

SENATE SELECT COMMITTEE ON AGING

THE WHITE HOUSE

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REMARKS OF THE FIRST LADY
TO SENATE SELECT COMMITTEE ON AGING

Capitol Hill

MRS. CLINTON: Thank you very much, Senator. Thank you, Mr. Chairman. I am grateful for the (inaudible) prevention, as the --

Q Open heart hearing --

MRS. CLINTON: -- exactly and prevention is one of the primary objectives of the Health Care Reform effort because obviously we believe that if we are able to encourage better habits and earlier care and treatment, diagnosis, it's not only good for individuals, but good for the entire system, and, certainly, good in an economic sense with respect to the costs.

I'm particularly pleased to be at this committee because I know that, having followed my friend, Senator Pryor, for many years in his efforts on behalf of the Aging Committee starting way back when he was still eating grits and sausage -- for breakfast -- (laughter) we have all benefitted from his (inaudible). And I'm very pleased that this committee is still here to have breakfast with me.

Q -- (laughter) --

Q We believe in amnesty -- conversion --

MRS. CLINTON: I wanted to say a few words about the two issues that Senator Cohen and Senator Pryor mentioned, long-term care and prescription drugs, because those are obviously the two issues on the forefront of the minds of most senior citizens, both as they express them to us individually and in their organized representation. And we believe that it is important as a matter of policy to address both of them in health care reform.

We intend to include a prescription drug benefits in the overall comprehensive health care package, and we intend to provide a drug benefit to Medicare recipients who, at least for the immediate future, will remain in a separate system, but one which we believe should be merged into the overall system.

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But certainly, for the short term, because of the two separate systems that will exist, we will provide the drug benefit within Medicare and within the comprehensive benefits package, but they will be compatible, so that as we phase in a merger of Medicare into a comprehensive continuum of care systems, those two benefit opportunities will be compatible.

Likewise, with long-term care, we think there are several available options to address the beginning of a long-term care system that will increase access to home-based care and intermediary care, begin to build up the facilities that are necessary and personnel that is necessary for being able to deliver on that, provide more choice to senior citizens within that range of options.

Now, it is, obviously, as you know better than most people in this country, very expensive and daunting to think about moving immediately to an entire comprehensive long-term care system. But we think a phased-in depth process will work, and it will include some of the innovations that have taken place in the states, notably with both senators from Wisconsin here.

Wisconsin has one of the more effective long-term care systems in any of the states. They've done some innovative work over the last years that provide different options for their citizens. It's that kind of state modeling that we find is really the basis for what we want to see available nationally.

In our state of Arkansas, with the health (inaudible), we were able in the President's last years as governor to put in a program we called Elderchoice, but on a very limited basis, because, of course, there had to be a waiver that permitted it. But we were able to take a proportion of our Medicaid nursing home money, and instead of only providing it for Medicaid nursing care, we were able to say to senior citizens, "You now have a range of options. We will now pay for home health care. We will now pay for adult day care. We will now pay for transportation. We will now pay for intermediate living situations." And, you know, that kind of range of options is what we're aiming for.

In addition, we believe that the opportunity for citizens to invest in a long-term care account on their own is something we ought to consider seriously. We view a long-term care account very differently than some of the proposals about medical IRA's for two reasons.

First of all, it is a targeted benefit, which is easily understood and explainable to people, which is, as a matter of choice, available to them should they so choose, and which, since we

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are moving in the direction of more long-term care, helps us build a base of financing that is both individual and governmental from the very beginning.

And I think that the opportunity of whether the Medicare Part C or something that would provide that kind of option for senior citizens would give them the chance to be responsible for their own future needs, but it would also, we believe, give us an insurance market that we could then better regulate, so that we wouldn't see a lot of the scams that you see in this committee of long-term care insurance that doesn't really mean very much at all, and would be, we think, a market that could grow with the introduction of a comprehensive benefits package for the under 65. And this could be available even for under 65 planning for their own long-term needs.

So, very briefly, those are the kinds of things we think make sense.

THE CHAIRMAN: Very good. The floor is now open. This is a rare opportunity for us to have a few -- five -- minutes with Mrs. Clinton and to talk about some of these things.

SENATOR: A large percentage of costs of medical care comes in the last 30 to 60 days of a person's life. Of course, you don't exactly know when that 30 to 60 days is going to be. And that fact, considered along with the Oregon plan, has there been any thoughts about rationing health care in those last 30 to 60 days, about not doing heroic, very expensive things that run up that cost?

MRS. CLINTON: Senator, there's been a lot of thought about that, and it's something that I think that we feel comfortable addressing in the following way.

We believe there ought to be a considerable educational effort made to talk with people about advance directives, living wills, the kinds of planning that many are doing on their own, but which are certainly not widely understood or available.

In my conversations with a lot of elderly -- and, really, we've got so many different stages of aging now -- but in my conversations I'm often told that people don't want a lot of heroic efforts, but they never really thought about it before the occasion arises.

We think, as part of the health plans that we are going to be encouraging, there ought to be some consumer education about exactly what life support means, what heroic effort means, encouraging people to have advance directives and living wills so that there can be some more thought given before the occasion arises.

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Secondly, within our medical system now, there is rationing that goes on already. We know that. And we know that certain people in certain communities are treated more heroically than people in other communities. It is a rationing that is inevitable in many ways, but which is not well thought out or given the kind of analytic understanding that we think a system of integrated delivery networks, such as we are proposing, will come to as a matter of both necessity and appropriateness.

So that, for example, there will be more opportunities for people who are more informed consumers, who are choosing these plans every year, to understand what is and is not realistic. I mean, we have comatose patients in nursing homes being taken for dialysis two and three times a week because family members are either unwilling or unable to make decisions about the continuance of heroic life support. And many physicians have become more and more reluctant to offer their advice and opinion because there's malpractice or other kinds of concerns.

So we think moving on all of these fronts at once will help create an environment in which more sensible decisions are made, as opposed to coming up with some kind of rationing system on the front end. So that is more along the lines of what we are looking at right now.

We do believe, though, that there will be some procedures that, as we are more accustomed to outcome analysis, that we will probably determine are not in the best interest of either the patient or society -- you know, the pacemaker for the 95-year-old.

You know, some of these things eventually, we think, will have to be addressed, but we want to do it on the basis of a better informed citizenry, doctors and others being more comfortable within these networks of care to support one another and make better decisions on behalf of patients, and a sense that we know where we're going and what we're getting for the kind of choices that this would require be made.

So that is kind of the approach that we're taking.

SENATOR: I'm going to read off the number of names here in order so we'll kind of know where we are. Durenberger, Specter, Jeffords, Krueger, Pressler, Kohl, Reid. --

SENATOR: I apologize I'm going to have to leave about 9:00 a.m. We're part of the Office of Technology Assessment. We went through an elaborate process to pick a new OTA director, came up with one woman in the whole interviewing, and then she turned us

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down. So now we're going back to make a decision on the male applicants that are left.

SENATOR: (Inaudible.)

SENATOR: I wondered if you would help us understand the directions that you're thinking in terms of financing access for the elderly, in particular, particularly given the current state of federal-state relations, with which we're very, very familiar.

We know the problems of the growing number of the -- we know how much money is going into chronic care, chronic illnesses, probably (inaudible). We also know that more than half of this Medicaid money is going to the aid of the blind and disabled program.

If, in fact, you are going to recommend that we go to one comprehensive Medicare plan, which would rather than spelling out what's covered under A and what's covered under B and things like that, would you adopt the same philosophy of the comprehensive benefits for the elderly as you're contemplating for everybody else? When you do that in one plan, and then, as you pointed out, think about adding in some part of the long-term care to that, that would probably go a long way, if you can figure out how the government can pay the premiums, and it would go a long way towards stabilizing the elderly (inaudible).

That issue is, how do we deal with changes that occur in long-term care systems? And one of the ways would be to take the current long-term care money, much of which is in Medicaid, and some of which is in programs here, and entitled money and so forth, and capitate it (inaudible), as you had indicated earlier with the Wisconsin reference, that each of the states start experimenting with how best to use that.

Would you give us a little of your --

MRS. CLINTON: That's exactly what we're thinking of doing, and you said it more clearly than I. Because we now have examples of capitated managed care for the Medicaid disabled populations that are very (inaudible) or manage it.

Let's split the Medicaid population. Put the long-term disabled, both the -- under 65 and the over 65 in one category and then everyone else, primarily children -- families, in the other.

In this first category we believe we can not only save money, but better serve more people by moving Medicaid into this overall system. And, as I said, the early results from these

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capitated managed care programs for the Medicaid disabled and long-term are very, very promising.

We also believe that with the second category of Medicaid recipients, there is no rational explanation for why that population costs so much more than comparable populations. I mean, every breakout we do of costs, if you take an insured population that is largely children, and you try to control for wages and the like, and you take an uninsured and look at what their out-of-pocket expenses are and the like, the Medicaid population in this second category just costs us much more.

Now, we know that one of the reasons is that they seek the most expensive care, the emergency room access, example. Therefore, we think by moving these folks into a non-means tested, non-marginalized comprehensive care system, where they may be in the area covered by (inaudible) clinics, will save us money, will free up more money, therefore, not only to help cover more of the uncompensated, but enable us to stretch these dollars further.

So on both accounts, we think the capitated approach is going to work.

SENATOR: I compliment our chairman and our ranking members who organized this and thank you for coming. I want to raise the issue of timing, which I consider to be a central issue. I brought this up briefly at our meeting on Friday. And it is my thought that a high likelihood of success or failure will depend on when the Congress considers the health plan.

Early in the year we have less to do, but as we move towards September 30th, the appropriations process becomes overwhelming, and it is my hope that we will find a way somehow to bring it to the Congress at the earliest possible time.

When we talk about the specifics, there are going to be lots of views on the subject. We're going to have to wrestle with those. But I would just urge you as strongly as I can to do it as soon as you can, and I'd be interested in your thinking as to what that earliest date would be.

MRS. CLINTON: Well, Senator, we are still planning to finish our work this month, and we are hopeful that as soon as we have finished it -- and by finished it, I mean with the kind of continuing consultation with you and others so that we can make sure that what we present to the President is as well-informed as possible -- then I think at that point, you know, the President will move as quickly as he can to introduce this. And I think that that has always been the plan, and that remains the plan.

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Q So your expectation is to introduce it at the end of May.

MRS. CLINTON: Well, I don't know if the bill will be. Our work will be done in May, but I don't know whether we'll be able to actually to turn that work into a bill that the President will feel is appropriate and ready for him to introduce. But we will continue to finish our work on schedule, and the President will decide when that should be introduced as a bill.

What we're hoping, obviously, is that, to as great an extent as is possible, the bill is anticlimactic, that we will have a great deal of support for major parts. Obviously, there will be continue to be differences from regional and other perspectives that will have to be hammered out, but we're hoping that when the actual bill is introduced, that as many people as possible within the Senate will have a comfort level with it so that we can narrow the scope of argument, if you will, and that is one of the reasons why we're on the kind of time table we're on.

SENATOR: Thank you very much. I'm going to have to excuse myself. We're having our Republican task force meeting at the same time. It's about halfway through at the moment.

SENATOR: That's no excuse.

MRS. CLINTON: Thank you, Senator.

SENATOR: Jim wasn't invited to the Republican council.
--(Laughter.) -- We'll take him at our table.

Q But, you know, I agree with you that we need one single system eventually, and we'll have to find out how to shift all the costs (inaudible).

Also, we're spending, as you know, \$900 billion. My question is involved in, what is the additional cost of long-term health care? Or is that long-term health care being covered in the \$900 billion? In other words, do we have a lot of people that are lying around with no long-term health care?

And that shouldn't happen, because it seems to me if it is in that \$900 billion, that if we could find ways to unshift the cost, then you don't necessarily have to raise \$50 billion or whatever it is additional money for long-term health care. Can you give me any idea as to whether or not there's a lot of people out there that that cost (inaudible)?

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MRS. CLINTON: Senator, I'm not the expert on this, but based on what I have learned about this, I think the answer is a little bit of both.

I mean, I think that there are people who are in need of some service along the long-term care continuum that is not currently available to them for a variety of reasons. And I think that the acute end of long-term care, therefore, is to some extent overburdened because it's the only reimbursable steady course of care for most elderly people who need something, but it may not be that.

So I think that there is money to be saved in altering the priorities of the system and providing a greater continuum of services so that the elderly then are better able to get those services that are the least costly, the least restrictive, at the point in time when they require them.

So I think that if we look at it, we can see that better allocation of the money we're currently using now to build a capitated service point I believe will help us serve more people, both in acute care and we'll be allocating that in a continuum of care.

But I think that we are running against the clock, which is ticking and pushing more and more people into a position of need every year, as both our population ages, and as the aging live longer.

So that that's one of the reasons why we're looking at options like long-term care accounts and creating an insurance niche which would be available so that we can enhance the amount of resources that we currently are putting into the system, even though we think we'll be able to cover more people by reallocating them.

SENATOR: Thank you. I'd like to ask two questions, rather broad and general but -- One, I recognize that you've got in mind that (inaudible) whatever changes are made would be instituted gradually. But is there any thought or is it a plan as far as your proposal to come up with any specific plans and mechanisms for that? (Inaudible) The second is as we look increasingly in this - (inaudible) -- any special thoughts about what happens in rural areas, some of which already have lost their -- perhaps their only hospital -- (inaudible) -- fewer people. They have a hard time keeping hospitals open and (inaudible).

MRS. CLINTON: Senator, those are two important issues. With respect to the first, we are going to phase in, but we're going to do it as soon as we can and get to the point that Senator Specter made before he had to leave.

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The timing of it is important from a number of perspectives, but we believe the sooner we can reach universal access and stop the cost shifting and push people toward understanding that primary and preventive health care is good for them, and they have a system that provides access to it, the more likely we are to start saving real money soon. And that would be accompanied by a lot of the other reforms that we're talking about, like single form reimbursement, for example.

So that we think that the phase-in is a double-edged sword as well as a double opportunity for us. The faster we can do it, the more money we'll save sooner, and the more -- not that any of you would be interested in -- political benefit we would give to you and your constituents, because we'll be able to show real positive results.

You know, the faster this can begin, and we stop, for example, underwriting practices to eliminate people from insurance, you're going to be going around and actually meeting real people who, for the first time in years, have medical insurance. So those are the things we should be thinking about.

And we believe that the combination of moving toward universal coverage, the reforms that we're talking about will enable the system to a great extent to be self-financed. That is what we are trying to achieve in this.

Now, there is no doubt that there will need to be some amount of front-end money to jump-start this system and to get it going. It's going to cost money to design the practice guidelines for physicians. I mean, if we're moving our malpractice system in a direction of reform, you have to have practice guidelines so that you know what it is you're trying to achieve, and you have to spend money up front to get those developed. That's just one example.

But much of this, we think, is going to be self-financing, with the initial costs essentially being paid for by states.

With respect to rural health care, there is a variety of changes that we want to see happen as a result of this reform that will benefit greatly health care in rural areas. I told the Senate Human Resources Committee the other day that the more I thought about all this and worked on it, I'm actually more convinced that we will end up enhancing rural health care than I am convinced we will deal with the very difficult problems of the under-served, inner city populations. I think that is going to be harder to crack. I mean, we have so many layers of problems there.

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The problem in a rural area is, yes, poverty, but it's also access, which I think we can cure. So that, for example, increased use of technology -- you have an example in your state that I think would be a good one to hold up. There's a little hospital in West Texas called Big Bend at Alpine, which is now hooked in with interactive video with the Texas Tech Medical School, 300 miles away. It is so state-of-the-art that the doctors in Big Bend Hospital could hold an X-ray up, and the X-ray can be read and analyzed by specialists sitting around a conference table in Texas Tech.

Now, the front-end capital cost of that is not that significant. They use the existing phone lines. You know, there are a lot of costs to it that, if we can find a way of meeting, will greatly enhance rural health care, in addition providing more of a base of professionals in those areas, including physician assistants, nurse practitioners, et cetera.

And, thirdly, having rural areas be part of integrated delivery networks so that they are part of a seamless system, and they're not out there on their own. So we think give new missions to rural hospitals.

And when I was in Montana with Senator Burns, they have hospitals that formerly were shuttered reopen, being run by physician assistants, under a special provision of Montana law, primarily for emergency care.

So there's lots of creative ideas out there that I think are going to really benefit rural areas.

SENATOR PRESSLER: In terms of the cost of long-term care, let's say, Alzheimer's patients, where you to spend 10 to 15 years sometimes in a nursing home, presently in most states they have to pay down their assets in order to pay the costs of that, with the impoverishment of the spouse issue. Under your plan, those Alzheimer's patients, will they have free care, or will the costs be taken care of, or will there still be an obligation to the family to pay down?

MRS. CLINTON: They would still have to contribute, but their contribution will -- we are not going to meet that long-term care. We think that's been one of the real mistakes. But we are going to require contribution from individuals and families insofar as they are able to make that contribution.

And we are also then going to have a greater variety of services. So that, for example, Senator, in one hospital I visited, they opened an adult day care center in that neighborhood, and the

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individuals who were taking advantage of that were principally Alzheimer's patients in various stages of deterioration.

The adult day care center costs \$35 a day. For many of the working families, that was too much. They could have paid \$10 or \$20 a day, which would have been appropriate, but because they couldn't pay \$35 a day, they spent down their assets to put their relatives in a nursing home.

So we think that a non-need tested access to long-term care, moderate contribution on some kind of a sliding scale basis, and providing a broader range of services that cost different levels will enable us to avoid the situation that you described, which is the only way you can get any kind of help, really, to get yourself into poverty, lie about it, transfer assets, do all the stuff we're now doing.

SENATOR KOHL: Yes, Ms. Clinton, during the campaign and since the campaign, I note here the American people have been told time and again that we have by far the most expensive system in the world, and that's one of the primary reasons for going into this health care reform, is to bring our costs more in line with other societies that are providing comparable levels of health care. And selling it to the American people, in my opinion, will require a focus on that.

I am concerned, and I think many of us are concerned, about our ability to sell this to the American people if the first thing we tell them is that it's going to cost you more. And down the road at some point, we're going to be able to bring our health care costs back in line, but in order to get to there, first we have to go the other direction. That is a difficult sell.

I'm wondering whether or not you all have given the kind of time and attention necessary to that proposition and explaining it in a way which is believable and convincable to the American people. Because what I think I hear you saying, and what I've heard, is that we're going to have to spend more money first to get some other place later, and that is in connection, for example, with insuring the uninsured.

But there has to be something there that we all can go and sell to the American people, because the first question on the first day is, how much is this going to cost, and why? And I don't yet myself understand thoroughly enough how we explain that in a believable way.

MRS. CLINTON: Senator, we are absolutely convinced we can explain it in a believable way and are working very hard to be

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able to explain it in relation to individuals, not at a macro national way, but in a real, kind of bottom-up way.

Because under this proposal there will be some people who will immediately save money. There's absolutely no doubt about that. Individuals and businesses will immediately begin to see real savings.

Now, there are some people -- and, of course, you all know this -- who have been getting a free ride. I mean, you take any town in America, and you go to Senator Pryor's home town of Camden, you take two retail establishments next door to each other on the main street. One has been insuring its employees; the other next door has not. But the other next door has employees who still go to that hospital and still take advantage of the fact that his neighbor has been bearing an extra cost for not only the employees of that first store, but that store next door.

Now, there's no doubt that store next door is not going to be happy that they're going to have spend money they didn't have to spend before. But it is unfair for the first store, its employees and employers, to basically underwrite the costs of the next guy.

So that, you know, there is no doubt, there is a small group of people -- I mean, two-thirds of small businesses already insure to some extent their employees. We believe we can, in a very straightforward way, say to Americans, "This is not a free lunch. If you just stand here and do nothing, health care costs are going to go up \$100 billion to \$110 billion next year without you lifting a finger and without you being any more secure and without us taking care of one more person. Not only that, 100,000-plus Americans every month are losing their health insurance, and you may be in that group."

So the status quo is this picture. If you're happy with it, fine, that's your choice. But we think there's a better way, in which we insure everybody, make everybody pay something, because right now there are a lot of people who are getting a free ride.

You know, I read all this talk about all these uninsured people, and how they're always healthy 25-year-old's, and they don't want to insurance, so why are we thinking about them? Well, fine. The next time one of them is taken to the emergency room in a serious car accident, don't ask me to pay my proportionate of share.

So my whole attitude about this is that nobody wants to pay anything in this country for anything. They want everything to be given to them on a silver platter with no costs attached. And we've gotten to the point where it's not only an economic and

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political problem, but, to go out on a limb, I mean, it's a deep social problem that is at work here.

Because people don't know how much we're currently paying for health care. They don't know that they are paying for that hospital down the road, whether they put up a penny or not, in some way. And I think if we can clearly present and we can give you the kinds of, you know, strong arguments to be able to make to the American people, I think we're going to be able to convince a majority. Because the majority out there, in my view, is still responsible, understand what the program is about.

But is it going to be easy? No. And are there going to be a lot of irresponsible voices out there trying to tell people they can get something for nothing? You know it as well as I do. And are they going to be paying for 30-second television ads? Absolutely.

But, you know, there comes a point where if you're not going to take on an issue like this, which is not a static issue, but a deteriorating one, then what's the point of doing anything?

So, I mean, I think we can make that argument for you, and I will really welcome the chance to sit down and talk with you about it, because we are very conscious of how we present this, and the language we use, and the arguments we make are going to be key to the success of it.

MR. CHAIRMAN: Let me tell you where we are. We were going to originally adjourn our breakfast session at 9:15 a.m. we're going to extend that -- Mrs. Clinton's going to have a press availability. We have five questioners still remaining.

MRS. CLINTON: I'm not in any hurry for that.
(Laughter.)

MR. CHAIRMAN: You're going to go out there and get some of the same questions out there that you just got here. (Inaudible.)
(Laughter.)

SENATOR REID: Thank you, Mr. Chairman. I was going to ask a question along the lines of Alan Simpson's, I'm glad that we're going to stay on target with the timing. I think that's very important, that we don't let it slip until too much time goes by and (inaudible).

I would like to ask this question, I've never heard you respond to this. What about the Oregon plan? Something that I'm personally glad that the (Inaudible) by this administration. What do you personally think of it?

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MRS. CLINTON: I supported the Oregon plan. I have supported the Oregon plan for several years, ever since it first came out. But I supported it out of a sense of desperation, to be honest. I mean, that, you know, we had to try some different things.

The Oregon plan only covers the Medicaid population. So even if the Oregon plan is a great success, in however we define that, in saving money in the Medicaid account, that doesn't solve our problem.

It would have been a much more interesting experience if, when all the people were voting, they were not just voting on what care the poor were going to get, but what care they were going to get. And that wasn't what happened.

So I think part of what we are faced with is to see how states like Oregon and Wisconsin with some of their models, and Florida and the like can move forward and try to give states enough flexibility so where there are some good developments in both quality and cost control, our reform doesn't impede those, but enhances them.

But the Oregon plan, I think, it was a very interesting first try at dealing with the very hard issues that Senator Johnston was talking about, but it was basically about somebody else. You know, it was about the Medicaid population and what they should be entitled to out of tax money. And our biggest problem is what all the rest of us, who are insured and think we're entitled to live 150 years, want to be able to have access to.

SENATOR: Well, thank you, Mrs. Clinton, once again for meeting with us. I think the response to Herb Kohl's question should be inscribed and we should carry it around with us, because it really clearly laid out why we need to do this.

I think that you ought to really be continually commended for the work you're doing. I'm glad that our Republican leader and Republican colleagues are here. I think you all are doing what has to be done on this issue. I mean, you've met privately with Democrats, you've met privately with Republicans, you've met jointly with Democrats and Republicans in dealing with all of the committees.

This has to be a bipartisan issue, and there's enough political capital in this for everybody to say, "Look how good we are," and it has to be done in a bipartisan manner.

I think that what you all are doing in the consultation process is incredibly important, and it's going to make our job much easier when we have to sell this to the Congress and to our

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constituents. There was a great bit of evidence as to why it needs to be done. You just outlined it, I think, very eloquently.

I think that the point I would make is that we cannot make it a tax bill. I mean, this will not be a tax bill. We cannot allow the debate to be how much it's going to cost before people know what's in it. I'm so tired of having the reporters come to me and say, "How are you going to pay for this \$100 million health bill?" I say, "What health bill? You know what's in it?" "Well, it's \$100 billion." And everybody's focusing in on the costs, and nobody's really yet asking the good questions about what's in it for everybody.

I'm really convinced that when people start knowing what the substance of it is, and in English, not in Washingtonian language, that they're going to be much more receptive to being willing bear some costs, which ultimately will result in reductions for all of our people with regard to health care costs. I think if there is one issue that we ought to be (Inaudible) it's got to be health care. There may be different approaches, but I really hope that we can come together on something that will be (inaudible) for everybody (inaudible) process (inaudible.).

THE CHAIRMAN: I hope the process is not wearing you out also. (Inaudible)

SENATOR: I hope you'll appreciate (inaudible) heard long-term care (inaudible) and raising this every chance I can. And what I'm hearing is very encouraging. Just a couple of quick, quick points. There was some discussion earlier about getting the states the funds and letting them do what they want. I think that's right. I feel very strongly that that should be only to home and community-based care, not for institutional care. I don't want to vote for any new federal dollars for institutional care until we make a commitment (inaudible). I believe that's the way you're (inaudible).

MRS. CLINTON: Yes.

Q And the issue of timing, in terms of getting the long-term care, of course, going. I know that you want to get it going as fast as possible, let me just urge you that I think it can be done very quickly. And that we need (inaudible) -- just as an example, (inaudible), there are a lot of people who are (inaudible), elderly people who are then transferred to a nursing home because the available (inaudible) isn't there for community-based care (inaudible). With just a minimum of help, those people could be taken care of (inaudible), at much less cost.

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I think the savings would be very (inaudible). We've saved hundreds of millions of dollars for families in the last 10 years. (Inaudible) I'm just saying, let's phase in as quickly as possible.

MRS. CLINTON: I think that, you know, the Wisconsin model is the kind of model we're looking at. And there's a very important lesson in what you said, too, Senator, about not letting the money go for institutional care, but letting it go for home-based and intermediate. Because we have a real stark example of government policy that had such terrible unintended consequences if you look at the deinstitutionalization of the mentally ill. And the idea wasn't supposed to be a one-two process. We'd deinstitutionalize them, then we would have community-based opportunities for people that would substitute for the deinstitutionalization.

Well, we got the first half done, and now we're living with, you know, our homeless population as evidence that we didn't get the second half done. And I was talking with Senator Domenici the other day. You know, the problem of the seriously mentally ill homeless has gotten so difficult for us to even think about that because -- [Gap In Tape]

MR. CHAIRMAN: -- (In progress.) -- America's First Lady, Mrs. Clinton on the issue of health care, especially those issues that relate to older Americans and I can tell you it was a very constructive meeting, a very informative meeting. And I can certainly say that it had a nonpartisan flavor to the meeting. It was a splendid meeting and I am consistently awed at Mrs. Clinton's command of the issues, complex issues that are involved in health care reform and also the mission that we all have before us. If I might before Mrs. Clinton responds I would like to call on our Vice Chairman Senator Cohen.

SENATOR COHEN: Well, let me reiterate what Senator Pryor said. Number one, we certainly welcome Mrs. Clinton's agreement to come to the Hill as often as we request here to do so -- third occasion that I've attended, once in Senator Dole's office, once last week with the bipartisan meeting and again here today for the Aging Committee. And to echo what Senator Pryor has said, all of us are deeply impressed with the intelligence and the commitment that Mrs. Clinton brings to this effort.

I was asked a question recently by one of the national networks (inaudible) mistake --for the President to have appointed Mrs. Clinton to head up this task force and my answer was absolutely not. He couldn't have picked a more capable individual to make this kind of study. She has a period of two or three months to focus on a laser on this issue and she's as well informed as any member of the

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Senate or House of the complexities of the issues that we are (inaudible) So I am hopeful that as we try to work with Mrs. Clinton and her task force we can come up with a proposal that a majority can rally behind. There will be differences of opinion and approaches, my hope is that we can try to resolve those differences in the best possible spirit.

I want to thank both Senators Pryor and Cohen and all of the members of the committee. The stakes in this health care reform are high for all Americans, but they are particularly high for older Americans. And it's very encouraging for me to work with members of this committee who are particularly knowledgeable about the problems of aging and the need for prescription drugs support for our elderly, but particularly for long-term care. And long-term care that includes home-based care and intermediate community-based care in addition to nursing home care.

I have never understood how we made the decision in our country to put all of our older citizens in the position that the only kind of help they could get would come only after they were impoverished, and would include only institutionalized nursing home care, when for most older Americans what they want is an opportunity to stay independent and self-sufficient for as long as possible.

And what this committee has worked on and what our health care reform plan will propose are ways of enhancing opportunities for that to happen. We want more older Americans to be able in dignity and with respect to stay in their own homes; where that is not possible, to stay in a less restrictive, less institutionalized setting than a nursing home. It is not only good for them, it is also a much more cost-effective way of providing appropriate care.

So we had a very interesting, informative and useful conversation this morning.

Q Mrs. Clinton, when do you expect your task force report to be ready?

MRS. CLINTON: We intend to be ready this month, as we always have planned.

Q Is it possible that your husband will wait until mid-June to -- (inaudible) -- unveil it?

MRS. CLINTON: Well, what we are trying to do is to get the work of the task force done. That's our first priority. And this is very complex work. It is something that Senator Cohen had

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said and many senators have been working on and studying for a number of years. We want to get it right. And then when we turn over our recommendations to the President, the President will obviously want to do whatever he believes is necessary to prepare a bill that will get the most support so that it becomes a nonpartisan American issue, which is what we're aiming for.

But we intend to move as quickly as we possibly can, given the complexity of this matter and the many, many people we want to be sure are consulted adequately before we actually present a bill to the American people and the Congress.

Q Well, around the country are we going to see incremental -- (inaudible) -- or are we going to see --

MRS. CLINTON: You're going to see a commitment to a long-term care system for this country, and it will begin with as much of the change in the way we allocate funding and how we provide alternatives to nursing homes as we are able to implement. We are looking particularly at some of the models in some of the states that have gone ahead, far beyond where the federal government had gone, and are trying to learn from them how quickly realistically we can implement an adequate home-based and community-based system.

So we're trying to move as quickly as we can but do so in a way that actually gets the job done. And that's what we're attempting.

MR. CHAIRMAN: One more question.

Q Will there be more -- (inaudible) -- next year --

MRS. CLINTON: We have to get started and we have to see how it works, and we have to gauge any problems and try to correct those. We have an aging population. We are behind the curb on that problem right now. What we need to do is to get out ahead of that. Several of the senators spoke very eloquently about the problems in their own communities. But Senator Graham said that the population just in Florida alone of people over 85 will double in the next years, between now and the year 2000.

So you're going to get a -- we're going to get a good start on long-term care that will lay the base. And we think that then we will have a much better idea of what else might need to be done. But at this point, we've got a commitment to the American people, particularly to older Americans, to start getting this system fixed, because they're not getting what they need out of it and it's costing too much money to give them what we're giving. We can do a

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much better job and save money at the same time. And that's what we intend to do. (Applause.)

CHAIRMAN PRYOR: If I might -- I think that's all the questions -- just a little bit of trivia, a little educational background for some of the media who might not be in tune with this fact. It was ten years ago in Arkansas that then Governor Clinton named Mrs. Clinton to chair the educational task force. The cartoonists and radio show hosts had a field day, politicians said, well there's no way in this lose-lose situation that this is going to be a plus. But six months after Governor Clinton named Mrs. Clinton to chair this task force she spoke to the Arkansas General Assembly, House and Senate, one hour, no notes and got the longest sustained standing ovation ever accorded anyone to speak before the Arkansas Legislature. I think when she unveils this plan and when the President joins her in doing it, I think, too that we are going to as a country and certainly as a Congress give them a long-standing ovation for attempting to cure a problem that is a crisis in America. Mrs. Clinton, thank you. (Applause.)

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