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REMARKS BY THE FIRST LADY
AT "SELF" MAGAZINE LUNCHEON ON HEALTH ISSUES

MRS. CLINTON: -- that are really important to people. I've told some of you before, when I've had the opportunity to visit with you, whether it be "Family Circle" or "Redbook" or "Ladies' Home Journal," that I'm a long-time and confirmed woman's magazine reader and believe very strongly in the role that they have played and continue to play, and think there is probably no issue which is more important for magazines and particularly women's magazines to focus on, than health care, not only in the personal way that it has been focused on in the past, but in the larger national debate that is now going on.

We are lucky to have with us some of the women who will be making the decisions about that, women like Representative Morella, who has been focused on domestic violence and other concerns that are health issues, even though they historically have not been seen as health issues.

The first time I came to the Women's Caucus, one of the things I was so impressed by is how women were working across party lines on women's issues and particularly health care issues, when that wasn't so common in the rest of the Congress.

Then Alice Rivlin (phonetic), who knows more about the federal budget than probably anybody in the country, and who will be, you know, as she has been, working on what some may think are the boring and difficult and perhaps incomprehensible issues about financing and numbers but which, as we all know, at bottom will have a huge role to play in how we shape this package and move it through the Congress.

So what I would like to do is basically just answer your questions before we go to the interactive video, and to know what's on your minds or what you might think are on your readers' minds, so that we could have a better understanding

of how to proceed with this national conversation about health care, and reach a destination that I think all of us agree needs to be reached, if we stay with this issue and are committed to it over a long enough period of time.

So I would be glad to answer any questions (inaudible).

Q I'd like to (inaudible). Would you consider, since this (inaudible) back and forth (inaudible) is there a consideration of allowing the private sector to clean up its excesses (inaudible) and get more involved in this plan (inaudible)?

MRS. CLINTON: Yes. In fact, the plan is designed to bring that about. I was struck, in the last several weeks, by how there are a number of success stories in the private sector in the health care industry which have not been, for a combination of reasons, followed or replicated. And, in large measure, that is because you do not have a marketplace in the health care industry. It is not like the kind of market you compete in or that Mr. Newhouse (inaudible) and I were talking about very briefly earlier.

You have not had any of the kind of external competitive pressures or market discipline brought to bear on health care in our country. It has been basically a blank check being written by both the private and the public sector over the last 20 years.

All of the incentives have gone in the wrong direction. For example, it is the only industry left of its kind, with respect to the sophistication of the services delivered, that basically operates on piecework. You know, doctors are paid on the procedures they perform, on the tests that they give.

It is only human nature, therefore, to order more tests and to perform more procedures. Everett Koop has estimated that there are probably \$200 billion of unnecessary costs in the current system. Until we change the incentives and create a really competitive marketplace, you will not have the private sector having enough of a reason to change the way they perform.

You will continue to have isolated and, I hope, increasing examples -- whether it be in Rochester, New York or Rochester, Minnesota -- you will have examples of doctors and hospitals and insurers moving in the right direction. But there is no incentive for others to follow. In fact, the incentives push them in the other direction.

So the idea behind this plan is to create a marketplace and to create incentives for the first time for physicians to make decisions not on how many tests they must run in order to realize whatever income they are looking at, but more on the basis of what is the per capita amount of money we should spend to take care of what population you are charged with caring for, and then make the decisions within that framework.

So that is the way we're trying to set it up now, and we have to really reverse -- we have to reverse 50 years of decisions that have gotten us to where we are, starting with insurance that pays for catastrophic and other intensive hospital care but not preventive care, all the way up to the piecemeal analogy that I just gave.

Q I saw Ellen Levine over there with "Redbook."

Q Question (inaudible) on this thought. I guess I'm assuming (inaudible) but a lot of it is flowing under the rubric of "defensive medicine" that is tied into malpractice anxiety. (Inaudible) is indicating two populations -- the physician population as well as the patient population who feels that, unless every test is performed, (inaudible), that they aren't being properly taken care of.

Can you discuss how your plan (inaudible) for malpractice control and for patient population re-education?

MRS. CLINTON: Those are really two important issues, because they drive a lot of the expenditures in the system. With respect to malpractice, we are recommending a series of measures to try to eliminate the fear of defensive medicine as much as we can and to control the costs that are generated by the malpractice system.

I have to tell you that this is one of those areas where there is much more heat than light. It is impossible to find an absolutely positive correlation between medical costs going up and malpractice cases or trying to prevent malpractice and costs going down. Depending upon who does the study, you get whatever result they want you to have.

What we've tried to do is to take all the studies and say, "Look, we know there's a problem. There is a problem with respect to doctors feeling that their decisions are going to be second-guessed and they're going to be dragged into court if they don't go to the extreme and practice defensive medicine. How can we begin to rein that in?"

So we want, for example, to require a certificate of merit before you can go to court. An independent doctor or an independent board has to say, "This is a worthy case." We want to promote alternative dispute resolution so that we don't even get to court with a lot of these cases. We want to limit attorneys' fees in malpractice.

And we want to begin to establish what we call practice parameters which will lay out what is the accepted practice with respect to a certain problem and, if a physician follows that, then he is presumed to be competent. Now, that presumption can be overturned with evidence of negligence. But if he does follow it, then at least he believes that he is doing the right thing and he is safe.

So we are moving on several of these fronts at once. The lawyers don't like a lot of what we're doing and the physicians don't think we've gone far enough. The physicians would prefer that we add capping non-economic damages.

In other words, when someone is sued and you recover all of the costs of what the injury is and what the possible rehabilitation time might be, there is this category of non-economic damages, which is largely pain and suffering and other kinds of issues that go along with that. We looked very hard at that, and decided that we could control what was wrong about the malpractice system by moving along the lines we're talking without undermining a victim's right to have full recovery if it were a legitimate negligent medical case.

So that's how we've tried to strike the balance and the fact that both the doctors and the lawyers are mad at us, I think, says that we've probably struck the right balance.

(Laughter.)

MRS. CLINTON: The second issue, though, about patient demand, that is a larger problem, and it's a real cultural problem. It has to do with our desire to be immortal and never to grow old and to have the belief, at least, that there is an answer to every problem, that there should be some kind of way to fix it if we only find the right answer. It also is related to physicians having different practice styles and encouraging certain kinds of behavior in their patients. So it goes hand in hand.

We have to better educate patients about what is really available to them and what their responsibilities are, and we have to, going back to the question earlier, we have to

change the incentive so that physicians will spend more time educating patients as well. Most physicians don't get reimbursed for sitting down and talking to you, unless they run a test. They have to run a test. They have to have something happen.

I'm from the school that believes a lot of what happens in health is how you treat yourself and what kind of advice you get and the relationship you have with your physician, all of which takes place in the time you spend learning about yourself and having a physician kind of guide you to that self-knowledge. If you're not reimbursed for that, it's not going to happen.

So we're trying to change the system so that we can start reimbursing doctors for spending time with people again and to having doctors know that they need to learn more about what works with certain people and what doesn't work, and to get better access to the information that's out there. Because we know that some doctors admit people to the hospital for reasons that other doctors don't, without any difference in quality. Yet, the second group of doctors may not know about the first group.

So those are the kinds of collective information sharing that we've built into this plan where we've got quality report cards, we've got patient and doctor education going on, where we've got the whole idea of having physicians reimbursed on how they take care of people as opposed to reimbursed for little things they do to people, which we think will, over time, make the differences you are talking about.

Q Jackie (phonetic), "Family Circle."

Q I would like to follow up on Ellen's question about patient-driven change. It seems that we do expect a quick fix, whether it's an 85-year-old who should have a heart transplant or not or a half-pound baby who should be saved.

What will the health plan, what (inaudible) are we going to (inaudible) health plan to try to (inaudible)?

MRS. CLINTON: I think this is a debate we have to have, but I think we have to establish a firm foundation of health security before we can engage in it as a debate.

I don't think, when you've got 37-1/2 million uninsured people and another 22 million who are basically under-

insured, you can engage in a debate about their making the right choices for health care because, right now, they're feeling left out of the system, and the system doesn't particularly work for them. In fact, the system rations against them all the time.

Another statistic Dr. Koop told me about is that if you have an uninsured patient and an insured patient show up at the hospital for the treatment of the same ailment, the uninsured patient is three times more likely to die than the insured patient. So we are rationing care every single day, but we don't talk about it and we don't do it. We do it by the financing mechanism that we have, instead of making the kind of hard decisions we should be talking about.

So what I'm hoping is that if we can get everybody secure, that they know they won't lose their health insurance, they know they're not being discriminated against because they're a single woman who is working hard for a living but doesn't have a job where she gets insurance and can't afford it herself, or whatever category you fall into, then we will begin to see this debate take shape in the way that I think it should, whenever everybody knows that their basic needs are taken care of.

They're not sort of fighting for air space, and they know that their getting something may mean somebody else doesn't, but that's all the more reason for them to get it because then they won't lose it, you know. Once we establish health security, then I think we do have to start talking about some of the hard questions.

I actually think the conversations, though, will be more likely to take place in a responsible manner among physicians and hospital administrators than the general public, initially because, all of a sudden, there won't be the same kind of incentive to engage in heroic medicine and to engage in the kind of decision-making which all too often we've seen, where somebody makes a decision to do something heroic which has very long odds, which means that, by making that decision, they expect eventually to get reimbursed for it, but they're making a decision against doing something more broadly.

The siamese twins case is a perfect example. When the decision was made that the operation was going to be carried out at the Philadelphia hospital, that's a hospital that already, I've been informed, is running millions of dollars worth of uncompensated care but they didn't have to worry

about that, because the federal government keeps plugging the holes on uncompensated care, so they could take that task on, even though the odds were very long.

I think it is more likely, in the future, when everybody is on a firmer financial footing, when everybody is insured, that doctors and hospital administrators actually will be more able to say no than they do now. I'll just give you one last example.

I've used this example before, because it was so striking. A hospital administrator, from a very large Midwestern hospital, told me how he had a cardiac surgeon admit a man, a 92-year-old man, for a quadruple bypass. The hospital administrator asked the cardiac surgeon, "Do you think this is appropriate medical care?" The cardiac surgeon said, "No."

The administrator said, "Why are you doing it?" He said, "Because the cardiologist who referred him refers me a lot of business and, if I said no, he wouldn't refer me any more, I'm afraid." He said, "I'm not sure this man can even survive the operation, but he wants it, there's no reason for me not to give it, Medicare will pay for it, we're going to do it."

The hospital administrator said, "You see the position that I'm in?" He said, "We've had no collective decision-making, because every doctor" -- going back to the piecemeal analogy -- "is a lone ranger." They don't have to be collaborative. They don't have to work together, to make hard decisions together.

If we have a system in which that hospital is part of what we call an accountable health plan and it's bid on taking care of the health needs of a certain large population and they set a price as to what that will be, then, within that, they will begin to make hard decisions, and those decisions will gain, I believe, public acceptability because people will understand what the tradeoffs have been. Right now, nobody has to be accountable. So, nobody is.

Q Nancy (inaudible).

Q Will there be a (inaudible)?

MRS. CLINTON: It will depend upon in what form they continue to practice. If they join a multi-specialty clinic, like the Mayo Clinic, they will go on salary.

Part of the reason the Mayo Clinic is high quality at low cost is because doctors are not charging by procedures. They get a salary. It's a very good salary. But nobody then has to worry about upping the ante. They get paid what they have agreed to be paid. So if they are in that kind of a setting, then, what they charge for routine services will be decided by the medical staff and whoever else makes those decisions.

If they stay in a fee-for-service practice, which is the common way that physicians are paid now, they will have to join with other doctors and agree upon what they will charge. They will have to have some kind of agreed-upon fee schedule because that's the only way they will be able to bid for the services that you and I would want to pay them for. But again, doctors be making those decisions more than they do today.

If they join an HMO, they will go on salary. If they join a PPO, they will go on some kind of a combination of salary and whatever other income is agreed upon. But it will depend upon the form of practice they choose, and that will be up to the physicians, because we're trying to eliminate what has been occurring, which is a practice of discriminating against physicians and telling them under what circumstances they can practice and how much they can charge, as dictated both by programs like Medicare and Medicaid in the public sector or by insurance programs and employers who basically call the shots now. We've trying to give more of that authority back to physicians.

Q (Inaudible).

Q Working couples (inaudible). Now working couples sometimes have two insurers and can shop for the best benefits (inaudible) and yet, in the future, if everyone must have their own (inaudible), how can one member of the family, their insurance protect the whole family?

MRS. CLINTON: If two adults in a family are working, if they have no children, each adult will be insured through their workplace. They will make their employee contribution and their employer will make their contribution, and they will be part of the large buying alliance, unless they are employed by a company that has its own alliance because it's big enough to be self-insured. And each will pay their share on that.

If they have children, then one of them will opt to

carry the family policy and it will depend, usually, as it does now, on who is the higher-paid worker, who has the most contribution from which employer. But one of the things we want to stop is the shopping that you just alluded to. It has been very unfair to employers who have provided insurance in a number of ways.

A number of employers have footed the whole bill for a family and even the employed spouse has basically declined insurance at usually her workplace and gone on to her husband's policy. That has not only had the effect of sort of what you would call micro-competitive disadvantages but it has had huge macro ones because many older industries, many industries with better benefits have indirectly subsidized a lot of the rest of the economy that has foregone benefits and pushed all that responsibility onto the backs of the employers who offer the benefits.

It's gotten to the point in the last several years that even companies that offer good benefits are offering spouses bonuses not to take the benefits but to take \$1,000 in hand so they go on to their spouse's plan, so that the employer of the spouse then bears the full responsibility.

It has had very bad effects on the labor market and on the sort of competitive opportunities of a lot of our industries. So we are trying to level the playing field, and if you're employed, you will be insured through your workplace but then, in a family with children, one of the employees will take the responsibility for the family policy and, based on our calculations, the combination will be less than what many people are now paying for a family policy. So we think that will be fairer.

Q Marsha Gillespie from "Ms."

Q Mrs. Clinton, I've been curious. You've mentioned education (inaudible). What exactly will happen in terms of education for prevention? Will (inaudible) huge numbers of people in this country essentially go to emergency rooms.

MRS. CLINTON: That's right.

Q And so what we're dealing with is really changing a whole mindset (inaudible) that last gasp treatment is something that is totally (inaudible).

MRS. CLINTON: That's right. And because we have had so many people showing up at the emergency rooms at the last

possible moment for the most expensive kind of care, often not being publicly insured or privately insured, we've had these continuing crises in financing of hospitals, but we've also had the costs shifted onto the backs of those of us who are privately insured.

Every time somebody goes in and gets treated, as they eventually do, we pay for it eventually, which is one of the reasons why premiums have gone up so much.

We're going to do several things. The first is, in the comprehensive benefits package, we will have a set of primary and preventive care benefits. That is different from most insurance today. Most insurance does not provide coverage for preventive care. We want to reverse that. We want people to get care earlier and more cheaply instead of waiting for a condition to deteriorate.

So in the package, we not only cover certain tests. We also have provided some tests free because we think they are so important, at a certain age. We looked at -- the best study we could find was the United States Preventive Services Task Force, which the National Institutes of Health a couple of years ago put into effect.

They came forward with a list of what are the absolute required preventive services. We took those and we are making those free. Then we are taking them and adding to them, so that they can be available at a very small cost as part of your insurance.

Let me give you an example. As a woman, I'm interested in pap smears and mammograms. Now, every woman will be covered for that, absolutely covered, no problem. You won't have to pay out of pocket for the whole cost. Depending upon the plan you join, you may, starting when you join the plan, get those services for free or for a very small co-pay, or a slightly higher co-pay. But there's no question they will be covered.

Then, when I reach 50, because of the preventive services guidelines, I will start getting free mammograms every other year. I can still get them every year if I want to, but I will have to pay in the off years, but the whole system will support that preventive care at a level of both insurability and free after certain ages. That's true for prenatal care, for well-child care, for vaccinations, cholesterol screenings, things we think will have big payoffs.

Now, once those are covered services, we have to widely educate people about taking advantage of them, and we have to get more primary care physicians into areas that have been underserved, so that people can have access. We've had quite a lengthy discussion about who should be primary care physicians, because we want to elevate them and give them more reimbursement.

So pediatricians, internists, family physicians, OB/GYNs -- I'm leaving one other out -- general practitioners, I guess -- family practice. We argued strongly for OB/GYN to be considered primary care because we know a lot of women who don't go to anybody else except their OB/GYN.

We argued with a lot of the people who study all this and they said, "You know, OB/GYNs are specialists." We said, "Maybe they're specialists to you looking at it as a male on the outside but, to most of my friends, they are primary care physicians." So we won that, and we've got OB/GYNs as well as the others.

That means they will be entitled to -- well, what has been happening -- let me just back up a little. What has been happening is that Medicare reimburses for the training of specialists and for the treatment that specialists provide. We want to start reimbursing for the training of primary care physicians and for the treatment they provide, to get back to the example of spending time actually talking to patients, doing some clinical workups with them.

So I think that that will give us a better source of health, in both underserved urban and underserved rural areas. We are going to pay back loans of physicians who are willing to go into those areas. We are going to forgive loans. We are going to change the laws. This is a big women's issue.

We're going to change the laws that discriminate against nurses, particularly advanced practice nurses. I've had so many nurses who have been military nurses, with a broad scope of practice. I mean, they are stitching up people on the battlefields. They are doing everything to take care of patients. They leave the military; they go into civilian practice and they're told they can't do anything without a doctor looking over their shoulder, signing off, et cetera.

We have these highly trained, advanced practice nurses out there, nurse midwives, physicians' assistants, et cetera, who are not being well utilized and particularly can be

utilized in primary care. So we have a whole raft of approaches we're going to try to take to make sure that we can change the sort of psychology that will enable people to take advantage of services that we hope will be there.

Q Kay (inaudible).

Q What we hear over and over again from our readers on an anecdotal basis are problems of not getting cutting-edge treatment. They end up being told they need a hysterectomy and are not aware that another doctor perhaps in another city has a laser technique for dealing with this. So it doesn't do you any good if your doctor sits down and tries to better educate you if he or she is not in the loop on new treatments. This just seems to be turning up over and over again. I wondered what thought you had on getting a better network of understanding.

MRS. CLINTON: Yes. Let me go back to the piecework issue. Because there are instance where doctors don't know. There are also instances where to send the patient to the laser treatment which is done by a radiologist takes money out of the surgeon's pocket. Let's just look at how this system operates.

The Park-Nicolette (phonetic) Clinic in Minnesota has developed a test called a mammo-test which is a radiologically administered test that does, in effect, what a surgical biopsy can do in many instances where there is a suspicious lump. They can't get anybody beyond their small circle of physicians to use it.

When I was in Minnesota, they gave me a whole paper on it how much money it would save, how quickly it can be done, how many sleepless nights it will save women, et cetera. But you literally have to transfer income from surgeons to radiologists in order for this to be available.

So when you are sent to a surgeon and the cutting edge technology is laser or radiology, if you are paid on a piecework basis and if you don't think you're being negligent -- I mean, you know, surgical intervention still works, too; it's not a bad thing to do, it just may not be the cutting edge or the most advanced thing to do -- you justify it. You say to yourself, "Well, we need to do this."

If you have networks of physicians who are collaborating so that the dollar out of the surgeon's pocket doesn't go directly to the radiologist but goes to the clinic, goes to

support the overall health plan, decisions can be made much more efficiently and, I would argue, appropriately.

That is really what we are dealing with. Your readers are running into exactly what is wrong with this system, is that yes, after we educate physicians and we convince them that something is in their interest to do for their patients, we put a terrible disadvantage in their way, which is that, "If I make this decision, I lose patients. What's going to come down the road that will get those patients back for me? Where is it? How do I make that decision?"

So the whole idea behind what we're trying to do is -- this has been called competition and it is going to have competitive forces. But it also is going to be collaboration, so that people will start working together again and where, if you are being paid on, "How best do we take care of this woman in front of me, because I've already known how much money I'm going to make this year because I'm part of an accountable health plan; they've priced the services at X amount and I'm going to be here working, whether or not we make, you know, this bid; I'm going to be here taking care of my patients, then I lose the incentive to send you to the surgeon, and I have an incentive to send you to the radiologist or for the laser technique."

But it takes a whole different mindset change that patients have to be aware of and physicians. It's not fair to blame the physicians. We've created this system. This is the system that exists.

I have had so many wonderful conversations with doctors all over the country who are as aware of this as anybody. They see it every day, and they see the binds that their colleagues are put into every day in making appropriate recommendations, and they really believe that, if we can change the incentives and the way that they are reimbursed, they will be freer to make better decisions.

Q (Inaudible).

MRS. CLINTON: Oh, that's an interesting question. We all ought to take ten minutes and write it down and pass it around.

I think that what she will face will, in large measure, depend upon the decisions we make now. I think that if we don't reform the health care system, if we don't deal with violence, if we don't do a lot of the things that I

personally think should be dealt with in our country, my daughter will lead a much more isolated life and a much more defensive life, that will bring with it all the stresses that come. Even though she will be very successful and she will be well-educated and she will be affluent and she will have all the advantages that the children of people like us have, it will be a very unpleasant existence.

I think what you can see if you look out -- I've not traveled widely, like you and your readers have, but I was always struck in some countries how, you know, you would pass row upon row of big houses with huge, huge walls, with broken glass on top.

I used to think to myself, "Oh, how awful, to live in a society where that's the only way you could pursue your private life, was behind walls with broken glass on top and where, yes, you could fly out to go to Mayo Clinic or yes, you could have the one, you know, great cardiac surgeon when your heart needed it, but you would have to pick your way through such terrible situations."

I think that there is, unfortunately, a real challenge to us right now as to what kind of society we're going to have. You saw the paper this morning. We are now back up into percentages of poverty where we were in the 1960s. And, in the 1960s, we didn't have the level of violence that we now are coping with. That will affect all of our children. No matter how well-protected we give them the tools to be against whatever is out there, it's going to be a very different life than the one I took for granted when I was her age.

I've often thought, and I remember, I think back on this a lot because I had -- we took for granted the level of security that we lived with and, even if you were poor or even if you had a lot of problems, you were not constantly, constantly struggling with the kind of stresses and challenges that kids are today.

My husband called me last night from California. He did a health care forum, and all people could talk about was the violence that was affecting their kids. He told me about this one kid. He and his brother transferred to go to a safe school and the kid is standing in line to register for classes and he's shot standing in line. Now, that is what I think we're dealing with right now.

So the kind of future my daughter will have will depend

upon how gutsy and willing we are to take on these ridiculous kinds of assaults on civilization. The health care system will fall apart if we don't reform it. There will be a two-tier system. You will have charity wards and incredibly awful conditions for people who can't afford them and the rest of us will be fine.

"The rest of us" will be a very small group because, in that article, it also said that those of us who are rich are getting richer. We are dividing this society right down the middle and the middle is collapsing. I didn't mean to get into that, but that's how I feel.

Part of what I think this health care debate is about is establishing a base level of security for people. We need economic security for them. That is where, to me, the budget debate started. You begin to rein in the deficit. You begin to try to provide some reward for people who work with the earned income tax credit. You start trying to put your fiscal house in order because you know it will lead to a more secure future -- health care security.

You give people the basic belief that they are going to be taken care of with respect to health care and then we work on physical security. You then establish a base where you can turn to people who feel alienated, left out, overlooked, victimized, easy targets for demagogues, and you say, "All right, now we expect you to be responsible and face the future and be productive and do your part."

You say that now, it's a joke. "Right, do my part? Where am I going to get a job; where am I going to get health care? I can't walk out my door without my kid being shot in the playground." How do you inspire people to be productive, optimistic, future-looking Americans when they're scared to death?

(Applause.)

Q Congresswoman (Inaudible).

MRS. CLINTON: She's an expert on violence.

Q (Inaudible). I just wanted to share with this very distinguished group the fact that I have never met anyone who has done more toward openly communicating this message to Congress. Mrs. Clinton met with the Congressional Caucus for Women's Issues way back, early on, to listen, and she took notes and whatever.

Then she met with us to talk about the program. And then she met with all of the Republican groups to talk about the program. And then she met with the entire Members of Congress who wanted to show up to talk about it. And then she appeared before the committee.

It was very interesting that Meg Rosenfield (phonetic) talked about her appearance before the committee, where she said that these people acted like (inaudible). But, at any rate, I feel every time a woman is elevated, all women are elevated.

But I think that even beyond that, I just wanted you all to know that, as somebody who is on the other side of the aisle, that I think she has done an incredible job of communicating, and I particularly appreciate not only the prevention that's in this program but the fact that pregnancy-related (inaudible) is in there, too, and I think thanks to her. So I just wanted to (inaudible).

MRS. CLINTON: Thank you very much.

(Applause.)

MRS. CLINTON: Thank you.

Q Can you take a couple of more questions? I've got (inaudible).

MRS. CLINTON: Sure. Sure.

Q I have one more question.

MRS. CLINTON: Sure.

Q Let's take two more questions. Marsha (phonetic).

Q I guess I wouldn't be (inaudible) if I didn't raise the abortion question. We've heard a lot of people (inaudible) that "You don't have to worry because the health plan will take care of it." And (inaudible) concerned about the real willingness of Congress to (inaudible) for abortion (inaudible). So that (inaudible) I think the real question is how do we ensure that this will not (inaudible) the situation that we're in right now, that we have a choice (inaudible)?

MRS. CLINTON: The way that we are proposing that this would be handled is that, as the Congresswoman said,

pregnancy-related services would be included in the comprehensive benefits package. The comprehensive benefits package is available to every American without regard to how the American's health care is being funded.

We are taking Medicaid and folding it into the health care plan so that you will no longer know the distinction between a Medicaid recipient and the rest of us. We think that will help gain them access to better coverage because people will no longer have any incentive to turn them away because they won't even know who they are. Their funding stream will just come with all the rest of us.

The pregnancy-related services will be available in all health plans unless a health plan, for example, is affiliated with a Catholic hospital and it chooses to exercise a conscience exemption. But individuals will be signing up for health plans every year, and they will be signing up for whatever health plan they think is best-suited for their interests. And, given the way insurance works, that will then be a decision left to the physician and the patient.

Now you will see in the Congress great efforts to eliminate abortion as a pregnancy-related service that is covered and I think that will be one of those challenges that the health plan will face. What we are trying to do is to keep in place what is available under insurance plans now but make that available to everybody because everybody will now be insured.

I can't predict how the Congress will act, but I think it is a very important issue for people to be aware of and to work on.

Q (Inaudible) do you think somebody will (inaudible) this Congress?

MRS. CLINTON: Yes.

Q And how much of the plan will pass (inaudible)?

MRS. CLINTON: Oh, I think it's going to be changed, and I think it's going to be improved. I think it's going to be a legislative process that will take the plan and will work with it. But I think the basic principles and the basic structure will stay intact because I think it is the right combination of the concerns that Members of Congress have expressed over the last several years.

It's not a perfect plan for any interest group. There are parts of it that people don't like and will be arguing over. But it strikes the right kind of balance that I think we need to strike in coming up with a plan that everybody can vote for and feel comfortable with.

Senator Chaffee, who is the lead Republican in the Senate on health care, spoke here at the Press Club about a week-and-a-half or two ago, and he set forth a very ambitious timeline. He said he wanted the legislation on the floor by the end of April. He wanted the Senate to vote by June. He wanted the President to sign it before the August recess.

I think that there are some who think we can do better than that. But at least that set out what I think is a very fair and even conservative approach, if we can actually get this debate up and going.

I think the real challenge will be whether we can keep our eyes focused on what is really at stake or whether, as so often happens to us, we will get pulled into all different kinds of ancillary debates by all kinds of interest groups who don't like one little piece or aren't going to be happy unless they get their little chunk or their little change, who are going to be running all kinds of ads, who are going to be trying to scare everybody.

I think that there is a core in the Congress -- what I consider kind of the reasonable middle -- in both houses, both Republicans and Democrats, who I think will keep it on track because I think they feel a responsibility for it. They are hearing from their constituents. Then, within that sort of broad middle, I think we will be working out all of the details.

Q I think that's really it.

MRS. CLINTON: Okay.

Q You are, as my son would say, awesome, pretty fantastic. I'm just proud of you and I think millions of Americans are.

MRS. CLINTON: Thank you. I'm (inaudible) --

(Applause.)

(End of luncheon.)