsidizing the next door business, because the health care payments that the first make keep the hospital in the town open, keep the physicians employed in a direct way. And those services are available to the employees of his neighbor and perhaps competitor. It has been an extraordinarily unfair competitive advantage for businesses with whom you compete or even smaller businesses that you have been paying for their health care. Often times not only for their employees health care, but for the owners health care as well.

What we are also hoping to be able to do is through a phase-in that will commence as soon as we would be able to pass this legislation, be able to move on a lot of these administrative fronts that you have asked about before.

I cannot give you this exact number until the end of next week when we finish all of our economic work, but we really believe that the gross investments will be offset by savings of an equivalent amount. Now, that will require action by the government as well as the private sector. So let me just give you two more quick examples to illustrate my point.

Medicaid currently provides health care for two categories of people generally: there is the Medicaid disabled population. Those are people with chronic disabilities under 65, often confined to a nursing home. And there are the Medicaid-funded nursing home patients. And we have some fairly good evidence, we think now, that the right kind of managed care will benefit the Medicaid disabled and -- (inaudible) -- less money, because there has been some very good models that have shown how we can achieve better quality care at less cost with that population.

The other category that is primarily children, if one compares what we pay for the Medicaid child health care, with either an insured child or an uninsured child who seeks comparable care, we pay a lot more for the Medicaid child care. There are a number of reasons but the principal reason usually is because they seek care from the most expensive source. The emergency room is the family's doctor.

By bringing Medicaid immediately into this comprehensive system and imposing the same kind of competitive discipline that we think will work with the rest of the system on that population so that they are part of integrated delivery networks, they are eligible to get access to a primary preventative health care physician, we will save an enormous amount of money that you will no longer have to subsidize, both directly through taxes and indirectly through your insurance premiums.

And a second quick example is that if one looks at Medicare, Medicare has done through regulation a job over the last several years of trying to control prices. One of the results of their attempt has been that volume has increased to a great extent. If we leave Medicare outside this system completely, where it is not -- not a part of the comprehensive health care reform, we will not get an end to kind of cost savings from the entire system that we want. So we will eventually, we hope, be able to move toward phasing in Medicare as well. And once everybody is in the system with their various payment sources, we think the total cost of the system will not only stabilize at the frightening figure of 14 percent GDP, which it currently is, and not go with the 19 percent projected for the year 2000, but begin to decrease. And so that is where we are coming from and looking at an employer-based system building on what we have but with that kind of approach that we think will save all of you money.

Q -- (inaudible) -- it's been suggested by some that during the transition period, and where we are today -- (inaudible) -- some form of inner price control would be required. Can you comment on that?

MRS. CLINTON: Yes, sir. We have struggled with this issue. And I don't know any easy way to get to a conclusion on it. But let me just outline some of the issues we have tried to think through.

As we transition to a new system, we, every month, lose ground because costs continue to escalate and eat up more and more of our disposable income. And if there were a way to wave a magic wand and have the health care providers, and those within the health care economy, voluntarily -- and mean it -- voluntarily impose discipline on themselves to control prices, it would be one of the greatest gifts -- and I would argue, and I don't want to sound like a --

(inaudible) -- but I would argue a very patriotic thing to do at this point in our country's history.

And as you know, from -- (inaudible) -- prospective, several major institutions have come forward with just such a proposal that the administration is looking at very carefully; because it would be our preference to avoid price control if we can do so. But we also know that in addition to the responsible members of the health care industry, there are many who do not air that -- (inaudible) -- and will be intent upon pushing the system to the limits because they are afraid of the new discipline that any reform would impose.

So we are considering looking at voluntary price freezes with legislative stand-by authority that could be triggered. The only reason we would do so is to try to stabilize the system where it is now; to try to send a message to the American people that not only the President is concerned about this but even the responsible people within the health care industry are concerned about this. They all know what a crisis it is. And these will be sun-setted or lifted as soon as we have made a substantial enough transition to this new system that we think will work. That is -- (inaudible) -- the administration is thinking about.

There are those in Congress, as the majority of the American people, who believe that price controls are the answer to health care reform. That is how they view it. They believe that everybody's made a tremendous amount of money off of the system in the last years.

And so there is a tremendous political pressure to impose price controls and do so as the answer to health care. The President obviously doesn't buy that. But some effort to try to stabilize prices while we move toward a new system, hopefully in a truly effective voluntary way, may be sought.

Q The good news is that in the first quarter we are seeing a dramatic reduction in our suppliers, both pharmaceutical and surgical supply; 89 percent -- (inaudible) -- year-to-year price increasing. I'm confident that the labor-intensive health care provider side of the -- (inaudible) -- of health care system that we can also bring down labor costs two to three to four percent year-to-year increasing. My big concern is how we win with voluntary or mandated global budgets if over 50 percent of our business will be frozen for up to two years as Congress is passing -- the House has -- on the Medicare portion. It's just impossible to do, you can -- (inaudible).

MRS. CLINTON: Let me say two things about that. And I don't mean this to be critical but just as a comment. It's an interesting comment on the market that any sector of the economy can drop prices so dramatically in such a short period of time. I think that that is a very salientary point to keep in mind, which is why I think some kind of voluntary action is entirely within the realm of the economically feasible for most sectors of the health care economy.

Secondly, global budgeting, as the administration considers it, is a fail-safe mechanism. If a competitive market really works so that suppliers and deliverers of health care truly are competing and don't have the kind of range of options to be able to pick and choose their prices without much fear of any accountability because they have no discipline then imposed upon them in the marketplace, then we won't need budgets.

I don't think the country, though, can take the chance that that will work immediately. We have a lot of cultural and attitudinal changes that have to take place in this entire system starting with the individual and going up institutionals.

So I believe that a budgeting system that sets targets and gives a realistic view to the entire country of how much this country is willing to spend on health care, which is allocated in at the state level, will have varying effects on individual hospitals depending upon where they stand currently within their own budget disciplines.

I can't answer what the exact impact of freezing GRGs and some of the other Medicare changes that the President is proposing will be in the short run, but we hope that we will begin to be able to move away from a lot of that regulation so that hospitals and doctors together will make the right decisions for patients. But we think that there has to be some sense of a budget within which those decisions should be made; that until the market in this sector of the economy -- and from my prospective, the market hasn't worked either in health care or in higher education financing or in a lot of other surface areas, effectively -- so until we can get more effective market mechanisms that work in this industry that had been immune from the market, I don't see how we can count on the people who are currently within it even effectively dealing with the changes in the absence of a discipline of a budget. So that's where we are.

Thank you.

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