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AN INTERVIEW OF THE FIRST LADY
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MRS. CLINTON: -- so many of the issues about (inaudible) and practice styles that (inaudible) familiar from our own situation in Arkansas. And it is a leap of faith to try to envision what different kinds of systems will look like, which I recognize, but everything we're doing is aimed at overcoming the concerns and objections that physicians have to the present system and the trends that we're going to be living with if we don't do anything.

So I thought it was a very productive session and I was glad that they asked very specific, pointed, challenging questions.

Q Do you think the doctors will be the biggest obstacle?

MRS. CLINTON: No, I really don't. Because if you look at what's happened, a lot of the big physician organizations, like the pediatricians and the family physicians and the internists and the emergency physicians, and you can go down the list -- in the specialty areas are very supportive of what we're doing.

And if you look even at the concerns of the more traditional organized medical groups, they have much more in common with us than they do really (inaudible). So I think we can narrow those areas of concern and work those through. I'm pretty optimistic about that.

There will always be physicians who are against any change, and there will be physicians who don't see the trends the way the rest of us see them and will be very resistant because they don't think that we're describing reality as they know it. But I think the majority of physicians understand that the status quo is very threatening to what we view as traditional medical practice.

I mean, we do have opposition, but I think it'll be

doesn't get a lot of headlines but which is important, all going on.

The entire appropriations process was going on at the same time, you know, plus other major initiatives like the crime bill and the education bill and some other things. But NAFTA dominated the landscape, just like the budget debate dominated it all the way up to the August recess.

So now I think health care will dominate the agenda when the Congress comes back after the recess.

Q Did the NAFTA issue, though, really undermine your support from labor? Do you think you'll be able to put them back on your side and working with you, or is this something that's going to take more than a few weeks or months?

MRS. CLINTON: Oh, I absolutely think that they'll be working with us. And don't forget, we had a lot of Democrats who, for a variety of reasons, did not vote for NAFTA, but I think that most Democrats will support health care reform.

Q I want to ask a question about the employer mandate and the Budget Act. (Inaudible.) There are a lot of things in common. You're encouraging (inaudible), but the employer mandate and the budget (inaudible) cost control are not there, and it seems like in order to prevent (inaudible) focus on your plan, (inaudible), that you've got to compromise in one of those areas.

Is that true or not true? And (inaudible), some sort of (inaudible)?

MRS. CLINTON: Well, you know, I don't know how you get to universal coverage unless you do one of three things. You either have a single-payer system with a broad tax that replaces private investment, or you have an individual mandate, which is the Chafee approach, that requires people to go out into the insurance markets, assuming it's been reformed, in some form, and, like auto insurance in some states, bear responsibility for their own health insurance.

Or you have what we think is the best alternative. You build on the existing employer-employee system. You've got to do something like one of those three to get to universal

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coverage. There isn't any other way to get to universal coverage. And at least a vast majority of the Congress is supportive, or seems to be supportive, of universal coverage, so at some point they're going to have to confront the financing of universal coverage.

And I think when that discussion gets serious, although the single-payer folks have a strong block in the House particularly, I don't think that they will dominate that conversation.

The conversation will be between those who genuinely believe we've got to get to universal coverage. And I think that includes the President and certainly John Chafee has said that repeatedly and his plan seems to reflect that. And those who say, "Well, we'll get there some day, but we don't have to have a mechanism for getting there."

So that's the first kind of hurdle we've got to overcome. And the President has said very clearly he's not going to sign anything that doesn't achieve universal coverage. So we think that the debate really is between how you design an employer-employee mandate or you figure out some way to provide an individual mandate that overcomes our concerns with it, so that you can achieve universal coverage.

And I think that's going to be the most substantive and difficult part of the debate because there are arguments, I suppose, in favor and against both approaches, but we've run the numbers on ours. We know how much our subsidies for low-income people will cost. We know how much the small business discount will cost.

And now that Senator Chafee has gotten his bill in, we're going to have to do the same -- run the numbers on all of his stuff, so then we can start having a conversation.

Q It seems as early as the campaign, the President was not even thinking or talking about a single-payer system. What led you and the President to decide not to even seriously consider that proposal?

MRS. CLINTON: Well, I think we seriously have considered it and have adopted its major goals, which are universal coverage and a much simplified paperwork system, to try to streamline the process of patients getting their health care and physicians being paid for it. But we had

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some issues with single-payer, one substantive and one political, that were hard to overcome.

Substantively, we have a lot of built-in inefficiency in our system right now. And we spend more money than any other country, by a long shot. And even if you hold constant for all the demographic factors you could imagine, and you factor out our rate of violence and our rate of AIDS and our rate of teenage pregnancy and all of that, there still is very little explanation as to why we spend so much more than we spend.

And you can see that most clearly in the Medicare system, which is, after all, a government system. I'm always amused when some member of Congress tells me they'd never support a government system. I say, "Well, do you support Medicare?" And they say, "Well, of course." So I say, "Well, you know, that is a government system. It's paid for with a tax." I mean, that's how it operates.

And you can see in the Medicare system, it has been very hard, in the absence of organized ways of delivering health care and providing some public/private kind of incentive to deliver health care more efficiently, to get the unnecessary costs out of the Medicare system.

And our fear is that if you look at single-payer systems around the country -- take Canada, for example -- their rate of growth in health care expenditures, even though they're a very low base, is rather significant because it's hard, if you don't have competing delivery systems, to really continually get the quality improvements at the lowest possible price that you would like to see.

And then, politically, it seems rather hard to imagine that the Congress, in today's environment, would vote for about a \$500 billion tax increase, even though you could tell people they would be, if they were insured, saving themselves money. There would be just a very hard sell to make on that, and many people would not trust the government to do it right and would not believe that it would work, and so we'd have all of those arguments to contend with.

So I think the single-payer advocates have done a great service by pushing the cause of universal coverage as hard as they have, and also pointing out how much money we waste in our system, to no discernible benefit. But we

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didn't see how we could take that concept and replace what we currently have with it.

So that's why we opted to build on the public/private model that we've got and to try to continually increase the incentives for delivering health care at a high quality and cost-effective way, which we don't think single-payer necessarily does.

Q I've heard some doctors say that you, in speaking with them, maybe not privately, but you've said (inaudible) you really would prefer single-payer plan.

MRS. CLINTON: I've never said that.

Q Somebody in some position with the national health care said that. Maybe he interpreted it wrong.

MRS. CLINTON: No --

Q What I'm curious about is if you ever see the managed competition being a link between what we have now and eventually going to (inaudible).

MRS. CLINTON: Well, let me tell you what we've done in the legislation. This may be where they got the idea. To be fair to them, this might very well be what they inferred.

We have a single-payer option in our plan. What we have said to the single-payer community is, "If you really think you can sell this to people, then we will give you the option of selling it on the state basis."

So if New York wants to go single-payer under this plan, they can go single-payer. And then you will have a period of time where people can watch the results. You know, that's how, if you think about how we're going to move from where we are, we've got some models around that we can watch develop, which is one of the reasons why we want to have a lot of state flexibility, so that individual states can do things a little bit differently within the federal framework.

I've said, "Look, if you can do that, that's terrific, you know, but you're going to have to do it on a state basis because we're not going to move towards single-payer on a national basis." I don't know that any state will

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choose to do that, but some states, particularly states with a small population in a big area, might think it was an important alternative.

Q There are some leaders here in Georgia that argue that Georgia should not forge ahead on the state level (inaudible) simply because they should wait until the federal government (inaudible) in Washington (inaudible).

Do you agree that states who are now considering reforms would be prudent to hold up?

MRS. CLINTON: No, and I'll tell you why. This is going to be such an intense discussion, the more that we can talk about alternatives at every level -- local, state, federal -- and the more people can be engaged and really having to learn the problems, so they're not just talking from anecdotal experience and their own particular point of view, I think the better off we'll be.

And secondly, those states that have moved ahead, many of them are much better positioned to take advantage of reform than others, and I think that's a real net plus.

The State of Washington adopted a comprehensive health care reform with an employer mandate, with a lot of the features that we're adopting. Because of that debate at the state level, their level of awareness among the medical community, the business community, general citizens, is so much higher than it is, say, in Arkansas or probably Georgia, because they've had to get in there and really talk about what we're going to do.

Florida, I would think, is better positioned than some states because they've already created what would be the alliance areas. They've got the voluntary purchasing cooperatives already going. They're beginning to save money and show that it will save money.

So I think states, even if they don't get a piece of legislation, the effort of trying is a really good educational tool for all the players, and I would really urge them to go forward with it.

Q So what specifically should states do, any state, right now?

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MRS. CLINTON: I know there was a commission appointed. Has it made its report?

Q It's made some recommendations to the governor.

MRS. CLINTON: I think the process of making those recommendations and trying to draft legislation around those recommendations: Here's what Georgia would do. Here's how Georgia would try to reform its insurance market. Here's how Georgia would try to organize the buyers of insurance better so that they could be positioned to take advantage of insurance market reform. And I think moving on some of those issues right now is a very positive thing to do.

If you look at the states, they're at varying levels of development, and I think even having the Georgia legislature bring down for testimony legislators and insurance commissioners and doctors and others from around the country who, at the state level, have wrestled with these problems could be a big plus, because even when the federal legislation is passed, it's got to be implemented at the state level.

And the framework of it is well known, and so the more that a state can begin to talk about these problems now, the quicker they'll be able to implement whatever we finally end up with.

I would urge folks here to move forward. I urge the Georgia Medical Association and Society representatives with whom I met to really educate themselves about what's going on in the health care market around the country, so that they, too, can know what they can do to be better positioned.

Q Something that we saw in the past month or so, as journalists, I think is that most Americans were incredibly confused about NAFTA, and it wasn't until just about the final week before the vote that people really stopped and thought about it and really sort of had some grip on what the issues were.

Both the pro-NAFTA and anti-NAFTA sides had corporate money or some kind of backing to run ads on television, to explain their point of view, to put out press packets for us. Who's going to push the advertising for health care reform? Where is the corporate money going to

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come from? Who can you rely on to help put out the message, so that we're not waiting until the last day or two before the vote to have the American public actually understand what the debate is?

Q And so that the issue isn't (inaudible) --

Q -- who do have the money.

MRS. CLINTON: Well, this is one of my biggest concerns, as you might guess. I went back and looked at Harry Truman's efforts. He introduced comprehensive health care reform in 1945, got beaten back, called a socialist, all of that. He introduced it again in '47. The best estimates are that the opponents of his health care plan spent \$60 million in 1947 (inaudible). I mean, that was real money back then. We're talking big dollars.

So I'm very concerned about it because unlike a political campaign, where you can raise the money to pay, to run a repetitive message, I don't know that we're going to be able to match them. I mean, I'm not sure we're even going to come close. And when I say "we," I mean the generic "we," everybody who favors reform, and there are lots of groups out there.

But when the health insurance agents have already spent \$10.5 million and apparently are going to spend two or three times that, and that's just one group of opponents, we're going to be outspent by a huge ratio.

And part of my problem, as I think about this, is that what we need is repetition of the same things over and over again. And what you all do is print something new every day, because otherwise it's old news.

And I don't know how to reconcile those two things because there isn't an issue that is of more personal importance to people than health care, but it's going to take weeks and weeks and months for people, like with the NAFTA, (inaudible) to finally kind of begin to form an opinion, and that can only be done if they get the same information over and over and over again.

So there will be groups who are supporting the President's plan who will raise the money and try to get out there with the message, but we're not going to be any match

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for the other side. I can tell you that right now, from what they're already planning.

Q Who are your potential allies? The labor unions? You talk about --

MRS. CLINTON: Labor unions, consumer groups, some of the physician groups, the senior citizen groups. We have some very powerful, strong allies, but very few of them are able to spend a ton of money and are able to do it over a long period of time. So I don't know what the outcome will be.

But I know that a lot of these groups feel strongly about it and they're going to try to do their best, but I can't predict right now what the breakdown is going to be. I just know you're absolutely on target. That's going to be one of our biggest problems, is to try to continue persistently.

I mean, I brought my brochures and my book for each one of you, and I hope you will read it. I mean, we're going to continuing and try to get our message out. But it's going to be tough. But we have some good allies. A lot of people can get the word out, but we have to rely on folks like you to keep this alive and talk about it and hold everybody to some level of scrutiny about what their real agenda is and why they're coming from where they're coming.

Q There's been some suggestion over the past couple of weeks that the administration will greatly step up its attention towards crime and come out with a crime package and that you would be very much involved in that. Is that true? And if that's true, isn't that taking on a great deal?

MRS. CLINTON: Well, we came out with a crime package and it passed both houses.

Q That there would be a stepped-up crime package in the next --

MRS. CLINTON: Not that I'm aware of. I think you'll see -- there are two things I think that will have to be done. Apparently we're not going to get the final crime legislation until they come back after the recess and after (inaudible) and all that. There will be a real effort made to try to make sure that it can be implemented as effectively.

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and expeditiously as possible so people can start seeing some evidence of the 100,000 new police and some of the other features that are in the crime bill.

And I think the President will continue to speak out about it. And I will, too. I think all of us will. And I've been pleased that the President has sort of drawn the linkage between violence and health care on a number of occasions, and we're going to keep on doing that.

But I think that we have to get the crime bill finally passed, and then begin to get it implemented and highlight its implementation, but it's not going to be a new legislative (inaudible), except for maybe some gun -- whatever we don't get in the conference, we're going to keep pushing on the gun control front.

Q Following what you said about the (inaudible), the people in Florida seem to indicate that (inaudible) their health alliances (inaudible) voluntary (inaudible) insurance industry (inaudible) pharmaceuticals and whatever, including (inaudible), and that the employers (inaudible) voluntary situation.

Who are the employers and the business folks (inaudible) of that battle, the give and take? If it's like 80 percent, 100 percent, how do you see that getting past that obstacle?

MRS. CLINTON: Well, I see it a couple of ways. I mean, if you talk to the folks in Florida who designed the system, they tried to get an employer (inaudible), and they couldn't because of what you're describing. But they will be the first to tell you that their system won't work unless everybody is in it. I mean, it'll work a little bit to help certain folks, but it's not going to work and stabilize the whole system.

And I think we're going to have a lot of employer support. We do have a lot of employer support. Once employers really put the pencil to it, and especially employers who are currently insuring, will, in the vast majority, save money. Their costs will be capped, which there's no way they can predict now. Small businesses who currently insure will be the most advantaged because they're currently the most discriminated against.

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And so as we begin to demonstrate to these businesses that we're out there working with how much money they're going to save, that, I think, is a huge incentive. And if you're capping your employers at 7.9 percent if they're above a certain level, above 75 on a sliding scale, and you have a huge number of businesses in this country who are currently paying more than 8 percent of payroll for health care, and you've got a lot of businesses that are paying between 11 and 15 percent, and you've got some very big companies spending between 15 and 20 -- don't you all have a big car plant down here? You do, don't you?

Q Ford and GM.

MRS. CLINTON: You know, GM spends 20 percent of payroll on health care. Now, if you relieve GM of that level of burden, that's a huge boon to the economy, to say nothing of their bottom line. So there are a lot of businesses that are going to be big, big winners and others which are going to be winners but not to that extent. And there's going to be a lot of small businesses that are in the winner category.

And if you cap small businesses at 75 or fewer employers at 3.9 percent of payroll and less than that, if they're real small and you subsidize low-wage workers, most businesses, when they stop and think about it, and don't get carried away with either ideology or anxiety, are going to end up saving money.

And what I've been telling small businesses is that most of them have survived minimum wage increases in the last 16 years. I think we've had three, if I'm not mistaken -- Kennedy, Reagan and Bush. We had three of them. There is no evidence that a minimum wage increase costs jobs. There just isn't. I mean, despite what the NFIB or other people might say, there is no hard evidence.

And if you believe that you can provide health security for yourselves and your family, plus your employees, for less than it would cost to raise the minimum wage, and if you're a small employer, for probably like a dollar a day, it's very hard to argue that businesses cannot afford that.

And if you're going to be folding in over time, if we move to comprehensive health care, the workers' comp part of your small business obligations, that's a real incentive.

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So what we've been finding, as we've gone around, and Erskine Bowles, who is the head of the Small Business Administration, has done a terrific job. He actually got a computer program set up so that small businesses, regionally, can go in and do their spread sheets and see how much it would cost them and how much they would save and all that.

And what he basically argues is that the more small businesses find out about this and kind of cut through the arguments that the professional lobbyists are (inaudible) at the small businesses, many of them will see that it's in their long-term interest.

Now, are they still going to be hostile? Of course. Are they still going to do everything they can to kill health care reform on the employer mandates? Of course. But we're just going to have to make that argument.

Q What do you envision is the transition period here? How long will this phase in, and won't that be a mess?

MRS. CLINTON: Well, I'm sure it'll be something of a mess. I'd be surprised if it weren't a mess to some extent, but I don't think it's going to be a big mess because we're phasing in on a state by state basis. And if the legislation is passed this summer, next summer, '94, then states are going to start coming in '95 and '96 and '97.

And there are some states, like Vermont and Washington and Minnesota and Hawaii and maybe California even, that are extremely positioned to get into this system. So we're going to start having states coming in within a year of the enactment of legislation and taking advantage of a lot of the savings that will come from that, and then everybody will be in by the end of '97.

And there will be technical assistance provided to states because some states are not very far along in thinking about reform, compared to their neighbors. But I don't think that -- I don't think it's going to be an overwhelming challenge to do it right because so much of the responsibility is going to be shared between the federal government and the state and local government and the private sector. So there's a lot of pieces that can move each other along, as I envision it.

Q But would a company's headquarters -- I mean,

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for example, would GM plants in Georgia be affected by what the Michigan legislature decides, or will it be --

MRS. CLINTON: No. If a company's larger than 5,000 employees, a company can decide it's going to remain self-insured, basically, and it can run its own health plan. And then it is governed under the federal ERISA provisions. It's not governed by the states.

But if you look at GM and some of the very expensively insured companies, it may be to their advantage to fold their workers in on a state by state basis because they get the cap on the contribution right away, and they don't have to have a benefits department any more and they don't have to worry about a lot of stuff they'd have to worry about if they stay self-insured, even though they think they can save money.

So I would think that a lot of companies will put their employees in. The employees in Michigan will be part of the Michigan alliance, and that doesn't really --

(End of side 1.)

MRS. CLINTON: (Inaudible.)

Q (Inaudible.) Where does the money come from (inaudible)?

MRS. CLINTON: Well, they're going to come down on a slope. They're not going to come down immediately. But much of the money comes from those employers and employees who basically use the health care system (inaudible) GM has paid for all these years, but they've not paid their fair share.

We're talking about increasing national expenditure on health care by around \$50 billion over the next five years, so that if you take the 37 uninsured, plus all the companies that that they work for, who will all be making a contribution, that's a huge infusion of new money.

And so from our perspective, the money that is in the system can be decreased without any loss of services or quality, as long as it's reallocated. And that's going to be one of our objectives in this, is to change the incentive as to how the system pays for services, so that we get to a more

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cost-effective kind of payment structure.

Take GM as an example. GM has basically subsidized not only the spouses and families of their employees, but all of their competitors, who either insured at a lesser level or didn't insure at all, but who used the facilities that the premiums from GM paid for. As GM lowers its payroll total, we are taking off of GM the obligations of retirees. That's going to be federalized.

People between 55 and 65 are no longer going to be the responsibility of those few companies that decided to pay for it, because that has been one of the real inequities that we've had. Oftentimes those people are the most vulnerable. They're pre-Medicare, and often if they're not able to keep a job because of an illness or their company doesn't provide any benefits after retirement, they become a real burden on society and on their families. So we're trying to federalize the retiree benefits, so there will be some money coming in from that.

Now, other sources of money, in addition to the employer-employee mandate and what it will create, we have the tobacco tax. We have a reallocation of money that is currently in the federal system. There is something called disproportionate share, which goes to hospitals that have a lot of uncompensated care.

We're not going to have a lot of uncompensated care anymore, with everybody having to pay something. That money is going to be used to help subsidize low-wage workers, and they can contribute and be in the system, as well.

So we've got all of the money kind of reallocated but not necessarily pulled out. And we also have a 1 percent payroll assessment on companies that decide to be self-insured that will go into the overall system.

Q Do you remain very confident of your numbers?

MRS. CLINTON: Absolutely.

Q People point out that both the predictions on Medicare and Medicaid were woefully low.

MRS. CLINTON: Right.

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Q What makes you believe so strongly that your numbers are right?

MRS. CLINTON: Two things. I guess the first is that I don't think there's ever been a process that has thoroughly vetted numbers before. My biggest surprise, when we got to Washington, is how little cooperation and communication there was among the federal government agencies. I can't even describe how amazed I was, coming from state government, where you've got people talking all the time, you've got the governor's office serving as the hub and making sure everybody is related and having all of it run --

Q (Inaudible.)

MRS. CLINTON: A very well run state, I might add. But compared to what you find in the federal government -- until we started health care reform, the actuaries who worked for the federal government on health care had never been at meetings (inaudible). They had never had the actuaries from Treasury, OMB and HHS and HCFA and the VA and DOD and I don't know how many other agencies who do health care cost projections -- they had never been told to work together to figure out what it was they wanted to communicate on a uniform (inaudible).

I was just blown away. I could not believe that. Part of the reason we've had all of these inaccurate projections and why the 1990 budget deal fell apart is they slaved over this budget deal and the budget got blown apart by unexpected increases in health care costs.

Well, my belief was that the federal government, until it could agree on a uniform economic set of assumptions and the actuarial cross-projections based on those assumptions, we weren't going to go anywhere with health care. I mean, that has been the biggest task, and it's been boring. You know, nobody has written any articles about it because it's literally taken thousands of hours.

But the net result is we have subjected these numbers to a higher degree of analysis than any had been subjected to, and we have sort of backed up our analysis by bringing in those few private institutions that had models that could model this, plus outside actuaries and benefit package people and all the rest of that. So I have a high

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degree of confidence about the numbers.

Now, there are policy implications for those numbers that may or may not be successful in the legislative process. I mean, for example, we believe we can cut the rate of growth in Medicare by \$124 billion over the next five years without in any way undermining the quality of health care.

Our plan depends upon being able to cut that \$124 billion, so if we can't persuade the Congress to cut it 124 and they only cut it 60 or whatever they'll cut it, we have to make adjustments, but at least the pieces of our plan are all accurate, so that we can begin to know what it is we have to add to or subtract from if they begin to move policies around.

And I guess the second thing I'd say about the numbers, in addition to our feeling confident about how they were derived and what kind of assumptions and work has gone into them, is that when you take these numbers in health care and you make projections, like people say about Medicare, "Gosh, they said it was going to cost \$9 billion in '65 and look what it costs now."

Part of the reason you couldn't get good health care figures on Medicare or Medicaid is because they were pieces of a system that were pulled out for individual attention, as opposed to being dealt with in a comprehensive package. So that part of the reason you've got Medicaid going up at 16 percent, even after the last budget, is because you have a huge uninsured pool who keep falling onto the Medicaid rolls.

So if you have a Medicaid system that is based on what 1966 or '7 poverty figures were and you now have a higher level of poverty than we had in many years, and the cost of medical care has continued to inflate at three times the rate of inflation, and you don't have all of the pieces marching in unison so Medicaid gets way out of whack, there's no way to have any kind of legitimate base for projections.

If you stop the cost shifting and you get everybody into a universal system with some kind of cost containment, you have a much higher degree of predictability than you do if you're only focussing on this one program or this one program and the rest of the system is going crazy. Because

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part of our program with these people who want to continue to reduce Medicare and Medicaid for deficit reduction is that they keep forgetting if you squeeze the balloon in one place in health care it pops out somewhere else.

So if you squeeze in Medicare and Medicaid and you pull the money out and you put it to deficit reduction -- you don't put it for health care reform -- then two things happen. Providers don't want to take Medicare and Medicaid anymore, because it doesn't cover their costs, or they at least don't want to take it as their sole payment.

And in order to make up for whatever costs they feel they're not getting from Medicare and Medicaid patients, they shift the costs over to the private sector, onto employer-driven health insurance. Costs then go up higher and higher for employers, so employers adopt all kinds of methods to control costs, like \$3,000 deductibles and the kinds of co-pays that make health care very expensive.

So more and more people opt out of the employer system, unable to be able to afford the insurance that is offered to them. They fall into the ranks of the uninsured. When they show up at the hospital, they finally get uncompensated care, which then we pay for out of higher taxes and out of increased premiums.

So all these things just keep feeding on each other. So we think if we get the universe here, we can have much better predictability and control over the pieces than we do alone.

Q Universal coverage is not the same as universal access.

MRS. CLINTON: No, it's not.

Q And that's an increasing part of the problem in lots of the country. I realize that's a separate issue, but they're kind of double first cousins. Is the administration giving any thought to how to address that?

MRS. CLINTON: Yes. I want to say a couple of things about that. A lot of people will tell you that their bill will get you to universal access but be very careful because that's not the same as coverage. We have universal access now if you've got the money to access the health care

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system. We don't have coverage.

They are double first cousins. Universal coverage will increase access for those who are the most underserved because once everybody has a payment guaranteed that they carry with them, then all of a sudden they become attractive patients.

You know, the big question I was asked at Grady this morning? If you have universal coverage, how are we going to compete effectively if suburban hospitals and private hospitals start opening up satellite clinics downtown?

And my response was, "You're going to have to compete. But isn't it wonderful that somebody else wants your patients, for the first time?" And I believe that a hospital like Grady will have first claim on a lot of people because they took care of them when nobody else would. But that's what this new system is going to do.

All of a sudden, poor people, uninsured people, Medicaid recipients, are going to be attractive because they have guaranteed funding, and therefore there's going to be more access for them.

Q How will rural people become attractive?

MRS. CLINTON: The same way, but you have to work a little harder at it. So we're doing several additional things in rural areas, too. We are providing incentives, through loan programs, loan forgiveness programs, facility development kinds of grants, so that providers in both underserved urban and underserved rural areas have some incentives to stay in those regions.

We are beginning to alter the Medicare-Medicaid disparity that has disadvantaged rural areas. Rural people, doctors and hospitals have been paid much less than urban areas under those programs. It's been very unfair to them.

We are increasing the use of telemedicine and technology so that practitioners in rural areas don't feel so isolated, and I've seen some incredible things. I mean, I've seen x-rays in doctors' offices held up to screens and being read 400 miles away at the medical school.

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Q The Medical College of Georgia in Augusta is doing that (inaudible).

MRS. CLINTON: Unbelievable. So all of a sudden, if you're a general internist in South Georgia and you like the lifestyle, you love to go hunting and fishing on the weekends, but you're feeling isolated and you're worried that you can't serve your patients, all of a sudden you not only have firmer financial footing, which maybe you can hire a young doctor to help you out with, but you've got much more support.

And it's also likely that you will find it to your benefit not to be in solo practice, but instead to be a practicing physician who is networking with hospitals and doctors up the line. So you might be part of the Georgia Baptist or the Atlanta Health Plan or something like that.

And that's what we're seeing happening in Minnesota, which has a high degree of organized delivery care. We're seeing Mayo's, for example, going out into the community and asking local practice physicians if they want to be on contract. You know, for \$125,000, \$130,000 a year, which is pretty good for a rural physician in Minnesota, as well as in Georgia, they're being put on contract and they then serve those patients who are enrolled in the Mayo health plan, and they're referred to Mayo's for tertiary care.

So that's the kind of thing that we see happening that will extend out into the rural areas, too.

Q Where do undocumented immigrants fit into this health care plan?

MRS. CLINTON: They do not receive a health security card. They are not entitled to the comprehensive health benefit. They will receive emergency care, as they do now, and they will receive public health services, as they do now. And we have funding for hospitals that have a larger than usual share of illegal aliens, and we do have beefed up public health dollars to take care of tuberculosis immunization, things like that that we need to deal with.

But we are pretty much keeping the status quo in the sense that they are entitled to those services, but we are trying to do nothing that increases illegal immigration. So that's the line we've tried to draw.

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Q Kind of high on the list of priorities for Georgians, according to the surveys, is to be able to choose their own physician, which I know it's true in a lot of states (inaudible). It seems to me there's some confusion about whether or not, in your plan, you guarantee there would be at least one option that they could choose their physician. (Inaudible) might be required to go through (inaudible). Which (inaudible) is that?

MRS. CLINTON: No, it is settled. We think we're actually going to be increasing choice. If you look at what's happened in medicine today, more and more employers are dictating who employees can go see.

I don't know if that's happened with your health insurance plan yet, but I've been with a couple of editorial boards when lots of heads started nodding because what has come down from on high is, you know, we'll pay X amount if you join the HMO, we'll pay X minus a lot if you don't.

And so that's part of what's happening right now. And we're actually decreasing choice for both patients and physicians right now because at the same time as we're saying to patients, "You can't have a choice any longer because of who you work for, and they're determining where you will get your medical care," we're saying to physicians, through insurance companies and these plans, "If you don't belong to our plan, you can never be referred to. And we're also saying to hospitals -- a lot of hospitals are being told the same.

Under this plan, we are guaranteeing choice because in every region there will be at least three choices. There will be an HMO, a PPO, and a fee-for-service network. And the setting of the prices will be left to the marketplace in terms of what they're going to be bidding for the services that they will charge the people who join their plan.

We are mandating a point of service option for every plan, so that no plan can tell you you can't go outside of the plan for a specialist. And I think that some of the confusion is, particularly in some parts of the country, like the Southeast, where you don't have a lot of organized health care yet, they don't know what that means, and they're scared about what they think it means, and they're very apprehensive.

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Whereas if you go to the West Coast or Minnesota, they're so much more comfortable with it and they like it, so that it's not a big deal for them. So it's really where you are seeing this from.

And I started explaining to people who are concerned, that what I'm trying to do is to give to every American the same options that members of Congress has. And if you think about what the members of Congress and all the federal employees have, they have an employer-based system in which the employer, namely the government, pays for 75 percent of the health care and the employee pays for 25 percent.

The federal government, as employer, does not mandate who the employee has to go to. Instead, the federal government acts as a clearinghouse for every plan that wants to be able to offer its services to federal employees. So they do the framework check, the same way we're going to have the alliance do. You know, are they capitalized? Can they deliver what they've said? But that's it. If they pass that kind of qualification, they're in. There's not going to be anybody telling them they can't offer their services.

And then every year, as a federal employee, you get deluged with all this information, and you make up your mind, and you choose. Do you want an HMO? Do you want a PPO? Do you want a Blue Cross indemnity plan? Whatever you want.

And I'm trying to make the argument that a lot of these members of Congress who are against what we're offering are very happy to sign up for that every year themselves and very happy to have their employer pay the vast majority of it and very happy to have the choice that comes to them as federal employees.

And so one of the things we are doing is we're going to fold the federal employee system obviously into this, so that we're offering to everybody what they now have and putting them into the same system. And that's the kind of choice that we want to make available for everybody around the country.

Q Will Congress itself be under the same system?

MRS. CLINTON: Absolutely. Because that's the irony, that they have the system that we want for everybody

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basically right now, the system I just described. And so for them to say, "Well, you know, this is socialized medicine. We don't believe we ought to do this. The government can't run this," and that's what the federal government, through the Office of Personnel Management, does for them every year.

And this will be done at the state level, at the so-called alliance level, so it's not going to be government-run by the federal government at all, but the alliances -- now, I would suppose in Georgia you'd have three or four or five. I don't know how many you'll end up choosing to have, but the alliance is the one that will basically say, "Okay, everybody, offer your services to the people who are part of our alliance and then each one of us individually will sign up." And the government will be -- you know, the people who are in the Congress who live in Maryland, they'll be in the Maryland alliance. If they live in Virginia, they'll be in the Virginia alliance. If they live in the District, they'll be in the District alliance. There's an incentive for them to make sure it works well.

Q What do you think are the major flaws with the House bipartisan plan?

MRS. CLINTON: Well, every time I answer this question people accuse me of being critical, and I'm just trying to be, you know, informative. So with that preface, I guess you're talking about the one that Jim Cooper has introduced?

The two biggest problems are that it does not achieve universal coverage, and it increases the deficit, and I think those are two very serious problems.

Q On that note we'll have to wrap up.

MRS. CLINTON: Thank you all very much. Don't forget your books and brochures. We're not a \$10.5 million ad campaign, but we'll keep you informed as best we can.

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