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AN INTERVIEW OF THE FIRST LADY
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MRS. CLINTON: -- where we're going. It is a long process ahead of us. CNN will sure probably have something to say about it every day, if not every hour, and I'm grateful for your interest. And I appreciated the (inaudible), as well.

This, from our perspective, is the second chapter of what we started this year. And although it's a complicated story sometimes to try to tell, the President, I think, sees all of this as part of the same theme, and particularly building on the first, from our perspective, responsible budget in a number of years.

If you look at that budget and if you look at what it's aimed at achieving, you'll see that we have taken big steps on the discretionary spending side and big steps in terms of deficit reduction, but that there are several issues outstanding, the largest of which is health care.

If you are going to have any kind of responsible fiscal budgeting from now into the future, then there's a big economic motivator behind what the President is trying to do with health care, but there's also a moral, human dimension that we think is so important to be emphasized as we move forward in the next year, because although it is true that we have to do what we're attempting to do to get costs under control, to try to make our health care system more effective in the way it delivers services, it's equally, if not more true, that it is just unacceptable any longer for our country to spend as much money as we spend on health care and not even provide access to all of our citizens.

So we're moving on both, a kind of economic and budgetary plane, as well as a moral and human one at the same time. We now have the bill in the Congress that will be

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probably used as a punching bag for a number of weeks while they try to sort out all of the jurisdictional issues, which I have nothing to say about and want to know nothing about. The worst part of making (inaudible).

But I'm very enthusiastic about the response that we've gotten and the kind of support that we have. And when the President has said and I have said repeatedly that we have a bottom line but that many of the other details are negotiable, I want to be very clear about what we mean by that.

The bottom line is the President will not sign a bill that does not achieve universal coverage, does not provide comprehensive benefits and funds it in a fair and responsible way. But there are a lot of details about how we get there that we are open to discussion.

And I think some who have been the commentators on this have not appreciated how difficult a bottom line universal coverage is to achieve, so they have said, "Well, you know, the President's open to negotiating all of these aspects of health care."

If we get to universal coverage with good benefits for everybody, that are totally portable, always guaranteed, that's 90 percent of the battle. And the details about how we structure the system and what kinds of other arrangements -- we have to be sure that we maintain the highest quality and we have a simplified system and the other principles that we talked about -- will fall into place around that core organizing principle.

So although we think we have the best approach to achieving universal coverage and the one that is likely to be most acceptable to Americans, ones that understand it -- we're open to other, better ideas. And we're really looking forward to it.

It may be that we are gluttons for punishment, but this first year has been extraordinarily productive. That story is finally being told. Various groups, like the Congressional Quarterly analysts and others are talking about it being the most productive legislative since either '65 or '53, depending upon how you do the calculations.

I think we've laid the groundwork for what has to

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Q What is the impact of the momentum you have coming out of NAFTA on this process?

MRS. CLINTON: I think it's hard to gauge because I never really think there are close linkages between these issues that will necessarily carry the second forward. I think that what comes out of NAFTA is an obvious recognition that the President knows how to get things done and is not afraid to do it, and is, you know, although a very friendly and congenial person, he's also very tough and able to get what he wants. I think that's the big impact of what comes out of the NAFTA fight.

But I think that the coalition will be so different. We will not have the kind of breakdown with as many Republicans willing to support the President on health care, by any means, and we will have to do some fence-mending to bring back some of our labor support and others who were very much against NAFTA.

The President brought more Democrats than anybody thought was possible, but that means he brought 40 percent of the Democrats and lost 60 percent, and he's got to have, you know, a big majority of Democrats on health care.

Q What's your (inaudible) concern is that the public may find this (inaudible) complex and they're not totally grasping it. What level do you expect (inaudible) public (inaudible) in the polls?

MRS. CLINTON: I think that's our key challenge, because it is complex, and there's no getting around that. But the more people know about it and the more comfortable they are, the more they like it. At least that's been our experience, in the kind of focus group research and anecdotal work we've been doing.

So I have a lot of confidence that if we can get the details out and explain the framework, it will be very favorably received by the American public. The problem is trying to figure out how to get to that level, that breakthrough, because what it requires is repetition. You know, you have to keep saying things over and over again.

And in a campaign context, a political campaign, you can pay to have repetition. We could pay to have, you know, the message over and over again. Here we've got to

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rely largely on the media and whatever we do to try to get it across, and one of our challenges is that, as is so often the case, repetition may be boring to those of you who put the news on, and most Americans are only now tuning in.

So if you don't say it over and over again, they can't fully participate in the discussion. And so -- I mean, there's always a tension between sort of talking to ourselves, the kind of elite talk, mummerat (phonetic) (inaudible).

You know, the mummeratis said, "Well, you know, that's old news. We've all heard that. You know, how boring. Don't keep saying it." And most people in America, they're just kind of getting into it. And it's gone by so fast that they can't keep picking it up and putting it together unless we have that kind of repetition.

And there's no way that -- we will be able to pay for some advertising, but there's no way we're going to be able to match the dollars that will be spent on the other side. So we're really going to be in a difficult position because, you know, the independent insurance agents have already spent \$10.5 million. They have a war chest of at least double that, and a lot of the other interest groups haven't even weighed in.

And I went back and looked at Harry Truman's efforts back in the late '40s. He introduced comprehensive health care reform twice. And in 1947 dollars, the opposition spent \$60 million. That was real money back then.

So when you think about what the opposition is already spending, some of which is visible, like the ads on CNN, much of which is invisible -- it's mailings and other kinds of things -- we're going to be out-spent by a huge proportion. And we're just going to do the best we can to try to get the message out and do it in a repetitive way, so people can finally get it and they think, "Oh, I understand now," and we can go from there.

Q Has the administration made any missteps or mistakes in trying to sell this package?

MRS. CLINTON: Oh, I'm sure we have. I don't know that I would point to any in particular. Much of what has happened in the last year has been really moved by forces

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that had nothing to do with health care.

The President had wanted to get this on the agenda as early as possible. The budget fight precluded anything coming onto the radar screen before that was settled. That didn't get settled till the August recess. Then you had NAFTA pretty much dominating the landscape.

But at the same time, it really wasn't a big disadvantage from my perspective because I now believe that Congress can only deal with one big thing at a time anyway, and that's not a reflection on them. It's like all the rest of us. I mean, it's hard to concentrate on that.

So the budget took up, you know, the first half of the year and then NAFTA from the August recess until the vote.

So it's hard to say. You know, I know we made mistakes and I know we made wrong calls at a lot of turns. None of them, I think, are particularly of long-standing disadvantage because I think we are now really at the beginning of the process. Much of what we have done up until now has just been preparatory.

Q What about your efforts to engage Republican interests? Or is the challenge in this case, similar to the tax issues before, going to be delivering a straight party vote and getting conservative Democrats in line?

MRS. CLINTON: You know, I'm not sure yet because if you look at the landscape, it's a really interesting one. I mean, you've got a very strong core of Democrats in both -- the House, about 85, I think, who are sponsors of the single-payer system. And they, I think, have five senators.

Then you've got a variety of disparate plans, several of which have -- well, one of which has bipartisan support, the others of which are strictly Republican alternatives in the House.

In the Senate, you have the closest approach to the President's in the bill of Senator Chafee. And the reason it's the closest is that it is recognizing you've got to have a mandate of some kind to pay for the system. And I don't know how many sponsors he ended up with, but he had about 20, I think.

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I think that the real shaping of this will take place in the middle, and if we can get a commitment among a majority of the Congress, and that would include probably all but a few of the Democrats and a respectable number of Republicans, that universal coverage has to be achieved, then I think you've got a coalition that includes, you know, Chafee in the Senate.

You've got probably about 25 to 30 Republicans in the House, all the way to the single-payer people, who I think are going to be much harder to get than some folks believe because they really think that they're right, and they are very committed to that approach. But at least I think you've got a working majority that you can have, which is bipartisan.

You know, because if you believe in universal coverage, there's only three ways to get there. Either you have a single payer system, which substitutes a big tax increase for all the private investment; or you have an individual mandate, which is the Chafee approach, which requires individuals, like with auto insurance, to have health insurance; or you have the employer/employee system that the President believes we should build on.

There isn't any other way to get there. Those are the only alternatives, and those are the three players that have recognized that. The others are promoting insurance reform. They're promoting some kind of better access to the existing system, but they don't have universal coverage as a goal.

Q Would you talk a little bit about the malpractice (inaudible)?

MRS. CLINTON: Yes. There will be serious malpractice reform in whatever the end legislation is. The President has come forward with, I think, some very good provisions that are matched pretty much by most of the other plans, but with some differences.

The President's approach is to try to move towards reining in malpractice on the front end. And we've got a couple of issues here. And the malpractice area is one where there is a lot of emotion on all sides, and very little evidence as to what really works effectively.

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But if you look at what the President is proposing, he's tried to strike a balance between getting the system under better control so that we eliminate malpractice, and trying to prevent attorneys from misusing the system, so that you don't add extra costs because doctors feel like they're having everything second-guessed.

So what we have proposed is alternative dispute resolution; certificates of merit so you can't go to court unless you get one of those, the development of protocols so that if physicians follow protocols, they will be, in effect, immune from malpractice cases, and limiting attorneys' fees.

Most of the other proposals that are serious include some variation on all of that, plus they cap noneconomic damages, which is pain and suffering.

We did not do that, and we didn't do it because usually those are only awarded in the most egregious kinds of cases, and we can't figure out how you punish the unscrupulous lawyers without also punishing the victims, so we're trying to strike that kind of balance in what we propose.

But no matter whose malpractice reforms go forward, there's going to be serious reform, which I think is important and good. I think it's going to be an important contribution.

Q (Inaudible) process of trading out in-patient days for less intensive care (inaudible.) It seems like we're doing what we did in the '50s and '60s when (inaudible) and you're saying that, when we're really not going to (inaudible).

MRS. CLINTON: No, that's not the accurate interpretation of what happens because I feel very comfortable with our finally being able to provide care for the most chronically ill, but we did cut back on some of the days that were available for counseling and for out-patient care under the kind of continuing battle we've had, which I think is going to be played out in Congress, about the appropriate role and cost of mental health.

This is the only plan, other than the single payer, which covers mental health. It's a huge step forward to try

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to bring some equity to the system. But the costing of mental health benefits by actuaries has been one of our most difficult struggles during this period, because most insurance plans don't have adequate experience with mental health coverage to be able to give you what are good cost (inaudible) projections.

And what we have tried to do is to be able to specify exactly what benefits will cost. And I think that what we've done, in the time period from the presentation of the plan in its very rough form, which was only meant as a draft, until the presentation of the bill, was to have intensive conversations with the mental health community and say, "Here's how much money we can spend as a whole on mental health. What do you want in that mix?" And what they want in that mix is what we've got in the bill now.

But that raises an issue that I really hope you all will focus on. Our bill tells you what the benefits in the comprehensive package will be. Our bill also costs them out. And I am so anxious for other bills to get the same scrutiny as ours has, because none of them have done that.

And in fact, several of the Republican alternatives and one of the Democrat alternatives don't set the benefits, but create this national board that, after the bill is passed, will tell you what the benefits are. You cannot have cost projections about health care reform if you don't have the benefits set, if you don't cost the benefits.

I think one of the big battles we will have is over those who don't want the Congress to have to struggle with how much mental health benefit are we going to have, or how much preventive health care can we provide free, both of which we have in our package, but instead are going to say this shouldn't be the Congress's decision. The people should just let the Congress pass general health care reform, and then we'll have this national board decide how much mental health we're going to get. I mean, would you buy an insurance policy that didn't tell you what the benefits are going to be?

So, from our perspective, this is one of the real strengths of the President's plan. And although there will be those who say you don't have enough and fill in the blanks -- you don't have enough mental health, you don't have enough this or enough that -- we can honestly say that our benefits

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package is as good as the vast majority of Fortune 500 companies provide today.

And although there are some that provide more in some areas, this is such a comprehensive package that there will be very few people who will have to buy supplemental policies to take care of specific needs they have.

So I think we're on very strong grounding, but it's going to be one of the real battlegrounds. And even keeping mental health benefits in the package will be a big fight. There is just so little awareness, or maybe there's so much denial about the importance of mental health as a comprehensive benefit available to every American.

And, as you point out, we are in the mess we're in because we deinstitutionalize people without adequate resources, and many of the people who receive any help at all in today's world get it in uncompensated settings. They go into the emergency room. They don't have insurance, et cetera. We have to change that, and this, we think, is a very good beginning.

Q So the question of cost is what -- when you get down to the point of really debating in Congress and voting on the final outcome, the question of cost is going to be the headline. And there have been a lot of discrepancies on that already, in terms of whether or not a tax would be needed in terms of how many people are going to have to pay more, what percentage of people are going to have to pay more than they now pay, today for the same kind of coverage.

There's concern over confusion when you get down to the vote on this, and your debating this plan against this plan against this plan could be a horror story in terms of the kinds of numbers flying around.

MRS. CLINTON: Well, by the time we get down to vote, there won't be any confusion. I mean, the way that confusion has arisen is members of Congress asking questions that were very legitimate questions but without having the data in front of them and without having the full explanation in front of them.

But now that they have the whole bill and they have any computer runs or any economic analyses that they want from OMB or from Treasury, now that the Congressional Budget

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Office is analyzing the bill in detail, we're very confident about the numbers and we're very confident that they're going to be equally understood, now that the whole picture is out there.

Let me just give you one example. In the questioning about who would pay more, the question was asked and answered with respect to only one segment of the population and only one cost of that segment; namely, there are about 100 million Americans who get their insurance through their employers.

If you only look at their premium costs and you don't factor in out-of-pocket costs and deductibles that have to be paid, then you get a slightly higher number who will pay a little bit more for the same benefits, but that's not the way most Americans think about health care costs. They think, "How much did I spend this year?"

If you look at that 100 million figure, about 70 percent of us, who are insured, if you look at all that we spend on health care, we will pay the same or less for the same or better benefits.

Now, about 15 percent or about 15 million of those Americans who are already insured have policies that are kind of catastrophic or high deductible policies. Sometimes the deductible is as high as \$3,000.

The vast majority of that 15 percent or 15 million will pay the same or a little more for much better benefits because they will get preventive care, they will get the mammograms, they will get well-child care, they will get the mental health, none of which they have now because they're in the category of people who are underinsured, basically.

Then there are about 15 who are primarily young, healthy single people, who will pay more for the same benefits because we're going to community-rate the system, which means that the fact that you and I have to pay more for our health care because we're older has given younger people a big advantage, until they get to be our age, and then they get hit the same way the rest of us do.

And in this book there's a chart -- I can't put my finger on it -- which basically points out what the average cost will be. Here it is. Under reform, two-parent families

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with children will pay less, single parent families with children will pay less, married couples with no children will pay less, single people will pay more. And that's the category that falls into that, that group.

Now, in addition, though, to the 100 million who get their insurance through their employers, I don't have it on the top of my head but there's like 10 or 12 million who are self-employed with insurance. They will get the same or better benefits for less because they get 100 percent tax deductibility, plus they're put into huge purchasing pools.

And then you've got the Medicaid population, you've got the Medicare population, and you've got the uninsured. Now, the uninsured will obviously pay more in terms of premium, but we have just looked at all of the data about how much the uninsured people end up paying for health care, even though they don't have any insurance.

They actually end up paying a lot out of pocket. You know, they have to go and buy the kids glasses. They have to go and pay whatever they can pay at the emergency room.

So actually, for the uninsured, they're going to be getting comprehensive benefits, and a great number of them, in that 37, 38 million category, are going to pay less than they pay now for a health insurance policy than what they pay out of pocket every year trying to keep up with their costs.

So when we lay all that out, the people who will actually pay more for the same kind of benefits they've got now are those single people, and you take the whole population, throwing in the uninsured, throwing in the Medicaid and everybody else, and they're about 6 or 7 percent of the entire population.

So for the vast majority of Americans, once they actually look at the facts and figures, and that's why we want to distribute as broadly as we can, you know, charts about payment, they're going to be much better off than they are today.

Q One follow-up on that. But in the legislative process, when there's going to be open discussion on the details, details are going to be ever changing.

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MRS. CLINTON: No, they're not going to be changing. They're not going to be changing. It's going to take some explanation to explain it, but that's why -- this bill is 1,300 pages, and a lot of people have said, "You know, you should have put in a shorter bill. It would have been easier to read. It would have been easier to understand."

But we put in everything because we wanted everybody to know everything was in there, and we wanted everybody to be able to see how it all worked together. And the cost figures -- there has never been any piece of legislation that has been more carefully costed out or analyzed than this piece of legislation. And what I want people to do is to focus on all of the facts and figures that underlie ours.

And I mean, we will spend whatever time -- if you want to send a group of people down, we will go through all of that. We will go into all the economic assumptions. We'll show you the computer runs and the like because it really works. I mean, if you talk to anybody in Treasury or OMB who's worked on it, the other plans don't work. They can't support what they claim, from our looking at it.

So we are anxious to have this debate start. We want them to get out there and talk about it because they haven't done the work we've done to support their facts and figures. But there's a difference between being able to support what we've done, which we can, and being able to explain it because, you know, people's eyes glaze over.

I've never read my own insurance policy. I always got my policy through my employer and, you know, I said to the guy who did it, I said, "Is this a good policy? Is it going to take care of me?" He said, "Yes." I said, "Fine."

So, like most of the rest of Americans, I don't want to spend my time worrying about this stuff. So we've got to be as clear as we can, but I'm not worried about the numbers. I'm worried about explaining them and about --

Q I'm not questioning the numbers that are now in there. I'm saying what if Congress goes and comes up with unlimited mental health coverage or something, that's going to change --

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MRS. CLINTON: They can't do that, unless they come up with more money for it. We have one tax in there, which is good, the tobacco tax. And if they pull out any of these --

Q This is a nonsmoking company.

Q No money out of this company. (Laughter.)

MRS. CLINTON: Good. If they pull out anything or they add anything, that's been our argument from the very beginning -- it has to be comprehensive and it has to be responsibly funded. So they've got to come up with the money if they're going to do that.

Q How will you mobilize the White House, the administration, to go forward on this, from a strategic point of view?

MRS. CLINTON: Well, we have in place an organized team that will be working -- is working now on a rapid response so that you all can get your questions answered immediately, outreach, surrogates, you know, all the pieces of it, and it basically builds on what we did at the end of the budget and what we did for NAFTA, the same kind of model, although I'm not in favor of the kind of martial metaphor. Instead of the "war room," we're calling it the "delivery room." (Laughter.)

Q With cost in mind and prevention in mind -- I know you've been really outspoken on that -- and both you and the President talk about personal responsibility, and I think everyone can buy that because we're certainly all involved in making sure we're all as healthy as we can be so we don't have to tap into the health care system.

But I know a lot of health professionals who work in the preventive field are concerned about (inaudible) to know what (inaudible), specifically in nutrition. If somebody needs nutrition counseling to help lose weight, so they don't have to be in a wheelchair (inaudible) operation, or an AIDS patient who needs counseling, who's getting out of the hospital, to be as strong as possible (inaudible). The specifics are not in. We don't see that what they pay now -- a lot of insurance companies don't pay for that. (Inaudible).

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MRS. CLINTON: Well, we added nutrition therapy to the benefits package, so I think that covers what they're concerned about, at least according to the American Dietetic and Nutrition Association. They're very excited and want to give me some award, so I guess it's what they wanted us to do, because we share that concern.

You know, we now know what common sense probably told us, but until recently, the medical community --

(End tape 1, side 1.)

MRS. CLINTON: -- and that was something that finally got approval by insurance companies this past year with Dean Ornish and his work on reversing heart disease. We know that we can have that kind of impact.

We also know that there are lots of other chronic diseases, like diabetes and others, that need a lot of nutrition counseling, and that there are nutrition therapies, particularly in combination with treatments for cancer, like (inaudible) therapy, like AIDS, that will help make the medical treatment more effective, as well as keep the person functioning better.

So we have tried to include all of that kind of (inaudible).

Q What about nutrition education for the American public? (Inaudible.) I was just looking at the figures on (inaudible) nutritional (inaudible). So it's not (inaudible).

Q Her beat is nutrition. (Laughter.)

MRS. CLINTON: It's a very important one. We do have some education, health education funding in the plan, as well.

You know, part of this -- I can't sit here and tell you exactly how this is all going to be done because, contrary to some of our critics, it's not going to be a government-run plan. This is not going to be determined in Washington where, you know, on Monday at 2:00 you have your session on nutrition. This is locally-driven, private-public system.

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And part of the problem in explaining it, frankly, is that we tried to take the best of both of those approaches and combine them. And for some people who are on the left, they want a totally public system, and for some people on the right, they think it's fine, the system we've got now, and want to make some marginal changes.

We want to have a stronger system that builds on our public health piece but is largely private market driven. So health plans will be within the comprehensive benefits package, making a lot of these decisions about exactly how nutrition education will be delivered.

And what we want to have consumers do is to make choices among plans based on these kinds of features. That's going to be a very important part of this.

Q Coming at it from the back end a little bit, what does the ultimate environment look like? What does your health provider system look like in the year 2000 and what major changes take place from here to there? We're sort of going through the telecommunications revolution right now, and we really don't know what that environment is going to look like, and that's a little scary in that area.

Do you know exactly, or pretty closely, what that's going to look like in health reform?

MRS. CLINTON: I don't know exactly what it's going to look like. I've got some, I think, hints about what it'll look like that I think are very promising. It will be a much better organized delivery system, but it will still be a varied one.

It will be -- let me back up and say probably the closest model that we have to what we want for the whole country is what the federal government provides for itself, not surprisingly. And what they provide for themselves and members of Congress. And this ought to be one of the questions you ask every member of Congress who's a member of the Federal Employment Health Benefits Plan.

And the way it works is that the federal government contributes, I think, 75 percent of the premium, and the individual contributes 25 percent. We have an 80/20 split, but it's basically the same. The federal government bargains with health plans all over the country to provide services to

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their individual employees.

And they have certain criteria that you have to meet. You have to be, obviously, able to deliver what you've said, but they don't draw that many distinctions in terms of what kind of plan you offer because they let the individual make the choice. The government doesn't, unlike many employers today, say to federal employees or their families, "You must join an HMO. Here's all we're going to pay for it and if you don't like your doctor, tough. You're stuck."

The federal government says, "We're going to contribute. We're going to screen the health plans to make sure that they're reliable and can deliver." But then they're going to sell their services to you. So every enrollment period, which is going on now for federal employees, you get deluged with about 20 to 25 different kinds of plans you can sign up for.

And the plans are slowly becoming more organized, in the sense that they are taking doctors and hospitals and forming networks so that they can help control costs, but they still also have indemnity plans, the traditional kind of Blue Cross/Blue Shield, fee-for-service approach.

And then the individual sits down and says, "Well, that sounds pretty good and that's what I want to pay. I don't want to pay any more, so that's the one I'm going to join." That's what we want for the whole country. We want the employers to contribute into the big pools, which are purchasing cooperatives we call alliances.

They're not regulatory. They collect the money. They basically say to every health plan that's out there, if you want to sell your services to our consumers, you've got to meet these criteria, which is you've got to be fiscally responsible, et cetera. And then, every year, instead of your employer telling you who you will sign up for, you sit down and make your choices. And if you're not happy, you don't get enough nutrition counseling in one plan, you move to the next plan.

Now, the best way this can work is to keep in mind there's a difference between the financing, the payment and the collection, which operates up here, and which, for most of us, we don't really care who gets our money. We just want to know that we're getting the best care we can get and what

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doctor we get to choose and what hospital we go to.

So what we hope happens is that under that kind of system, where people are really going to have to be more efficient in the way they deliver health care, we will have more doctors and hospitals joining together in networks.

We'll have more multi-specialty clinics, like Mayo's. Doctors there aren't paid on the basis of how many procedures they do. They're paid on a salary, so there's no incentive for a surgeon to keep that woman with the lump in her breast, to do a surgical operative procedure. He's perfectly free to send her to the radiologist to get the latest needle biopsy, because it's not direct money out of his pocket.

In most parts of the country, it is, which is why surgeons keep women with lumps, instead of sending them to the new technology, which is less invasive, faster and, in many ways, less anxiety-producing.

We want to move away from the incentives that currently exist, which pay on the procedure and the test, and treat the whole health care system in kind of a capitated way. So, you know, we've got all this money, what's the most efficient and fair and high quality way to spend it without having doctors making decisions that are in their pecuniary interest, as opposed to their patients' interests, which even the best doctors today will tell you, if they don't do, they struggle over doing because that's how they get paid.

So the more multi-specialty clinics, the more networks, the more capitated plans, the better off we'll be. Now, how do we make sure, though, that those are well run and that they are not just herding people around from place to place? Well, we've got several options to make sure that happens.

First is we're requiring every plan to issue a report card on quality indicators that can be compared, apples to apples, so that we know, you know, what is the diagnostic rate for determining breast cancer, and what's the outcome? How many children get immunized in this health plan? Those are the kinds of things we should be looking at which will help us do better.

We also want to have the kind of organized delivery

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system that can begin to have quality outcomes so that we can determine how our money is being spent, which we don't have now.

So I think there's a great market in telecommunications and consumer information and quality outcomes in the health care field because that's how I want the whole system to be moved in the future. But it's going to take a lot of changes for us to do.

Q How or who should pay for experimental treatments? Like, say, for example, bone marrow transplantation for breast cancer. Right now you have a real hard time getting insurance companies to pay for that. Isn't there going to be even less of an incentive for them to do that?

MRS. CLINTON: No, I think that we've got the same kind of provision in our plan that you would find in most good insurance policies, which is that health plans will be continuing to do experimental procedures and reporting those procedures.

And then we do have a national board that will make changes in the comprehensive health benefits, as clinical data support it, so that if we learn more about what is good clinical practice in bone marrow transplants for breasts cancer, then it becomes part of the general benefit package. As it is now, it depends totally on who your insurance company is.

Q And that's why it's difficult to get more data, because we don't have women getting into these studies --

MRS. CLINTON: That's right.

Q And the doctors can't give them information.

MRS. CLINTON: That's right. And that data will all be centralized. I mean, we're going to start having a broader data base that could be active. One of the things that struck me as I began this work is how there is a sea of information about health care out there, but there is little of it effectively delivered to physicians on the front lines. I mean -- and it's all filtered through a million different hands, whether it's insurance companies or drug companies or whatever. There is no good source of information, unless

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you're associated with a research institution and you really have the time to spend, that make it clear to physicians, "Here's what will work." Most physicians get their information about medication from drug companies, which are trying to them a new drug.

We need a fair and neutral basis for delivering that information, so it's not just coming from the manufacturer, who's sending out the drug reps to every doctor's office. It is the same thing with procedures. We need to collect that information. Then we need to disseminate it so people can make better decisions. We don't do that.

Q How does this plan speak to children?

MRS. CLINTON: It emphasizes primary and preventive care for children, and it emphasizes prenatal care and well-child care. Most insurance policies today -- and I've found this and I'm sure you have, too, with your children -- they won't pay for the well-child exam, but if your child gets sick they'll pay for the admission at the emergency room. I couldn't believe that when I first --

Q That's our system here at CNN. We don't have well-baby care, and you have it in your plan. Congratulations.

MRS. CLINTON: Yes. Well, we need to have it. It makes economic sense. So here's what we've done. We have provided insurance for prenatal care and for well-child care and for immunizations and for a lot of diagnostic tests which we think are important, like mammograms and Pap smears, cholesterol screening, et cetera.

There are some things we think are so important that we're actually providing them free. So it doesn't matter what plan you're a member of or what your co-pay might be; they're free. Some prenatal care and some well-child care fits into that category.

And the cost for this is not significant when you look at it. It saves money. But the problem is -- this is how we got into this situation -- health insurance started in the late '30s and it started through the Blues and it was basically a not-for-profit kind of enterprise to take care of catastrophic sorts of illnesses.

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Commercial insurers got into the business in the late '40s, which is one of the reasons why Truman was defeated, because all of a sudden commercial insurers saw a new market which they'd never paid any attention to.

The Blues had always community-rated their catastrophic care, which meant that everybody was in the same pool and nobody was eliminated from coverage. Commercial insurers, starting in the late '40s and then rapidly accelerating in the past decade, saw that if they experience-rated, even for catastrophic care, they could make a whole bunch of money because they would end up insuring the healthiest people against odds that they weren't likely to ever meet.

And that's how we got into the mess we're in now, where you've got people eliminated from coverage, where you've got all kinds of different policies out in the marketplace aimed at different segments of the population.

It was always assumed when the Blues went into catastrophic care, and this was the idea in the '30s, that public health and that sort of maintenance, preventive care would always be affordable, within the range of what most people could pay for. So nobody insured against that because the poor would be taken care of by public health. And my doctor, when I was growing up, in my suburb of Chicago, charged \$5 for a house call.

So until really about the late '70s and '80s, preventive care was accessible to most middle income people. Then, with the whole skewing of the health care system, with huge dollars going into tertiary care and into the high-end costly technology that was paid for by commercial insurers and the Blues, in order for primary and preventive health care physicians to make even a decent income and cover their expenses, they had to continue to raise their costs.

So it began to be \$60 to get your child immunized. It began to be, you know, \$50 for a well-child exam. So the number of people who could afford that began to diminish. So even if you were insured, you would postpone taking care of those kinds of costs because you got first-dollar coverage if you got real sick. So if you got real sick, then you could take care of it. So we've just had all of these forces going against primary and preventive care.

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So we're trying to reverse that in this. And for children, it will be especially important because it's not only paying for that coverage and making some of it free; it's getting the idea of a medical home for children established, because a lot of people, particularly low-income but not just low-income, middle-income with no insurance for preventive care, no longer have a family doctor, no longer have a pediatrician, no longer have a place of entry to the medical system, which is why they go to the emergency room.

So by telling them, "You now have all of this preventive care, but the only way you can get it is to go to the pediatrician. The emergency room's not going to give you a well-child exam. You've got to go to the clinic." We're going to be taking costs out of the hospital and moving people into care where they should be. So we think it's going to be doubly beneficial for kids.

Q A think-tank columnist, Mrs. Clinton, last week complained that you've already allowed the 9 million members of the Federal Employees Health Benefit Plan to opt out of the program, at least temporarily.

MRS. CLINTON: No, what we've done is -- actuarially, the problem with the federal plan is that it's got 9 million people all over the country. And we couldn't figure out a way to fold them in on a state-by-state basis because if you've got, say, 10,000 federal employees in Alaska, that's not a problem. When Alaska's ready to go into the overall system, you could kind of incorporate them.

But if Maryland goes before Alaska, so you pull out a million and a half, then the coverage for Alaskans collapses because you can't sustain the federal basis when you're pulling out so many people on a sort of yearly basis, as opposed to all at once.

So all the federal employees go in all at the same time. They all go in. There are no opt-outs. They go into the same program. They get the same coverage. They don't get anything more or anything less. But they don't go in when states go in. They go in all at once, in 1996 or '7. When all the states have to be in, they all have to be in.

Q Is it not true that if they choose the year before that not to go in, because they don't like the performance, that they can opt out?

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MRS. CLINTON: Not -- as far as I know, it's not true. I've never heard anything like that. I mean, if somebody slipped it in, I'll be interested to hear about it. But as far as we know, that is absolutely not true. They all have to be in the plan. Congressmen have to be in the plan. The President has to be in the plan. Everybody's got to be in the plan.

But see, if we can get this passed, our goal is to get it passed next summer, before the August recess. That's our goal. Then states can start going in '95. Every state has to be in by '97. So all federal employees have to be in in '97. That's our plan.

Q (Inaudible.) How are you going to (inaudible)? How much of you are you planning to dedicate to this?

MRS. CLINTON: I think as much as it takes. I mean, I think this is an historic moment that we will all kick ourselves for if we don't get it done (inaudible).

You know, one of the many things I have learned is that as we know more and more about the human genetic make-up, and that's something that's right on the horizon -- you know, we're finding the genes that we think cause Huntington's disease and we're finding the genes that maybe are related to Alzheimer's, et cetera -- as we learn more, and there's going to be an explosion of this knowledge in the next four to five years, millions and millions of us, until eventually everybody in the country will have a preexisting condition.

We will all be uninsurable because we will all have some kind of gene that, if under the wrong circumstances, can trigger diabetes or Alzheimer's or Huntington's disease or whatever. So I am, in a personal way, trying to beat that. I don't want to know, in 1998, that I've got some gene that makes me uninsurable for the rest of my life because of our crazy insurance policies. So I think that all of us ought to be concerned about that.

But that's the kind of race we're in. If we do nothing -- although there have been some temporary decreases in prices, I view them as temporary because I think in the absence of continuing pressure to reform, they will not stay. And the system will continue to eat up more and more of your income as a company, your income out of your own pockets, and the country's income. And we will continue to spend more than anybody else and get less for it, by any measure -- I

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mean, in terms of longevity, public health, et cetera.

So I just think that this is the time, and anything I can do to make it happen, I'm going to try to do my best.

Q Well, this is a major story for us. (Inaudible) to cover it very (inaudible.)

MRS. CLINTON: Good. We appreciate it.

(The interview was concluded.)

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