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CBS BRIEFING HEALTH CARE

THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript

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REMARKS BY THE FIRST LADY
AT HEALTH CARE BRIEFING WITH CBS

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Q (Inaudible) CBS, and we are (inaudible), especially during the week, all our programs are going as much as possible (inaudible). As I explained a moment ago, my mother call me every day, "What does it mean?" That's all. It means something to all Americans.

MRS. CLINTON: That's the right question.

Q And that's why we're here today, to try to sift through -- so thank you for the time.

MRS. CLINTON: I want to thank you for your coverage this -- over the last months, too, because you've stayed with it. And I think that your mother is right, because what has been good for me is the bottom-line question, "What does this mean?" (inaudible).

And we will need, all of us, to be as clear as we can in trying to explain this. And that's why I'm grateful that you all that could come in, because we want to provide as much information as you need so that we can get this out, so people like your mother and my mother will understand what it is about.

I want to spend just a few minutes talking about the plan and then mostly answering your questions and having you tell us how we can better help you.

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I assume some of you have seen the plan that is circulating. It is a draft, and it isn't meant to be a draft. And it is meant to be open for the kind of conversations and suggestions we are engaged in on the Hill at this very moment. I need you to go back up there.

But there are certain principles that are the bedrock convictions that we bring to this that we will not compromise on. I mean, there's a lot of details about this that are going to change 100 times, but we believe we have to provide health security everywhere, and that means reaching universal coverage as soon as feasible. We would like to reach it by 1997, which is our target date for me to get this plan passed, next spring, and up and going.

We believe that every American is entitled to a benefits package that takes care of their medical needs and includes primary preventive health care, which have not been part of the (inaudible) insurance package in the past.

We also believe that there are savings in the system that will result from reorganizing the way we pay for medical care and the way the insurance company industry works, and that those savings in both the public sector, primarily through Medicare and Medicaid, and in the private sector, can be better utilized within the system, to give more people quality care than they are currently provided.

We also believe that it is important to maintain the choice available to Americans in their selection of physicians and health plans. And, in fact, we think that this plan, which transfers the decision-making from the employer to the individual, will increase the choice in that regard.

As it is now -- I don't know what happens at CBS, but many employers that contribute to health insurance are now telling employees where they have to go for their health services. We want the individual to make that choice.

We also believe that this system will improve quality, and we want to begin to have a real quality outcomes system. And what we've got now is a kind of patchwork micromanagement, which counts how many procedures are done and reimburses on that basis, and makes doctors be reported

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if they've sued for malpractice in this information data bank and all the rest.

But for most of us, information about what happens to patients is not readily available, and we want it to be broadly available. We believe that if you have a report card kind of approach to the health plan, then every year when we go out choose our health plans, we will not just be saying, "Well, you know, I kind of like Dr. X, and maybe -- you know, my brother likes him."

We'll be able to say, "Well, tell me what you all -- give me your information," and we can make better judgments about what we intend to be paying for.

We think the system has to be simplified. We need to move toward a one-form, single-form, hopefully electronically formatted payment system, instead of what we currently have, which is 1,500 different insurance companies with thousands of different forms.

And finally, we really believe that responsibility for paying for health care and making choices about health need to be in the hands of every person. And that is at the root of why we think that building on our current employer-employee system makes sense, because we currently have a system in which people by and large have contributed something toward that. But there are many people who are basically getting a free ride from the system who we think should have to contribute as well.

So within those broad principles, there are a lot of -- there's a lot of room for movement. And there will be a lot of movement over the next month. We are, at this point in time, much, much closer to the moderate Republican position than I ever thought we would be. We are much closer to the large provider groups.

And now if you saw the AP story yesterday, where the AMA said it's "cautiously optimistic" about our health care reform plan, six months ago I don't think we would have that kind of reaction. And it's because as more and more people have worked together, as we've tried to bring people together -- we have met, for example, with 1,100 different groups, not meetings, groups. Some of them we've met 10 and

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20 times with. We've had hundreds and hundreds of meetings with the Hill.

As we engaged in that, we have caused something to happen which hasn't really happened before, and that is to translate the discontent about the system beyond the rhetorical level into a level of analysis where everybody has to come to the table and say, "Here's how we think it can be fixed."

They can't just say "single-payor," "IRA accounts," and get off the stage and you all write it down and report it. Now, we're saying, "Fine, single-payor. How do we pay for it? IRA, Medicare account, fine. What will you do with people who get dropped from health insurance?"

In the course of that, everybody has begun to see the same problems. And what I view as a kind of great middle, the reasonable middle that we're aiming this toward, is beginning to appreciate that there aren't quick and easy, Republican-Democrat, liberal-conservative kinds of responses, that this is going to be an effort that is going to require some new thinking. And we're very gratified by the level of involvement we've gotten.

So with that, I'll answer your questions.

Q Can I ask you a question about -- which has nothing to do with the big issue here -- just curious about abortion coverage --

MRS. CLINTON: Yes.

Q -- because it obviously has pregnancy-related services in the plan, and it's just not clear to me whether that covers abortion. And the (inaudible) proposition, I'm sure you know today, embraces questions about whether that is going to be included more -- in more detail than it is now?

And I understand that Mr. Magaziner was quoted as saying last week that it was, that you weren't going to see the whole plan go down the tubes if it comes down to a fight over this one issue -- as I say, you were quoted as saying.

MRS. CLINTON: Well, let me tell you, what we're

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trying to do is to preserve the way this is -- the way this is now our insurance policies, which do not mention the word "abortion" by and large -- what insurance policies do is talk about pregnancy-related services, medically or necessary medical treatment, and that the access to abortion is available through that insurance policy when a physician and an insured make that decision.

We are not trying to increase the right to abortion to decrease the right to abortion. We are trying to make it part of those services that would be available in the normal course of medically necessary or appropriate treatment.

We are not changing any state laws. We are not expanding Roe v. Wade by doing this. We are trying to build on what has already been out there.

And there may be some, but I don't know of any -- are there some insurance policies that specifically mention abortion?

AIDE: Some.

MRS. CLINTON: I guess there are some --

AIDE: Some, but not very many.

MRS. CLINTON: -- but very, very few, based on our survey. And so that's what we're trying to do, is just aim right at what the standard practice has been with respect to that.

Q So if it's medically necessary, it's likely to be in the plan?

AIDE: Medically necessary or appropriate --

MRS. CLINTON: Or appropriate.

AIDE: -- but that covers all of the services.

Q That covers everything.

AIDE: I think what -- that quote I think was Senator Chafee had been asked on a news show about his view,

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and he had something to that effect. And then I just said we agreed.

Q You agreed what?

AIDE: That this abortion issue is going to be a contentious issue, but that there is a lot more at stake in the health issue than just the abortion issue.

So what we're looking to do is to preserve the status quo that exists today, where people can choose health plans that will provide that service, and they should continue to be able to do so. They will under what we're proposing.

MRS. CLINTON: And from our prospective, we are getting hit on one side, saying, "Make it explicit, you know, make it in writing, put it in the plan, make everybody have to do it."

We're getting hit on the other side, saying, "Make it explicit, it is not in the plan, it is not covered. Take it out. I won't vote for it."

Those are both positions that don't reflect what goes on today. What we're trying to do is to build on what goes on today, which is that, as I've described, the way most insurance policies handle it. And we think that no matter what we do, this is something that Congress will ultimately decide, as what we're trying to do is to say this is what exists today and tell people who are adamantly one way or the other that is not the way insurance is currently provided, and so we're going to try to (inaudible).

Q Can you spell out what exactly what do most insurance companies do regarding abortion? I mean, what is your understanding?

MRS. CLINTON: Most insurance companies do not specifically mention abortion in their policies. They talk about pregnancy-related services, reproductive-related services, and then they have a general standard, they will pay for medically necessary or appropriate procedures. So it's not just an abortion standard; it's a coronary bypass standard as well.

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They let people go in and they access services based on their relationship with their physician, and that is what we think is appropriate.

Q Does that mean that if a girl then wants to have an abortion for other than some kind of pertinent medical reason, that insurance companies do (inaudible)?

MRS. CLINTON: If it's appropriate, and "appropriate" is broadly defined. I mean, once -- I mean, what we have told a lot of people who want us to be more explicit, is there is no way to cover every possible contingency. You cannot do it. And so the broad language of "medically necessary, appropriate" has worked. Why don't we say (inaudible).

Q Did any (inaudible) --

Q Is it appropriate or --

AIDE: Psychological needs of the mother as well.

MRS. CLINTON: Yes, everything is within that standard.

AIDE: But it --

Q If the physician says?

MRS. CLINTON: Yes, that's (inaudible) --

AIDE: Yes, (inaudible).

MRS. CLINTON: That's the physician --

Q If the physician says --

MRS. CLINTON: Yes.

Q -- this is necessary for her?

MRS. CLINTON: Right. Or her (inaudible), which is a less strict (inaudible).

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Q But if Henry Hyde and company, for example, want there to be no reference to this whatsoever, you're willing to let this go till the present plan goes through?

MRS. CLINTON: We are willing to let the Congress -- I mean, this is an issue that has tied up the Congress for 25 years, and the Congress will finally decide on this issue, one way or the other. We are trying to present what we think is the appropriate treatment of this issue.

We are not to make a lot of people happy, because we're neither mandating it or prohibiting it. And we know that. So if we (inaudible) any position, the Congress is still going to decide it. So we thought if could come in with what we felt would be a correct position as to reflect what is available now and how it should be handled -- we don't think that insurance companies or government or anybody else ought to be defining "necessary, appropriate." It ought to be up to the doctor, and then the insurance company would pay based on what the doctor said, which is what they do now.

Q To get back to Jill's point, which is the same one that a lot of us are hearing (inaudible) travel around the country, everyone's mother, everyone's friend, and everyone's something wants to know how they're going to get and figure out what they can get, whether they'll have to -- whether maybe they'll get more or less, the same amount, whether they'll pay more or less, the same amount, whether they'll pay more or less or the same amount.

How are you going to make it available in terms of information? At least, you know, what new proposals are in? Somebody calls, saying, "Linda (inaudible) covering this for us," and says, "You know, I'm hearing all this stuff. Can we do a story on X, Y, or Z?" And will there be enough information for her to easily, without making 8,000 phone calls to try to sort out where the truth lies -- is there going to be some kind of a bottom line here that we'll be able to see when all this over. And just (inaudible) on that, you should (inaudible) --

MRS. CLINTON: Well, I --

AIDE: (Inaudible) number two --

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Q (Inaudible) -- you know, we are kind of wondering what the President's speech is going to be like next week in terms of answering some of these questions. What will his role be in this (inaudible)?

Q (Inaudible) if you want to keep (inaudible). There's lousy early criticism of the draft that has focused on the size of the projected savings, which seems to me is something that is not encouraging totally. So how do you sell that on Capitol Hill, because it's quite critical obviously to their plotting into the program that they believe you're going to generate the kinds of saving you're talking about.

MRS. CLINTON: I'll let him answer that, and then I'll go back to this.

AIDE: Well, (inaudible).

MRS. CLINTON: All right.

AIDE: First of all, I think any -- I mean, anybody that we have talked to that has (inaudible) this health care system, doctors, nurses, clerks, patients, knows there is a tremendous amount of waste in the system.

You can go into a hospital -- we studied for a couple of years a series of hospitals where we went around with nurses and looked at what they did day to day and so on. The average nurse is filling out 19 forms per patient a day, many of which are driven by the needs of the reimbursement. They have nothing to do with medical care.

There are then utilization review departments that check what the nurses have done.

And then it goes to coding departments that separate out to get the maximum reimbursement.

And then it goes to billing departments to draw coding from 15 different formats for different insurance companies.

And then it goes outside the hospital to fiscal intermediaries to judge whether it's an appropriate bill

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before they send it out for payment to the Welfare Finance Administration.

Another copy goes to (inaudible) PROs that judge whether it's appropriate care. And then they have disputes with the hospitals on whether it's appropriate care. There's a whole consulting industry who provides hospitals on how to handle those disputes.

And then there's a super care that evaluates the PROs and that agency (inaudible).

I mean, this is a bureaucratic system bar none. 20 years of business (inaudible), and I have never seen any industry less efficient. And everybody works in it knows it. Everybody who accesses it knows it.

The savings would not have been savings in this system. It's, to me, a Washington disease. And coming to that, Medicare savings, Medicaid savings, (inaudible).

Health care and Medicare and Medicaid is projected to grow now at four times the rate of inflation. There is no -- people aren't getting older that fast. They're not getting sicker that fast. Four times the rate of inflation.

All right, health care is already 14 percent of our economy, compared to 8 percent -- in terms of 7 percent in Japan. Yet we don't cover everybody; they do. We have less rich benefits than they have; already we're (inaudible). We never say (inaudible) has to go up four times inflation.

What we are saying, we've identified the specific savings. This is not a smoke-and-mirror exercise. We have identified specific savings that have been scored by CEO, scored by OMB, for how we can get those Medicare (inaudible) savings.

And we believe that also by capping the rate of growth in the private sector for health care spending, (inaudible), that we can slow the rate of growth (inaudible). Those can be done by identifying the ways that are enforceable and scorable. I think the question that people are raising is, is there the political will to do that?

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And our view is that it is not right to go and ask the American people for a broad-based pass to finance universal coverage and essentially feed it into so many so inefficient a system, that you need to in some way get the growth of costs under control if you want to help finance the program. We do have a sin tax for (inaudible) the program, but we don't want to go to a broad-based tax program to feed that kind of inefficiency.

Q (Inaudible) the argument over to be exactly how much and whether the projections you are making are really realistic?

AIDE: Well, there is flexibility in what we're proposing. For example, we have identified specifically \$124 billion in (inaudible) savings (inaudible). We also have \$91 billion deficit structure (inaudible) won't be scorable.

If some group in Congress says, "Look, we don't -- we think (inaudible)." we're going to bring that down to 110 (inaudible). Maybe instead of getting the 105 in sin taxes, we get 110 or the deficit reduction should be 91 or it should be 71, whatever. I mean, there's room to talk about all that.

But what we felt had to do be credible was to present a detailed plan of what we think should be financed, and then we'll have that discussion.

MRS. CLINTON: But I want to make one other point. There has been so much loose talk in the couple of years about capping Medicaid and Medicare. I mean, you know, people make speeches on the floor of the House and the Senate, and they talk about (inaudible).

And then when we come forward with very specific cuts that will be spread out over seven years that are not in any way cuts in essential services, they are rate -- they are reducing the rate of increases. And not only that, we are giving new benefits to the elderly, through the prescription drug and long-term care benefits, so that there is almost a tradeoff there that is going to benefit the population that's being served, people who have stakes in the way Congress has always operated, say, "Oh, no, that's too much. We can't do

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that." And I understand that.

But if you go and look at a lot of the bills that those same people have put their names on to introduce over the years, they have asked for even deeper rates of reduction.

And so what we try to do is push this analysis to the point where we can make a decision, instead of all this theoretical -- and so once people start talking seriously, as they're beginning to, about "Well, what is the real target for growing Medicare?" Because we're still talking about growing.

We're not talking about, you know, in any way getting the below the base. It is going up, even after the budget reconciliation -- up 11 percent a year. People don't get old that fast. Our population of elderly eligible for Medicare grows 1 percent year.

So we're not talking about dropping below the base. We're talking about not necessarily growing 11 percent, but growing 16 percent, which is still a huge, huge increase when you've got a trillion dollar program out there.

So part of what we're trying to get people to do and understand is what we're really talking about, and it is complicated, and there is a lot of room for scare tactics and people to stand up and say, "You know, you can't do it."

But once we get them to the table and talk specifics, then we think that we can realize a lot of these savings. And that's what Reed was talking about.

I hope that we will give you enough solid information so that you can answer those questions. I mean, that is our job. And we are working very hard on it, in addition to everything else. Because what will happen in this debate, I believe, is that individuals and businesses will finally cut through all the rhetoric when they get, you know, all of the stuff out there about how this will be a terrible thing and whatever is going to be said.

And they will say, "Look, what are the benefits of this, and how much will I pay for them?" That's the bottom

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line? "And will I always have them?" "And even if I am a little bit concerned about it, is the concern worth taking that bet that it's going to work, because I will have health security."

And so that's exactly where we want this debate to end up, because we think if that's the way it is discussed, then we will get national health care reform. And we have to keep trying to help you get the information you need to make those judgments, and that's one of the things we're going to try to do.

Q (Inaudible.)

MRS. CLINTON: Well, we're putting together a lot of written material, a lot of experts. We're trying to get people all over the country that you can talk to. We'll give you a whole stable of surrogates and people who don't have any direct financial stake in keeping the system the way it is, as a lot of the people who are going to be opposing this do, and try to help you sort out for your own benefit those people who aren't going to agree with us 100 percent but who agree in general enough that they can give you the kind of solid information you need to put together your presentation.

Q In advance, you would do that?

MRS. CLINTON: We're hoping to.

Q That would be very helpful.

MRS. CLINTON: We're really trying to.

AIDE: One of the things that might be useful for you to do is to look at -- I've read some of the newspapers recently on the debates that took place around Social Security, about 1935 (inaudible). And we had a less sophisticated media event. But if you read some of the newspaper accounts -- I mean, people thought the world was going to end. It was going to bankrupt the countries. It was going to take people some jobs. It was going -- you know --

Q I think they still blame that.

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(Laughter)

AIDE: And, you know, we're still (inaudible).

Q But Social Security runs a service.

AIDE: But see, they're --

MRS. CLINTON: If our health care system ran the way our Social Security runs, which is what we're trying to get it to do, we will be a whole lot better off.

Q It certainly won't be there in another 30 years though.

MRS. CLINTON: Yes, it should be self-financing. It won't be there if we have to keep putting it over on a deficit because health care costs are out of control.

AIDE: And that's what has happened.

Q If it turns out that these numbers don't add up -- I mean, there's a lot of talk about the Medicare numbers, because there's the political question of whether --

MRS. CLINTON: But ask me -- no, but ask me specifically, what doesn't add up?

Q No, but it -- well, but the question is how do you actually cap (inaudible)? I mean, are you really going to limit the reimbursements to doctors to the point where doctors might want to talk Medicare patients? That's sort of the (inaudible).

AIDE: But let's talk about this now. I mean, I think -- let's take that one specifically, because that's one people bring up. And let's understand the background. First of all, we have to (inaudible) opposition. We have a specific itemized stack of savings that are scored savings. But let's look at this position paper, because here's where I think there's a lot of scare tactics; that's all it is.

Physician incomes, on average, have gone up six times as fast as the average of all other Americans. And that's for ten years. Three times as fast as people with

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comparable education levels. And the base line projections for health care are projected to continue to go up at six times as fast as everybody else.

Now, the industry -- health care industry has had no productivity improvement. They have no productivity improvement. If they get 2 percent productivity improvement a year, they'll continue to go up six times as fast as everybody else. God forbid they shouldn't get productivity improvement. Maybe they'll go up three times as fast as everybody else. This is not the end of the world.

When they talk about a minus 1 percent adjustment on the Medicare physician factor, which they all say, "Well, that's minus, that's" -- do you know what that means? That means that they go up at 6 percent a year, a physician.

Q So they are talking about though lowering the reimbursements for the doctors?

AIDE: No.

Q And that would be the obvious -- the most powerfully --

AIDE: The doctors? Not true. Not true. the doctor piece of it is very small. So -- I mean, I would like to do more on doctors personally, but you don't get enough money out of it.

(Laughter)

AIDE: No, because I think basically there's an issue of the rate of increase there. But you don't get enough money just to go after doctors on this thing.

What we've done is we've presented a battle series of savings that again are slowing the rate of growth. They are all scorable savings. There will be people that will oppose us, individual ones. But we're not going to get the cost shift out of it, that -- you know, will they see Medicare patients -- because we're going to cap the rate of growth in the private sector as well. And we are going to allow Medicare to grow faster than the private sector guaranteed package, so Medicare won't be shifting to the

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private sector.

One of the things you might look at in this is that despite the comments from experts and so on -- I mean, the AARP, the American Hospital Association, the people you would have thought would have thought would go running out in the streets, have basically kept (inaudible) violence, and they've been working with us on this for quite awhile. And we have -- as leadership groups, they understand what we're doing and they're not against it.

Now, we have a job to do in selling it to the members.

MRS. CLINTON: But I think that -- see, one of the problems we've got, and we're not -- we're not sure how to solve it -- is that these are 00 these are the right questions to ask, because these are the questions that will be out in the public debate.

Well, doesn't this mean that you're going to, you know, force doctors to give up taking care of Medicare patients and therefore people won't have access to care? And there are -- there are so many pieces of this which show why that is an absolutely absurd claim to make and why anybody who is responsible won't make it.

What we're struggling with is most people can't understand the system the way it is now -- I mean, a little brief thumbnail sketch that Ira made about the checkers checking the checkers and, you know, the giant bureaucracy about that, most people don't know anything about that. Most people are not going to know anything about the new system when we get it into place.

What most people are going to want to know about is "Am I going to have health care that I can afford to pay? And am I going to be able to pick my doctor?" That is all they care about. They do not care about all the rest of this stuff.

If they know that what we mean by reducing the rate of growth of Medicare is not to cut the amount that is being spent, but to try to take the difference between it increasing at 6 percent and 11 percent and give our older

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citizens, my mother and yours, a prescription drug benefit and begin to build home-based and community-based care for long-term care, things that are not available now, that's an enhancement of benefits. So for the average person, that's not any kind of loss of benefits.

Then if we do as we say, in addition to beginning to try get our public house in order, we're going to get our private house in order, then you don't have physicians who will turn their backs on Medicare patients, because they're going to begin to face the same kind of discipline in the private sector, which up until now they never have. So it goes hand in hand. And we've got to figure out how to explain that.

AIDE: But let me just one thing, just to --

Q That discipline though -- what is with discipline of the doctors (inaudible).

MRS. CLINTON: Okay, I'll get back to you. And let him finish with his (inaudible).

AIDE: Okay. So -- I mean, one thing that you have to understand about the whole financing of this, the Medicare savings that we're looking for are less than the increased spending on the Medicare drug benefit and the long-term care program. So basically, I mean, if a senior -- and that's why they are -- he supports our program.

But if you basically -- and then the funding for universal coverage comes mainly through the requirement that individuals and employers contribute to their health care. So if the senior citizens of the country say, "Well, I'm a little nervous about those Medicare savings, and I'm nervous about them," if they want to take less of the new drug benefit or less of the new long-term care program and have less Medicare savings, we can do that.

But our view is that there's inefficiency that can come out. You know, every -- of every five people hired by hospitals in the past 10 years, four are administrative personnel. Four are administrative personnel.

MRS. CLINTON: Well, and that goes back to your

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point about doctors -- (inaudible) doctors used to spend 25 percent of their gross on administrative costs -- you know, hire the bookkeeper, the person who filled out the forms. They're now spending 48 percent.

If we squeeze that out, unfortunately, for my friend Ira, we're going to end up making physicians even more money, because they will not have to have the infrastructure they currently have to argue with insurance companies over who pays what.

So -- but let me go to Connie's point. But this is the second piece of that. If all we did -- you know, a lot of the proposals that have floated around about capping Medicare and Medicaid have done it strictly in the contest of deficit reduction. You know, the position that a lot of people on the Hill take.

If that's all we did, all of the bad effects that you've asked about would likely happen, because you would scratch it down to the public sector expenditures, and you would shift those costs that were no longer recoverable from Medicare to Medicaid, into the private sector.

Those of us who are insured would pay more. And they would have a ripple effect, as we currently are experiencing, because as private insurance goes up, more employers can't afford it. They therefore quit covering people. Those people fall into the public till, and so the whole thing is just a never-ending spiral of increasing costs.

What we're doing instead is saying we want to get rid of the micromanagement. We are tired of the government saying, "Here's how much you have to charge for a cataract operation or we won't reimburse you."

We are tired of the insurance company -- some executive sitting in some air-conditioned office a thousand miles away telling my doctor whether or not he can order a test for me. That's how we --

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-- and individuals will pool their money, health plans will then bid to cover the people in that purchasing cooperative, just like health plans come and try to sell CBS on what you should join.

In order to determine what a budget should be for the private sector, we want it to be based on what actually happened in the marketplace. These health plans will bid. You will then take an average of what the premium is. That will serve as a kind of per capita measurement as to how much money in general should be spent in a particular area.

So instead of having a doctor told, as he is now, by the government on the one hand, by insurance companies, doctors will make those decisions. They will have a huge pool of money in which to serve the people they are serving. And there will be different ways of delivering the services that we know about now, HMOs, fee-for-service, et cetera. That's the way the budget will work.

Now, there will be some back-up enforcement mechanisms in order to make it real. And otherwise we don't think we will change behaviors. Otherwise people would say, "Ah, it's another attempt to control us, and move us in a (inaudible)."

Q Are you just bringing in a democracy bill? Or --

MRS. CLINTON: No, in fact, we're eliminating it, we think -- considerably.

AIDE: If I can describe the difference in the -- in what we talked about. If somebody were to say to you, "You've got a half hour to do your news shot," that's setting some limit on what you can do. But then, let's say, you have a choice on what you do within that half hour. That's what we're proposing.

The alternative, which is what exists today in Medicare and Medicaid, is that somebody says, "Here's what you do minute one, here's what you do minute two, here's what you do minute three."

Q There's a big difference though, and I couldn't understand -- is it regional funding? A question sent from

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Chicago, from Illinois as well -- so there's Chicago, and that has a certain standard. Does down state -- how do you -- how does that all blend in? How do you set these (inaudible)?

MRS. CLINTON: Well, there's a national framework, and the national framework is, here is the benefits package every American has to have. And then in Chicago, all of us, employers and individuals, we do what we do with work now. When your FICA payments are taken out, you never have to do that. Your percentage goes into the big collection pool. The same will go with your health insurance premiums.

But then every year your purchasing cooperative will send to your place of employment what the available plans are. You will sign up for those. The amount you pay in Chicago, because you start with higher fixed costs, may be greater than what is paid in Carbondale. And the efficiencies will come more slowly in Chicago, because they're starting at a higher base.

But if you look at Rochester, New York, and Rochester, Minnesota, you've got two of the finest health systems in the whole country -- at Mayo's and then in the Blue Cross system that exists in Rochester, New York. They are able to deliver quality care on an almost per capita basis much more cheaply than most of the rest of the country. Nobody would doubt the quality of Mayo's, for example.

What we want are more health providers to be more efficient like that. In order to get there, we have to create this kind of pool of money in which they then make those decisions about how to allocate resources more efficiently. And there will be different decisions made in Chicago and Carbondale, because they're starting off at different levels, but we think eventually they will be on a par.

Q What is my incentive though to go serve, for instance, in an indigent, poverty-plagued population, as you do these different groups are defined conglomerate, A, B, C, D, or E, or Bob and Joe who decide together that maybe that's a business they want to go into? What's my incentive to do that?

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And how do you get the health care that's so desperate -- more desperate -- perhaps more desperately needed out there to those people, because they're not getting it now? And I don't see where the incentive is to really provide it.

MRS. CLINTON: The incentive is money. I mean, for the first time there will be a fair rate of reimbursement that every person carries with them. I mean, right now the reason why it's such a loser in most inner city and rural areas is that you have a higher than average poverty population. You have a very high uninsured population, even though they're working. There is no reimbursement strength.

And what we believe is that now there will be an incentive to serve everybody, because everybody is going to have a reimbursement strength.

Q It sounded -- but it sounds like one of those things that is so ripe for that kind of bad Medicare fraud. I'm a bad doctor, and I'm going to go to a bad neighborhood. And --

AIDE: No. It's totally different.

Q -- and rape these people some awful.

AIDE: No. There are a couple of things that are different in what we're proposing. One is that the same quality outcomes that are going to be measured as part of the national quality system will be measured in that poor area, as elsewhere. Right now there is no way to know that the quality of care is worse or better. Now we'll be able to measure that.

The second thing -- and this is very important -- we recognize that even if you give everybody a national health security card, which we will do, that in certain urban and rural underserved parts of the country, there's just not a sufficient health care infrastructure. So we built in a couple of different things into the plan to help build that infrastructure.

There is going to be a central provider provision with a direct funding scheme from the federal government to

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community-based health financing -- and charity hospitals already exist in these poorer areas -- to help them invest and build for the new environment.

Q Attract?

AIDE: Yes. Secondly, there is what we're calling a risk adjustment package. And let me just talk about this for a second.

Today, what insurance companies do is they employ thousands and thousands of people they call underwriters to basically figure out who is not going to get sick. And then they want to insure only the people who are not going to get sick today. We're going to outlaw them from doing that, right?

They're going to have to take everybody -- there'll be a community rate, which means that how much you pay in will be the same, whether you're a 20-year-old and healthy or whether you're an AIDS patient.

Once that money is paid in, there will be a differential payment out to health plans, depending upon their population. So if you have a population that is heavy on AIDS patients, you're going to get more per person on the premium -- your premium -- than if you have all healthy people. That discourages health plans from just seeking the healthy people.

In most poverty areas, you have an accumulated under-service which has contributed to poorer health stats. That's the kind of thing you can take into consideration for risk adjustment.

So, the First Lady's point, what we're doing is we're changing the financial incentives in the system from what they are to something different which we think will help provide more uniform (inaudible).

Q (Inaudible) ask you (inaudible) questions. Going back to the campaign, what we heard as -- about health care and what the Russians (inaudible) and (inaudible) a small business man -- you are really (inaudible). A number that's be thrown around now was what, 3.9 percent of people --

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AIDE: Except if you are employed, you are required to pay them more, that's --

Q The health care of all full-time and then gradation down on other persons --

AIDE: That's right.

Q -- 10 to 30 hours of work.

AIDE: That's right.

Q Are you going to be able to sell that to a sector that's creating the most jobs?

AIDE: Right.

MRS. CLINTON: Well, interestingly enough, the small businesses that are creating the most jobs -- the fastest growing small businesses are the ones most likely to be already offering insurance.

And if you saw The Wall Street Journal piece I guess a day or two ago, they went out and got small businesses to open their books and cut through the cost figuring. It will be a big economic boom for small businesses already insuring.

For those that have not insured and choose not to insure, there is going to be additional costs. But we tried to make it as affordable as possible, because in effect we're subsidizing all of them. I mean, we're already giving them (inaudible).

Q Wait, where's the subsidy? Is that -- comes out of the savings/cigarette tax?

AIDE: There are specific identified places. But let me just say one more point about this, and I'll come back (inaudible).

You know, we've done a lot of work in surveying companies to see what the effect of any part of the real stories in this debate that's going to come out, despite the

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NFIE's campaign, is that the majority of small businesses in this country buy health insurance in this country. And they're going to get a windfall from this. They're going to get a big savings from it.

And a whole lot of small businesses, when they really look at this program, are going to say, "Hey, this is good for me."

And I went into my own hometown, to some of the stores in the town, and the thing that I found most is that the family who ran the store couldn't get insurance very often, or if they did, they were paying an arm and a leg for it.

Under what we're proposing, they're going to be able to save enough on their own family's insurance, to help make the contribution for the two or three workers they're hiring in the store.

MRS. CLINTON: And also this whole plan is the Chamber of Commerce plan -- I mean, based on the Chamber of Commerce (inaudible) and employer requirement. They differ with us on how big the business should be to have to go into the health alliance. But basically, they support the employer requirement.

So from our perspective, there's a lot of business groups that understand the economics behind this and are willing to support it, and we just have to make sure that their voices get heard, in addition to the ones that are against it.

AIDE: But in terms of the subsidy -- well, just to finish his question -- there were three places where the money comes from. One is from the tobacco tax (inaudible) fund.

The second is that when Medicaid people now go to work, people who have Medicaid work part of the year (inaudible), Medicaid continues to pay their health insurance.

When you have the employer mandate, his employer contribution for that person while they're working, there's

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a savings to the Medicaid system, which is about \$9 million a year. That will go into the subsidy (inaudible).

The same thing happens with Medicare people when they go to work. Today most Medicare people are Medicaid eligible, and they work -- it might be at McDonald's or someplace, and they don't get covered. Under our system, they would, because there's an employer contribution. And that savings, which is about \$10 billion a year, will go into the subsidy (inaudible). So there's an identified specific set of offsets that moves back (inaudible).

Q You said only if the back-up (inaudible).

MRS. CLINTON: No, it's a sin tax. We don't know your -- we don't know that.

AIDE: It's one distinction that hasn't been made.

Q And do you (inaudible)? Would you have any idea of how -- what the size of that would be?

MRS. CLINTON: We need, we think, about \$15 billion a year for the next seven years, about \$105 billion.

AIDE: \$105 billion.

MRS. CLINTON: And (inaudible).

AIDE: \$50 million a year -- 15.

MRS. CLINTON: 15 over 7 years.

Q (Inaudible) make up the difference?

Q An eight-year over seven years?

MRS. CLINTON: Yes. So it would be \$105 billion over 70 --

AIDE: Well, that's for (inaudible).

Q But you claim the projected savings --

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MRS. CLINTON: Right.

Q -- over the protected costs?

MRS. CLINTON: Right. In part because we've got this -- we've got this problem of getting our savings scored by CDO. As you know from the retirement on the Hill, that the CDO will score a budget. They will score a single-payor system. They will score heavy regulations. They will score government micromanagement. Even though our experiences, that hasn't saved money. They will still score it.

So when we come in and you say you think the market and competition will save money, they say, "Yeah, but that's not directly under the government, so we can't score it."

So we need this -- we think we will have a lot of savings as people change the way they are practicing, but we can't get any credit for that. So we need to make up (inaudible).

Q But we'll have -- but it will be only a sin tax at this point?

AIDE: Yes.

Q I mean, we're not talking about anything in addition to this?

MRS. CLINTON: Not at this point.

AIDE: No, not at this point.

MRS. CLINTON: There's going --

AIDE: I think they're -- the scoring. I mean, what we do will be scored.

MRS. CLINTON: If it hasn't (inaudible), that's what we'll do.

Q But that's -- that's inclined to how many cases or --

AIDE: No. They're --

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MRS. CLINTON: If your company decides to opt out of the regional alliances because you're self-employed already, you've got 5,000 employees, then you think, no matter how good our plan is, you can beat it basically, then you could do that. But there are certain costs in the whole system that everybody has to share. And so we think that you have to make a contribution to medical schools, you have to make -- you know. So that's what the assessment (inaudible).

AIDE: Let me just -- I mean, what we're proposing is 50 score -- the budget and the enforcement record, so it will be scored, the savings.

Well, I know the First Lady is saying, is that we believe that it's a competition that will really produce the savings. The budget is more a backstop discipline, to it. Some people will score the budget. They don't know how to deal with the competition, but we think that's protection (inaudible).

A I just -- well, I just -- you've really moved off on this issue of the part-time employees (inaudible). As I understand, one of the things that, I think, Business Roundtable, for example, is a real (inaudible) of where their comes.

Have you reached (inaudible) cutoff on (inaudible) employer is only responsible for part-time?

AIDE: Public -- the employer is responsible for all part-timers.

Q All part-timers.

AIDE: Hanging up a potion.

Q At least 10 hours a week, is that what you --

AIDE: Yes, by if they worked 10 hours a week, then the employer is responsible for one-third, 80 percent of one-third. So it's not a full responsibility, it's a proportional responsibility.

Q And to your (inaudible) -- in other words, if I worked for -- you know, Lord & Taylor 10 hours a week and

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particular problem. But remember, you've got a distorted labor market, in which part-time workers are being hired in large measure because you don't pay them benefits. So we all pick up the cost of those people, because they still get sick, they go to the hospital, nobody has got a funding strength for them, so our insurance goes up anyway. I mean, it's a vicious circle.

So we've got to get the part-time workers in, and there may be some -- then, readjustment. People may be giving more full-time jobs to people, because it may be more efficient, et cetera.

Now, on the full-time workers, the people who are already in the insurance system, what we have tried to do is to come up with a benefits package that is a good benefits package that most middle-class people with insurance would recognize as a good package, not a bare-bones, catastrophic something or another. And we have also tried to price it in a way so that most people who are currently insured will not pay more for that benefits package.

Now, if you are insured only for major medical or catastrophic, you may pay more, but you will get preventive care, and you will get a lot more benefits than you currently have. So there's -- you're not paying more for the same. You would be paying somewhat more for more. But if you have a good insurance policy, you should be paying no more and, in fact, less for what we're going to (inaudible).

Q If (inaudible) savings --

MRS. CLINTON: Well, yes -- no, you just -- starting off -- starting off.

AIDE: Starting where you -- (inaudible).

And, if you -- in our preliminary distribution tables, we'll have these panelists speak out. About two-thirds of the people in here want, as far as I know, to pay less for the same benefits they have. There'll be another group of 20-some-odd percentage for paying more and getting more. There's a small group, the rest, who are looking to pay more for the same thing. They are mainly

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people in their 20s who are single, who, because of community rating, they might pay less, because now we're going to have the (inaudible).

MRS. CLINTON: (Inaudible) change that last one.

AIDE: 12 or 13 percent. But -- and those numbers are going to be refined this weekend, so I'm here to --

MRS. CLINTON: Yes, but the problem, of course, is that, you know, a lot of people say, "You shouldn't make a healthy 25-year-old have insurance. It's not fair."

But, you know, my response to that is, "If that healthy 25-year-old will sign a release that when he has a motorcycle accident or falls down drunk and slashes his head open, then we leave him on the side of the road, then that's fine."

But there is no way to predict health for any of us, and that's what insurance is supposed to mean.

AIDE: And what happens now is that person goes to the hospital, they get treated, as they should, but those of us who are insured pay for them.

The way we get the 15 percent savings, there is no mystery about this. Everybody agrees, every hospital association, every medical association, CEO, or me -- such -- everybody can -- there are about \$25 billion of this uncompensated care in the system, people getting treated who don't have insurance and they can't pay.

When you have universal coverage, that \$25 billion should go back to the people who are now paying insurance. It's their money. They should have a savings of about \$25 billion (inaudible) new money coming into the system. We built that into the base rate of our (inaudible). And there's also a couple of things that administrators say (inaudible).

And that's what allows the currently insured to pay less year one of the program. And there's almost no actuary in the country who would disagree with that number. That's a solid number. That's what gives the initial savings to the

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currently insured. Those not now making a contribution are going to have to make a contribution, and that's where the new money comes from.

MRS. CLINTON: But see -- but if we let the tail wag the dog again, people will say, "Oh, my gosh. You're going to have, you know, 10 percent of the people who are going to have to pay more to get insured."

And while the 90 percent of us are going to do a whole better, and all of a sudden we're going only worry about the 10 percent, who aren't doing their fair share now. They are not taking responsibility. That's how we always kind of veer off and how we don't ever get to closure on a lot of these hard problems, because there's always an interest group, there's always a lobbyist who can hold up what is best for the vast majority by focusing on the problems of a very small, relatively small number of people.

And I would argue that the same is true in the business community. If you take the huge amount of money that is currently being spent by many employers, who have basically subsidized our whole health care system over these years, who are paying 15, 18, 20 percent of payroll for health care costs, and you begin to bring their costs down, then for the first time we can see wages increase, we can see new investments, because that money won't be tied up in health care benefits.

All of this, from our perspective, is a big job-creator, a big economic boon. I'm not saying that there won't be some people in some situations you are really going to have to really hustle to make it work for them, but they are such a small percentage of the overall population. And what we're trying to do is to get a system that works for the vast majority of people. And so that's why we've done everything we can to make this affordable. We've driven down the costs.

We've got a policy, a single policy, that is a we think is fairly priced, that is heavy on preventive care, which we think will save money. And so we look at all of this, and the pieces of it all fit together from our perspective.

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AIDE: You (inaudible).

Q Well, I just have a question about the quality of care, because I thinking they're (inaudible) in these town meetings, that's a question that we possibly get most often peppered with.

AIDE: One was related to that.

Q And as people begin to see this plan take shape, I think one of the biggest concerns is this whole question of the specialty training of doctors and the fact that they're -- you see medical schools around the country telling their young students, "We're going to have to encourage you to become general practitioners."

The students say, "No way. I've got \$20,000 in debt. There's no way I'm going to go to a lower-paying job. This is taking five years to pay off my debt here."

What do you see happening to the quality of care? And can you insure those folks who -- you know, we read something today in The Wall Street Journal about hematology training. There are too many hematologists in New York. They might as well forget it, go find another specialty. But what do you see happening along that line?

MRS. CLINTON: Well, I don't think anybody would seriously argue that we don't need more primary preventive health care people. We have too many specialists, and we've got a hugely disproportionate number. And there will have to be some changes in the mix.

What we think though is that through guaranteed loan repayment programs and other support for medical schools, it won't be an economic loser devoted to primary care. A lot of young physicians will tell you all the time that they made the choice for specialty because they could pay their debt off faster, just like you said. If we can begin to relieve them of some of that debt, we could give them some opportunity to decrease their loan load, which we're going to do in this plan, then they can make what we think will be an open choice between primary and specialty care.

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Additionally, there is a lot to be said for what we currently see in the system is a very unfair reimbursement rate, which favors specialists. You know, we have -- and I don't even know how this got started, but we have created the system we are now living with, because Medicare undid graduate medical education, and it only funded specialty care.

So the reason we have all these specialists is that's where we put all the money. We are going to, in this program, change that. We're now going to be putting some money into getting good primary care physicians, internists, pediatricians, and ob-gyns, and others. So once we do that, then I think the market is going to sort itself out, because we will be paying these people what they fairly should get.

Q But how do you allay fears that you're going to lose any sort of advantage we have with the specialty care we now provide, that this plan won't diminish that?

AIDE: Well, I think the, you know, by any comparison of the countries or even from one city to the next -- if you look at the Medicare program, getting medical care in Boston costs twice as much as in New Haven -- twice as much, same city. Measurements were made -- Jack Limberg -- (inaudible) -- you know, he's made an analysis, among others. There is absolutely no difference in following up, yet it's twice as much.

Now, part of that is you've got twice as many specialists throughout -- I mean -- so they blame -- the supply finds it's own demand in a program like (inaudible). I think until somebody can demonstrate the differences in quality outcome, there is no way (inaudible) the fact that you've got two or three specialists for that, you couldn't raise, you know, 300 (inaudible) lists 73rd new specialists. The most recent medical school graduating class, only 14 percent (inaudible). So the most recent was actually up to 86 percent specialists.

In other countries, it's the exact reverse. In Germany, they've got 70 generalists and 30 specialists. We're going to try to move over time towards a 50-50 (inaudible). Almost every group we talked to would say it's a better --

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MRS. CLINTON: But (inaudible). Two of the aides told me they have to leave and go back up to the Hill again. The other point to recall, too, is that it's not just two to one between Boston and New Haven. You take Pennsylvania, which has collected data on operations for the last several years. The same state, you can pay for a coronary bypass anywhere from \$20,000 to \$80,000.

There has been a lot of study (inaudible), do people who pay \$80,000 get better faster, do they live longer, do they feel better after the operation? Absolutely not. There is no discernible reason why one hospital should be able to charge \$80,000 and another hospital \$20,000 for the same operation on the same type of patient.

And what we are finding is that there are no incentives in the system for the \$80,000 hospital to move toward the \$20,000 hospital. And why should they when they just keeping getting a blank check that we (inaudible)?

Q Would you mind playing this quickly? On the standard care business, if you go up the street a mile and find an internist, a primary care person, and there will probably be people who'll probably be out all next week who will say, "Right now I have a practice that is structured where I take X percent Medicare patients. They pay me X dollars. If it goes down to X dollars less, I can't give these people the quality of care I think they should have as a physician." So the argument then will be made, that you're shorting particularly the people who can least afford it, the Medicare patients.

MRS. CLINTON: Well, see, but the reason the internist says that is because they are thinking about the current system as it exists. They are thinking to themselves they are going to further reduce the rate of reimbursed nonmedical.

"It will not be worth my while to take care of more Medicare patients, because I have to fill out all those forms, I have to have all these" -- as Dr. Gloven would say -- "girls in my office calling to work the forms out, and all that sort of thing."

So they go through the current system, and they

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say, "Therefore, I won't be able to do it."

Q Well, what this guy was saying was I can only spend -- this is my conversation -- "I can only see so many patients an hour. If I have to see that many more to make up (inaudible) costs, but I can't spend the time with them."

MRS. CLINTON: But he's think about the costs, and they currently are. They -- unless he's a very unusual internist, he is spending at least 40 percent of his income on these paperwork costs. Put aside rent and utilities, and talk about his bookkeepers and his clerks and other people that he has to have on the phone hassling to get his reimbursement level. What he doesn't understand is that that will be gone. Now, his rent may stay fixed, but his overhead should drop. And so we think that this -- but we only -- we can only get there by streamlining the system and simplifying it, and that's what we're (inaudible).

AIDE: And the other issue, just, you know, 23 percent of all elderly people were admitted to the hospital (inaudible) -- are admitted because two prescription drugs they are taking, specified by different doctors, different physicians, conflict with each other and made them sick -- 23 percent.

Now, when we talked about that -- and that then has a cost to the system. Now, if you look at that and say, "Well, I have to treat that elderly person because they have come in with a serious illness (inaudible)." But if you had a better integration of the care in the first place, that would never have happened.

MRS. CLINTON: And if the older person were not going to two different specialists --

AIDE: Exactly.

MRS. CLINTON: -- who never communicated because there was no primary physician to serve as the gatekeeper to, you know, call in the specialist, you wouldn't have this kind of problem.

AIDE: Precisely. So -- and that's why you've got to change the incentives and the nature of the (inaudible).

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And that's not going to happen overnight. But we're talking about the Medicare statements being seven years. What are you doing (inaudible) the system (inaudible)? If you don't do that, this whole (inaudible) cycle, you (inaudible).

MRS. CLINTON: We thought of that.

AIDE: You guys, we've got to wrap up. She's got to go to the Hill.

Q Would you identify three of the remaining problems that (inaudible)? What do you have to turn in to get this passed?

MRS. CLINTON: Well, what we've been talking about -- I mean, the -- to make it clear we are not talking about reducing services in Medicare and Medicaid. We are talking about reducing the rate of growth. The system will still continue to grow, and we will provide more benefits.

But there are people on the Hill who have made their careers out of the Medicare-Medicaid systems. I mean, they are very proud of those systems. They don't want anything changed about them. They are proud that they've grown faster than the entire rest of the economy. So we've got -- you know, we've got some compensations to deal with.

Secondly is the financing mechanism of this. We believe it should be a system in which employers and employees together contribute. We think that is better than a big tax that would replace all private sector adjustment. And we, at this point, think it's better than what we believe that some of the Republicans will come with, which is an individual requirement, like auto insurance, you have to be insured, so you have to go into the market to buy it. We don't think that works well. What we want to do is just to build on the existing system. But, you know, that will be something that we'll work on.

And then finally this whole issue of quality, because the bottom line, is to go back to your very bright first question is, what are we going to tell our mothers? And beyond that, I don't want to have a health care system that is not going to work for me or anybody else. And we have to -- and we're making change -- constantly be

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reassuring people that it's going to look, for them, very much like what they currently have. What we are doing is changing the way we finance this system and putting new incentives which we think will enhance (inaudible). But we will have to make those arguments as we go along, but those are legitimate arguments to make.

I think all three of those -- I mean, there will be a lot of other side issues that will dominate the headlines, but the three issues, how we're going to pay for it, how we're going to make savings come from it, and simplifying and how we're going to assure quality and choice, that's really the bottom line to me.

Q Thank you very much.

MRS. CLINTON: Oh, thank you very much. And we'll do this again.

(The briefing was concluded.)

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