

**FEDERATION OF AMERICAN HOSPITALS**

**ANNUAL CONFERENCE**

**REMARKS OF  
SENATOR HILLARY CLINTON (D-NY)**

**TUESDAY, MARCH 7, 2006**

**MORNING SESSION**

*Transcript by:  
Federal News Service  
Washington, D.C.*

CHARLES N. “CHIP” KAHN: It is a great privilege for me to present to you this morning the junior senator from New York, Senator Hillary Clinton. Without question, she is one of the most knowledgeable leaders in this country on the issue of healthcare.

In her role in the Senate in recent years, she has reached across the aisle. She has worked with our speaker from yesterday, Newt Gingrich. She has joined with the majority leader Senator Frist in the Wired For Health – health IT legislation, which has passed the Senate and is now awaiting House action. It may be the only major piece of health legislation that passes this year.

Obviously she has a long-term commitment to seeing all Americans receive healthcare coverage. And it’s just a real honor to have her here this morning. Now, Senator Clinton.

(Applause.)

SENATOR HILLARY CLINTON (D-NY): Good morning. I am delighted to be here. I know you have just heard from my friend and colleague, John Ensign. Obviously your gathering here today is a sign of not only the annual meeting but the concerns that you and I and others share about the direction of healthcare policy in our country. I thank Chip for the introduction and I thank you for the invitation.

Many of you have spent your careers trying to make our healthcare system work better, better for patients, better for doctors and nurses, better for the business and labor community, and better indeed for the larger community as well. As I’m sure you remember, I did a little work on healthcare myself and still have the scars to show for it, so I feel your pain because it is a constant challenge to figure out what we are going to do and then to summon the political will and the resources to do it.

When we last addressed seriously the challenged posed by our nation’s healthcare system more than a decade ago, we were mostly concerned with the increasing number of the uninsured and the increasing costs of healthcare. Well, we have the same problems and some new ones as well. Costs have continued to rise, the ranks of the uninsured have increased, the strains on our system and its ability to provide quality care have worsened.

I think it’s important, though, to start with what is right about America’s healthcare system both because we don’t hear about that enough and because if we study what works, we will get some guidance about what to do to fix what doesn’t work.

We do have dedicated, skilled, and caring doctors, nurses, and other healthcare professionals. We have medical innovation that remains second to none but is now for the first time in a global competition to determine whether that remains the case. We

have hospitals dedicated to improving care and to making gains in efficiency and quality. And we do have community innovation bringing together businesses, patients, medical leaders, and others to try to figure out how to hold down costs, make sure those who need care get it, and make sure the care that is delivered is a higher quality.

So let's talk about the challenge. We are not getting our money's worth for our healthcare dollars. We spend more per person than any nation in the world yet when you look at indicators of health, and there are dozens and dozens of them that are used internationally, everything from life expectancy where we rank 34<sup>th</sup>, to the number of uninsured, which includes 13 million children, we have to ask ourselves what is wrong with this picture.

Last year our country spent over \$1.7 trillion on healthcare. We are now up to 16 percent of our gross domestic product. It is anticipated that within the next five years we can be at 18 percent and within the next 10 years at 20 percent if the system is left unreformed. It is an incredible statement that we are seeing health insurance premiums rising five-times faster than incomes. In five short years, health insurance premiums for families jumped by nearly 65 percent and deductibles by over 50 percent.

Now, some people believe that the only solution necessary or available to our present cost explosion is to shift the cost and risk onto individuals in what is called consumer-driven healthcare through programs like health savings accounts. Well, I disagree. Although I do believe there needs to be more consumer information and consumer decisionmaking, and there may even be a role for some kind of personal health account in an overall comprehensive approach, I don't think that that alone is an answer.

These plans do not ensure that health information is provided to consumers, and even that the information is accurate. A recent McKinsey study showed that the biggest problem for those who had opted for health savings accounts was they couldn't get accurate information to make the kinds of choices they were now expected to make. So I support giving patients greater control over their own care, but I also believe they must have the knowledge and the tools to make these decisions; otherwise, they confront a host of very difficult, often actually life-risking decisions without adequate guidance.

I am also concerned that some consumer-driven plans shift the costs, risks, and burdens of disease onto individuals who have the misfortune of being sick, and there, for the grace of god, go all of us. Think about the times you have been sick or injured or even a family member -- the trauma, the emotion associated with that experience. How able were you under those circumstances to think about negotiating for the best price or shopping for the best care?

This cost-shifting approach actually causes individuals to delay or skip needed services, often therefore setting up a cycle where we have worse health and more expensive healthcare needed later. That is why I oppose the administration's current efforts to address our national healthcare needs solely through initiatives like HSAs.

They are no substitute for comprehensive health insurance and more than that that, they are no substitute for taking a look at the entire system.

Now, maybe HSAs are a good resource for the relatively healthy and the well off, but hospitals are in the business of treating sick people. Eighty percent of your costs, just as it is in our entire system, are accrued by 20 percent of patients, patients who have an accident, who are diagnosed with a life-threatening disease or who have a chronic condition. HSAs do not address the need for catastrophic coverage and will leave more and more Americans with charges they cannot afford and hospitals with more bad debt.

And of course the private health accounts that are being proposed primarily serve those who are already insured. We face a far greater challenge of serving the tens of millions who lack insurance, not to mention the tens of millions more who are underinsured. Even though they think have insurance, they show up at one of your hospitals to find out that they may not actually be covered for the course of treatment that their doctors prescribe.

Finally, in serving the healthier and mostly wealthier, private health accounts will inevitably make insuring the less healthy more difficult and expensive, and that will result in less coverage, more last-ditch emergency medicine, more unpaid bills, and even more bad debt for hospitals.

So it is a lose-lose in my opinion at a time when our healthcare system needs a few wins on the board. When you have millions of working and middle-class families uninsured or under-insured, when businesses are struggling to provide healthcare benefits to their employees in an increasingly competitive global economy, when emergency rooms are overcrowded and ambulances are on diversion, we need smarter, better policies that reflect the evidence and real concerns of Americans.

The fact is that the president's healthcare plan is driven by ideology, not evidence, and the American people and American hospitals will pay the price. Now, it may be -- and I will be the first to admit -- that we tried to do too much too fast 12 years ago. But now I think we are neglecting and putting forth flawed policies instead of having the kind of broad debate, even conversation, I would prefer, about what to do going forward.

Recent Medicaid cuts will mean higher premiums and co-pays for over 7 million people, including 3.5 million children. And there is a considerable body of evidence from independent investigators like the RAND Corporation to the Urban Institute, that if you increase co-pays and premiums, people skip needed care and may lose coverage entirely because we don't yet have any comparable system for working with Medicaid patients about education on healthcare, and we are not yet even considering moving any kind of performance measures into Medicaid. So that will add additional pressures to the already over-burdened acute care system.

I think the healthcare safety net, Medicare and Medicaid primarily, need reform, but again, I would argue passionately that needs to be part of overall reform, not handled

off on the side as though what we do to Medicare and Medicaid won't have ripple effects throughout the entire system.

We need to reform our payment system, which is upside down – too often paying for costly and debilitating treatment, but not low-cost prevention. Medical professionals confront this every day, and some of you may have seen a recent series in The New York Times that talked about the growing problem of diabetes. Our system of health insurance will pay tens of thousands of dollars for amputations, but not a low-cost visit to the podiatrist or the nutritionist.

Hospitals struggle to provide preventive treatment and rehabilitation in the Byzantine system of reimbursements. A number of hospitals in New York opened diabetes clinics, and were actually making progress in changing behaviors and habits, and helping people better understand and cope with their disease, but they couldn't get reimbursement from anywhere to do that.

We need to provide both adequate insurance coverage and reimbursement for appropriate preventive care, and it's particularly important that we do so with respect problems like diabetes and obesity.

So how do we get there? Well, let's start by dragging our healthcare system into the 21<sup>st</sup> century. We should be moving full-speed ahead to create an interoperable health IT infrastructure and put it at the disposal of doctors, patients, and hospitals. And I want to thank the Federation of American Hospitals for supporting the effort to modernize our healthcare infrastructure.

By developing a secure, interoperable health information infrastructure that makes patient privacy paramount, we can reduce redundancies and waste and make our system safer and more accountable at the same time. It is also the only way to actually empower patients to become partners in managing their own care.

After a long effort working across the aisle with Senator Bill Frist, we passed health IT legislation in the Senate. We can't get it through the House and we can't really get the administration to give it the kind of press that it does when the president is behind something.

We are going to work hard to try to get it passed the House, get it to the president's desk for signature because Senator Frist and I and others know that technology will pay dividends in research and performance, but what we don't want is for every individual hospital to go off and buy its own hardware and software, which can't communicate with the hospital down the road or the clinical practice next door; but instead, that if we have a framework that sets targets that people will aim for so that we not only encourage and provide some funding for you to make the investment in your own hospital, but at the end of the day, we will move toward a seamless system so that someone who lives in New York who visits Nashville who gets sick can have that electronic medical record transmitted.

When I visited Houston after Katrina, it became abundantly clear that in the absence of an electronic medical record, medical records were lost for good. And one of the first things that the Houston medical society and the Houston hospitals did was to try to create electronic medical records for the people there. For many of them who had been evacuated, they didn't know the names of the drugs they were taking, particularly the frailed elderly. They could say I take a pink pill in the morning and a blue pill in the afternoon. They didn't know what those pills were.

And for most people, there was no place to go to try to figure that out. For some of the large-chain drug stores, however, there was an answer. They could work with those systems and find out for those particular patients. And clearly we have to make privacy paramount but there is no reason we can't use technology to create an upward cycle of quality and coverage.

While we move forward, we have got to make certain we are not taking steps backwards. Like you, I am deeply concerned about the growth of physician-owned specialty hospitals, and I support a continuing moratorium on establishing new specialty hospitals. I even go further. I think we should take a hard look at whether any specialty hospitals should be permitted going forward.

I am pleased that the Department of Health and Human Services will be required to study the ability of these hospitals to appropriately disclose investment information and provide charity care, but I just look over the horizon. If we have an explosion of specialty hospitals, we will undermine the role and capacity of the comprehensive hospital and thereby undermine, if not eliminate, the capacity to provide trauma care and other care that no specialty hospital is going to offer.

We have to ensure that physician-owned specialty hospitals provide the same level of clinically appropriate high-quality care that we require from all hospitals without conflicts of interests.

Another important piece of the healthcare puzzle is our preparedness for disasters, manmade and natural. We can't wait for the worst to happen. I worry about our ability to deal with bird flu and some of the other challenges we confront because I don't think we do a very good job dealing with seasonal flu. Approximately 36,000 Americans die of seasonal flu with more than 200,000 hospitalizations each year. These deaths are largely preventable. We could stop them if we increased immunizations, had a secure vaccine market, and made sure everyone understood the importance of vaccines.

I have worked with Senator Pat Roberts to introduce legislation to create a stable flu vaccine market for manufacturers by increasing coordination between the public and private sectors, also enabling the Centers for Disease Control and state and local health departments to share information to help high-priority populations get the care they need. Unless we take steps now to reform the distribution tracking and communication means

for seasonal flu vaccine, we will not be prepared to provide credible information or treatment if and when a pandemic arrives.

Finally, we need accountability. We need to be able to answer the question, who is in charge? I recently participated in a tabletop war-gaming exercise around pandemic flu and it became quickly apparent no one was in charge. In post-Katrina, that question is one the American people deserve and answer to. So obviously we have to do a lot more on health preparedness, and the hospital sector has to be on the front lines.

I am also concerned that the way that the president's plan for pandemic flu is laid out – the responsibility is shifted; it's shifted out of Washington to state capitals, and -- at least in New York -- the state capitals are now shifting it to counties, placing the responsibility for solving these problems on the backs of hospitals and other providers and stakeholders in the healthcare system. I don't think we can leave you and other hospitals basically on your own to confront an enormous challenge.

We need to provide more resources to our state and local partners if we expect to be truly prepared: increased funding for hospital preparedness, increased coordination, and work with hospitals on a regional basis to ensure that if and when a disaster hits we have a smart, reliable, tested plan in place, and one that can deal surge capacity because that to me is one of the problems that we still haven't addressed in a very thoughtful way.

You know, after 9/11 our hospitals were prepared for survivors. There weren't very many. But a different kind of attack, particularly a bio-terrorist attack or a biological attack, chemical attack could very well leave us with thousands of people who would need hospitalization. So if we are to be prepared for the worst, we need to take first things first, a system that works, and let's focus on the seasonal flu, try to get that right, use that as a model for what we then need to do with respect to pandemic flu.

Well, there are lots of issues that we have to address with healthcare. I think we need a public-private sector consensus. Many of the CEOs who come to see me from New York and elsewhere only want to talk about healthcare. They are distressed that their efforts to control costs have been less than successful. They see no end in sight for rising costs. They resent the freeloaders. They are facing global competition, and they know they can't do it on their own, but they have to be at the table.

There are simple steps that could be taken while we search for a more comprehensive approach. I heard Chip mention the work I have done with Newt Gingrich, which just goes to show that that old saying about strange bed fellows is true. And Newt and I did a forum together at the National Press Club last summer.

And one of the recommendations that he made was that we require there be a single form for all insurers, public and private, and that there be a common vocabulary so that the coding was the same and people could actually track what they were being charged and follow the payment request and understand what was being – what they were being held responsible for. And when he finished, you know, it got a good response.

And I said, well, you know, that is so interesting because that is one of the things I recommended back in 1993, and it got a very negative response then because it appeared to be mandatory to require the same form and the common vocabulary that all insurers would have to use, and it also worked against the time-proven theory that complexity is the friend of the payer but not of the provider or the patient. Well, we could still do that. And the buying power in the private sector could push that.

There are lots of smaller steps that we could take before we stood back and said well, what more do we need to do to have a healthcare system that continues to improve quality, that rewards quality, that empowers patients, incentivizes prevention, understands that we are all in this together; we can't segment the market and expect the whole system to flourish. And I hope that we will have that conversation. It is long overdue, and the longer we postpone it, the more difficult and expensive the solutions will be.

So I appreciate greatly the work that the federation does. My office works with your representatives here in Washington and I look forward to continuing that partnership in the common cause of trying to give America and Americans a healthcare system that is really reflective of our best values and our smartest decisions. Thank you all very much.

(Applause.)

MR. KAHN: Thank you, Senator Clinton.

(END)