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First Lady's Remarks to
Health Care Reporters

MS. CLINTON: I think it would be useful to spend just a few minutes for me to describe where I think we are and what the fundamental issues are and will be as we move forward in the debate.

I want to start by stressing that the president has stressed and what all of us who are promoting this plan have stressed repeatedly in the last several weeks, because I don't think it can be said too often and its implications are sometimes overlooked or understated, and that is that the bottom line for any health care reform that he will sign is universal coverage with comprehensive benefits.

The reason that I restate that and want to begin my comments today talking about it is that I think that there has been a lack of understanding among some people as to what we mean by that and what the implications of our commitment to that are.

Some people try to use the words "access" and "coverage" interchangeably. They are not. There's access now for anybody with the money to obtain coverage, but we're talking about coverage, not access. We are also talking about coverage including comprehensive benefits, not bare bones benefits, and benefits that are affordable for all Americans without the kind of barriers to care or usage that are often constructed now through high deductibles, high copays, high premiums, barriers that include preexisting conditions, and the like.

In order to get to universal coverage with comprehensive benefits, there are a number of issues that have to be addressed, some of which can turn out different ways than what the president has proposed as long as they actually achieve universal coverage with comprehensive benefits.

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Everything in this debate is not equal. I mean, the debate over how the alliances are constructed, or their size, or how they collect the money they collect is not on the same plane as whether or not we achieve universal coverage with comprehensive benefits.

I think that's important because a number of the alternatives that have been put forward, whether in proposal or a bill form, don't meet this fundamental test as far as we're concerned. The only ones that have as a goal to achieve universal coverage are the single payer proposals, the Chafee proposal, and the president's. The Graham, or Cooper, or Michel, or (inaudible) proposals, or any other that I'm aware of, don't even have as a stated goal the achievement of universal coverage, and do not, as a matter of design, move in a direction that could be fairly construed as achieving universal coverage within any reasonable or even possible period of time.

So, as far as we're concerned, therefore, in the absence of both a commitment and a structure for achieving universal coverage, there really cannot be any comparison of the president's plan with those that do not meet that threshold.

I think that the other piece of this which is important is that concerning comprehensive benefits because, again, the description of the benefits and the actuarial pricing of the benefits is a precondition for determining what kind of system you're going to have, how much it will cost, and what the financing mechanism has to be.

In all that, the single payer system, which describes generally what the benefits should be, you don't even get to that level of specificity. The other proposals leave the benefits package to be determined at a later date by a board to be appointed. It's very hard to know how you would create a system that is rooted in accurate, adequate financing if you don't know what the benefits package is. For some of the proposals, it goes even a step further, which results in some confusion in our minds as we try to analyze and work with the sponsors. For example, in the Cooper proposal you've got a national board which sets benefits which is then keyed to an actuarial value which insurance companies can then alter so long as they stay within the actuarial value.

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So when we come to look at these various proposals, we are going into a level of analysis and scrutiny that we would obviously make available to the press and to anyone else interested in these issues. I think it's a very important distinction to draw between premiums that are specified in price so you know what you're buying and the American public knows what it is getting, and benefits that are either unspecified, unpriced, or even when later priced can be changed by insurance companies within the language of the legislation.

So if we look at where we are now, from our perspective, other than the single payer bill there is no other bill. Senator Chafee's proposal is the basis of our comparison. But at least the Chafee single payer and the administration bill moves us in the direction that we think has to be achieved.

Now, why is that so important? Just let me just say a few words about that. We don't see any way to accomplish the cost savings that have to be achieved through the forum in the absence of universal coverage without benefits that are comprehensive and priced. There isn't any way that we can think of, if you do the arithmetic or the projections, that you can achieve the savings that have to be achieved in order for this system to operate more efficiently in the absence of universal coverage and a premium structure with benefits that you can assign some actuarial value to.

You cannot stop cost shifting. You cannot deal with the deficit. You cannot do the whole list of additional issues that need to be addressed through health care reform without doing those two. So it goes for the human reasons that we want everyone covered and we want to do it in a fair way and divide quality care and affordable price, but also for the economic reasons that many of you know so well. In the absence of a commitment to universal coverage, you can't get there on the economic side either.

The second thing I would say in general is that we are working very hard to disseminate information about this plan, this book, which I hope you all get a copy of in the brochure. Obviously part of that -- because we want people to know everything there is to know as accurately as we can communicate it about what we're doing and how we've reached the decisions that we've reached, because we think the more people know about the president's proposal, the more they

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like it. We've seen lots of evidence of that in the last couple of weeks.

So with those sort of introductory comments, I'd be happy to answer your questions. I don't know how many we can get in in an hour, but we ought to try to have some sort of internal agreement that not one person ask all the questions. I'm not going to try to referee you. You'll have to do that yourself.

Q Since the opposition, a lot of the opposition in your proposal tends to focus on the extent to which the federal government and state government would increase their regulations in the health care industry, could you explain why you've come to believe that the government, in fact, would do a better job in making the decisions than private interests that make them now could do it?

MS. CLINTON: Well, I think that that characterization, which I've certainly heard, is just off the mark. You know, there's a lot of government regulation in the health care business right now where they were talking about the regulations governing medicare or medicaid, or the fact that it was a federal government piece of legislation that created HMOs and that still largely regulates them, or whether we're talking about state government where, through their insurance departments, at least try to keep tabs over the cost of premiums that insurance companies charge.

I think there's an enormous amount of government regulation. I happen to think it's often the wrong kind, that it is micromanagement and overly concerned about details as opposed to setting the ground rules and then getting out of the way.

That's really what we are proposing in this plan, is that you would have much less government regulation than we currently have. You would eliminate a lot of the micromanagement that has driven up costs without any discernable increase in coverage or quality.

Through the creation of alliances, you would have an opportunity to peak on a much more effective basis to get the best possible insurance price. But the federal government is not going to be supervising these decisions that are going to be made at the state, local, and regional level.

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The alliances are going to be taking any qualified plan. They are not going to be making decisions among these plans as to who can or cannot offer their services. So I think if you were to really take a list of what we are eliminating with respect to government regulation and compare it to what we think is the kind of basic framework for the guarantee of health coverage for every American that we are establishing, I really don't think you could make the case that we have more.

We have a different type of framework for both the federal and the state governments to operate within. We have delegated a lot of the authority to the states and have worked very hard to limit the powers of any alliance to serve in any way other than a kind of purchasing cooperative, which is the original idea behind managed competition.

Q Ms. Clinton, last year Senator Moynihan and others raised the issue of raising the tax on gun ammunition. Are you seriously working at that? If so, how are we going to see that?

MS. CLINTON: Well, we think there's enough money in the proposal that we have proposed, and I still think there is some misunderstanding among the public about how this is funded. Too often we see people saying well, my gosh, only a tobacco tax. That's not enough money, overlooking the fact we're going to be asking everybody to contribute to their health care for a change so that every employer and employee will be making their contribution. So we don't think you need any more income revenue from any taxes.

But as Secretary Bensen said, you know, we're going to consider Senator Moynihan's proposal seriously, whether it's with respect to health care or some kind of law enforcement program to try to diminish violence. I think that will have to be looked at if the administration moves forward with it.

Q Mrs. Clinton, (inaudible). You talked about the link between health care crisis and violence in America. Obviously you're focused on health care right now totally. But at the same time, are you considering taking on this issue of violence and crime in America as a full-time effort, a major effort, after health care?

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MS. CLINTON: Well, I hope that we have health care passed by the summer of 1994, which is next year. I also hope by then we will have a crime bill worthy of its name, which is what the administration is working on now. We will have the beginnings of seeing more police on the streets and alternative punishment centers like boot camps and more drug treatment so that we will have, I hope, the beginning of a good law enforcement structure.

I hope by next summer we will have the Brady bill. We will have a bill banning assault weapons. We will have a bill trying to control the use of guns among teenagers so that we will have some additional legislation that will strengthen the hand of the additional police that we're going to be putting on the street.

I intend to continue to speak out about it and do whatever I can because I think it is one of those issues that I have described as kind of part of the security triangle that I've spoken about and that the president has talked about in speeches with economic and health and personal security. So I feel very strongly about it.

If there's a specific role when we finish the work we need to do on health care, and I can't really predict when that is because once we have the legislation, there will be a lot to do to make sure that it's implemented right, in the right way. But I'll continue to speak out, you know, now and into the future.

Q Are there plans for a national crime summit coming up this year?

MS. CLINTON: I don't have any idea.

Q Mrs. Clinton, when you talk about universal coverage, and you talk about the safety bill, and the (inaudible), you invariably talk about all the drawbacks (inaudible). Do you see or have you thought about what the possibilities for (inaudible)?

MS. CLINTON: Well, I think you've got it exactly right. I mean, I think this conversation should take place among the single payor advocates, the Chafee position, and the president's position because they are the only ones that recognize the importance of achieving universal coverage.

I'm sure that the conversations that we have had

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with Senator Chafee and his staff and the staffs of other Republican senators, as well as the members themselves, will continue to develop because there are a lot of, you know, great ideas that need to be explored on both sides and ideas that need to be analyzed.

I mean, part of what we have to begin doing in cooperation with Senator Chafee and others is to really put some analysis behind their ideas so that we know exactly what their assumptions are economically and with respect to behavior.

For example, we have worried that an individual mandate in the absence of any employer responsibility would leave an untold number of employers to do one of two things, either shed employees they currently ensure, which would be a tragedy for those employees as well as an economic challenge to the plan that they would have in effect, because the second thing they might do would be to keep wage levels below whatever the federal subsidy level might be.

Now we have not had time yet and we, as I said, look forward to doing this, to really get into the level of analysis that we need to be. The one thing that I can tell you about this plan that the president has presented is that it has been analyzed endlessly by nearly anyone you can imagine. We have literally millions of pieces of data to back up everything that is in the plan. We have run as big a projection as we can on each individual piece of the plan.

We will have to do that to the same extent as we consider any attempt to meld approaches. We don't have any set view on that, but we're obviously pleased to be working with people who believe as we do of the destination of universal coverage and the test is how we get there.

Q Just a follow up on that to try and get some (inaudible). The president (inaudible) repeatedly (inaudible) but that everything else is negotiable. Many people (inaudible) hip bone (inaudible). Could you give us specific examples of something either that is nature that you call (inaudible) change or that you see as a kind of (inaudible) where there might be some substantial numbers?

MS. CLINTON: I wouldn't if I could, and why would I do that? Let me give you an example. The question about bureaucracy and regulation that was inherent in, you know, why are you adding more government, obviously you don't think

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we are adding more government. But if there is a cleaner, simpler way to achieve the goal of enhanced bargaining power so that individuals, and small businesses, and medium-sized businesses, for that matter, have the same kind of clout in the marketplace as the largest employers are beginning to have, we're open to that.

I mean, you know, that's not to us something written in stone. We have a lot of guarantees, we believe, in the plan for ensuring quality. If somebody has additional or better ideas, we're open to that. I mean, the principles that the president set forth, you know, security, and savings, and simplicity, and quality, and choice, and responsibility have to be met. But how we do that, you know, we're open to discussion with people.

Q (Inaudible)

MS. CLINTON: I mean, I don't know. I mean, obviously we want to have the kind of conversation that will enable us to do so. Let me go back to what I was just saying. It's not enough for somebody to come to us and say we've got a better idea. We have to say great, sounds good, let's run the numbers, let's see what, you know, the best minds think about it, let's try to figure out how it would work in practice, you know. So that's the nature of the kind of substantive discussions that we're going to have to be having.

But I think we absolutely mean what we said. If there is a way of getting financing that is sure and stable and adequate other than the employer/employee contribution, but is politically palatable to the majority in the Congress and to the country, you know, we're open to that.

But the thing that I don't want people to misunderstand is that by our being open and willing to explore new ideas, debit being number one, we will agree with them. I mean, that is, you know, not at all the same. But number two, if we do wait and we make some changes in the proposal that comes through the legislative process, we will only do so if we believe that they will not jeopardize the fundamental commitment, the universal coverage, and comprehensive benefits as soon as possible.

I began to get a little bit of a flavor in the last week or two. People said, well, if everything is negotiable,

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then what do they really believe? Well, getting the universal coverage is no easy matter. There are only three ways to get there if you're going to finance it. You're either going to have a big tax increase and replace the private sector investment, or you're going to figure out how to make the individual mandate work without the possible or slippery slope effects of decreasing employer contribution, or you're going to build on what we've got, which is the employer/employee system.

I don't think anybody would argue that any one of those is better or easier than any one of the other. It's just that given where we are and looking at what works for most people, we believe the best approach is the employer/employee. So getting to universal coverage is not a pure ordained conclusion. If we don't get there, then we don't have health care reform, in our view.

Q Can you envision, for instance, giving ground on a percentage that employers would have to pay from dropping the 80 percent down to a figure lower?

MS. CLINTON: If somebody can come up with a way to do it that is fair and doesn't penalize either employers who provide more or put too much of a burden on employees and can keep the subsidy scheme workable -- when I say I'm open to it, I absolutely am.

Part of the reason we ended up with the percentage that we have is that we know we have to subsidize a number of small businesses and individuals in order to achieve universal coverage within the employer/employee system. If somebody wants to change that percentage, then if they have to put more money into the federal subsidy pool, they're going to have to tell us where that money comes from.

So sure, we're open to all these things if they are workable and if they achieve our goals without sacrificing any individual element that is necessary for universal coverage.

Q Did you ever imagine the scenario under which the alliances would not be mandatory?

MS. CLINTON: You know, I'm sure there are scenarios I can't imagine. I'm open to anything that will work that would get us to where we need to go.

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Q That's a possibility?

MS. CLINTON: I don't know. I mean, I can't answer that blankly because I can't answer it in general. There's a lot of folks out there floating around saying they had, you know, nonmandatory alliances. The problem with nonmandatory alliances is you've got to assure you've got community rating. You've got to assure you've got adequate bargaining power. You've got to assure that everybody is in one, whether they are nonmandatory or some kind of alternative bargaining unit. So there are a lot of conditions that have to be met before I could answer a general question like that.

Q You said that the more people know about the plan the more they support it. There are polls that show support slipping from the president's speech from the 23 of September of yours scheduled for next week. Since then, it's come way back down to earth. Are you concerned about all the attention in the past week about how many people would be losers under this plan?

MS. CLINTON: No, because when I say that more people know, I don't mean just an open-ended question like, "Have you heard about the president's plan? Do you oppose it or support it?" I mean that if you go into focus groups polling, as some people are now beginning to do, or even if you go into town meetings and you have somebody well enough informed who understands the plan, once -- even if somebody says they are opposed and you start to ask them questions and you start to go into details, support rises again.

So, you know, this debate is just beginning. The only people who have been advertising it are people opposed who set forth, you know, basically misleading information about the plan. There's not been an opportunity to have a concerted public education campaign, as there will be. But every time that we have looked at any forum in which accurate information is conveyed, the more people know, the more they like it.

We're in a shakedown period. I mean, this is going to be a long process, hopefully culminating this summer. But, you know, in politics, 24 hours is a lifetime. So we've got a couple of months of getting this information out, and getting people familiar with it, and getting them to understand the questions to ask. I think, you know, to take the 70-30 number, I think you have a winner. I mean, once

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that becomes well known to people -- I mean it just removes all kinds of fears.

Once they realize the 30 percent consists of people who basically have catastrophic insurance that's not worth the paper it's written on, and young people who haven't paid their fair share, it goes off the charts. So, I mean, it's just a question of slowly and steadily and persistently getting information out to people, letting them see for themselves. Then, every time we have done that, we have seen, you know, support grow, and I anticipate the same kind of outcome.

Q Mrs. Clinton, are you also able to negotiate on the range of benefits that are included? A lot of people are expecting mental health benefits and have to drop from their plans -- too expensive -- and other benefits that might have to be rolled back? Is that something that's --

MS. CLINTON: Well, I think it's going to be very difficult. You know, there's a lot of talk around without looking at the numbers or without seeing the actuarial work that has gone into the creation of the benefits package. The mental health benefits that are in there now are reasonably priced and we think totally credible. They are not all the folks who are advocates on behalf of mental health would have wished for, but they make a very good statement of support for mental health benefits and establish a base that we then can build on.

I think a lot of people are making statements or really hypothesizing about the benefits without knowing all the work that went into creating the actuarial underpinnings for them. So I think that mental health should be a covered benefit. I think the way it's being presented in the plan will be sustained as we move toward, you know, a resolution. There will be some who will want to take it out and there will be some who will want to add it in.

I think the burden should rest on both of those people. I mean, those who want to take it out should tell us how we're going to take care of these particular illnesses which not only have health cost consequences but, you know, homelessness, crime, et cetera. Those who want to add are going to have to tell us where the money is going to come from.

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So I think once we get engaged in the real analysis of the legislation, the burden which we have basically borne, which is we answer all your questions, you have all the articles about us, we're compared to basically, you know, some, as yet, undeveloped alternative, the more people are going to see how much work has gone into establishing this plan, and then the burden will shift to them. If they want to come with an alternative, they're going to have to come with their facts and figures and everything else to support it.

Q How far away do you feel like you are from Congressman Cooper on the universal coverage? He seems to think that prior to an insurance market reform you could get virtual, virtual, universal coverage and there would be very little (inaudible). Do you buy that or do you think, looking at his plan, that you really are (inaudible)?

MS. CLINTON: Well, you know, I think that -- I don't know anyone who has looked at his plan who has really studied it from the perspective of achieving universal coverage who believes it achieves universal coverage. That's said for several reasons.

First of all, the insurance market reforms, there's no indication it achieves universal coverage. Even under the CBO analysis of the version last year, which is not so different from the one this year, would leave, you know, many millions of people uninsured. What would we get for our money, because the deficit would continue to go up? So, I mean, I don't understand the cost benefit ratio in that kind of approach.

The second thing is that without specifying the benefits in the package and leaving that to a national board, it's very hard to know what the price would be. So how can we determine what would be affordable for people because there's no pricing that has been applied to benefits as yet undetermined.

Thirdly, as I said initially, under the legislation as I read it, after the national board sets the benefits and assigns an actuarial value, insurance companies are permitted to alter the benefits within the package so long as they correspond to the actuarial value. So if the national, you know, benefits set by this national board -- which I think having all the benefits sets by a national board can be very

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difficult for the American people to accept. They're going to vote for health care reform and not know what they get in return. He adds an extra layer of uncertainty if insurance companies are then free to say well, as long as we stay with the package that costs --

(End of side one of tape one.)

MS. CLINTON: -- is that unless you buy the lowest cost plan in your region, you don't get any tax benefits. If that lowest cost plan is a plan that has been altered by the insurance companies but has maintained the actuarial value so you have to buy that plan whether or not it has benefits in it that you as a family or an individual might need, otherwise anything above it you will be taxed on, I don't see how you do that to a vast majority of Americans today who are insured and think that what they want is some control over the costs not the range of benefits. I don't know.

There's a lot about it on the universal coverage side of it and the pricing side of it that we don't agree with. There are other things that obviously we do agree with, you know. The whole concept of purchasing co-ops and the whole concept of competition and using the market, you know, are things we all agree with. But in the absence of universal coverage, I don't see how you get there.

Q You've tried several times today and previously to get to the (inaudible) coalition to be developed between what is (inaudible) motivate this whole universal coverage. But it's also possible that another coalition could coalesce around some other principles (inaudible) Chafee and Senator (inaudible) and Cooper and some of the other plans, that they should get together and (inaudible). Do you have any commitment at this point (inaudible) from your cosponsors that they also believe that universal coverage (inaudible) bottom line?

MS. CLINTON: I've been at several public forums with Senators Chafee and Kasselbaum and Dole and Danforth in which they all claim that that is their objective. You know, I have no reason to doubt them whatsoever. I think that Senator Chafee has studied this issue for a very long time. I think he is committed to universal coverage. I have no reason to doubt that he is.

Q Do you feel that you're not concerned about the

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prospect that they might at some point decide (inaudible)?

MS. CLINTON: Not unless the other plans can make a more credible case for achieving universal coverage. You know, there's a big difference between insurance market reforms that don't achieve universal coverage and a commitment to an individual mandate that will achieve universal coverage. That is a huge leak.

You know, that is why when I talk about those plans that are in the same ballpark as the president's, the Chafee plan is there in terms of its stated commitment to universal coverage and its willingness to have a mechanism to achieve it.

You know, the individual mandate is a mechanism for achieving universal coverage. That is very different than insurance market reforms with no real design for helping people make sure they're covered once those reforms are in effect.

Q Getting back to your (inaudible) the president's plan. Originally, the task force (inaudible) the plan called it (inaudible). It seems that (inaudible) is gone, that there are other types of cost controls in the plan that have been, I think, described in (inaudible).

Could you please confirm that there is no (inaudible) in the president's plan and explain (inaudible) that could or could not (inaudible) health care? (Inaudible) what is the negotiating end (inaudible)?

MS. CLINTON: There is no global budget. The guaranteed benefits package will serve as the baseline for determining what premium increases should be permitted, which is not so different, if you think about it, between what large purchasers of insurance do now and what state insurance commissioners do when insurance companies come in and ask for increases.

I mean, I've been sort of surprised by the kind of stir that the insurance companies have raised about this when every day in every state they are in appearing before insurance commissioners to get increases in their rates. That's what they do. Nobody thinks that's out of the ordinary.

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Where it hasn't worked is because you have 50 states with, you know, hundreds and thousands of insurance companies. There hasn't been any capacity for comparing apples to apples because if insurance company X offers 10 policies with different benefits sold to different kinds of businesses and insurance Y offers 20 policies with different benefits sold to, you know, as many different businesses as individuals that they can market to, there's no way for the insurance commissioner sitting in any state to make those determinations.

They have to go on the kind of grossest of measurements so that, you know, you've got a situation like Empire in New York and, you know, the insurance commissioner doesn't know how to even evaluate whether what is being told to them is accurate or not. When you have a comprehensive benefits package, which is the same benefits for everybody in the country, which has an actuarial value assigned on the average which then can go up or down in comparison to the base that has been established, depending upon the region of the country where you are, you have a much better and clearer way of determining what is a fair, reasonable increase in premiums. That is all we are talking about.

I mean, they try to make it sound like there is some great big apparatus out there that is going to be, you know, making all of these determinations. Well, what we are attempting to do is to rationalize what goes on now in 50 states when insurance commissioners make these kinds of determinations but can't do it because there's no way of having a baseline that exists on which they can make those judgments.

Now, if a particular health plan is bidding for the business of the people in a particular region, just as what happens now when Calpers (phonetic) goes out for bids, when the state employees in Minnesota are put out for bids, when the federal employment planners goes out for bids, or when your employers go out for bids, we will all know what we are asking that be bid upon because we will have this set of benefits.

There will be some historical experience that can be looked to. Most regions of the country and most health plans will not have any trouble living within whatever the backstop budget happens to be because there is so much money in the system right now, and don't forget, we are going

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to be adding money to it. Under this plan, we go from 13 percent of GDP to 17 percent of GDP within 5 to 6 years because you've got billions of dollars flowing into the system for new payers.

So that, you know, I don't think that these horror stories that are trying to be created are in any way fair. Yes, it is true, but we are going to try to have some budgetary discipline imposed upon insurance pricing practices when it comes to premiums for the guaranteed benefits package. There will still be an insurance market for everything over and above the comprehensive benefits package because we don't have a global budget.

There will be, I would imagine, a growing market for long term care insurance because although we're going to try to fund the infrastructure for long term care, there's no way we can meet what will be the increasing need of an elderly population.

So there's going to be a lot of insurance markets left that will be basically back into the same bailiwick of comparative pricing that we now look to states to try to achieve on their own. We're only talking about the comprehensive benefits package.

Q (Inaudible) of business and the reliance (inaudible) and the alliance (inaudible). They have the power over the employees to deny that increase?

MS. CLINTON: Yes. They have the authority to say why is it that of all the health plans in this region, you're the only one who can't stay within a reasonable rate of increase? Maybe you all need to take a harder look at how you're doing business. We think that's very appropriate. That's what is done with, you know, insurance departments making judgments about insurance prices all the time.

There are a variety of tools available to any health plan. You know, we're not going to ordain what they do, but there are a number of things that have nothing to do with delivering the benefits or guaranteeing quality because the benefits have to be delivered. If they cannot deliver the benefits, then they will have to be others who will fill that void. We expect that to happen. That's what competition is about.

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For example, if you go into regions of the country now where the cost of medical care is three times or two times what it is in some other region -- compare Miami to San Francisco. They are both metropolitan areas. They both have concentrations of high cost health care patients. Yet, the medicare costs in Miami are two times what they are in San Francisco. That says to those of us who look at this data Miami needs to get more efficient.

Now we're not going to come in and say immediately to Miami you've got to charge what San Francisco charges. We know there are regional differences, but over time we need to get to a more uniform national standard of what it should cost to take care of somebody in all parts of our country.

There is no justifiable validation for the disparities in costs that have to do with matters unrelated to medical care like practice styles, for example, or, you know, just as a custom that in some communities if you have, you know, a temperature above a certain degree, you go into the hospital or whatever, when in other communities you're taken perfectly good care of with antibiotics at home.

So those are some of the issues that the health plans and the insurers are going to have to look at more carefully than they have in the past.

Q Mrs. Clinton, do you think health care reform needs to address the question of medical care that's given in the very last stages of life when there's no hope that a person can pull through, basically just keeping somebody alive? Along those lines, how do you feel about living wills? Do you have one yourself?

MS. CLINTON: We are going to sign a living will. We're looking for an opportunity actually to do it and then to talk about it publicly. We're not going to sign it in front of you guys, but, you know, we're going to talk about it. Yes, we really do believe in that. We're trying to encourage advance directives in living wills because we think they're important.

See, I think that we will be able to start having the kinds of conversations we need to have about such issues once everybody has health security. It's hard for me -- I mean, I am very torn about this because anyone who has looked at it can see that there are expenditures that are made in situations where it is perhaps inappropriate and is not --

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it's only prolonging the inevitable. Everybody knows that who has looked at these figures.

But on the other hand, there's another figure which just haunts me which is that an uninsured person who shows up at the hospital with the same ailment as an insured person is three times more likely to die. I don't know how you can start talking about making hard decisions until everybody has health security and until everybody is covered.

I mean, universal coverage is not just to take care of all of us and to do it in a way that is responsive to our needs. It's not just for economic purposes and to get the deficit down. There's a moral imperative in universal coverage.

I mean, we should not have a country as rich as ours with the high quality medicine that is available to some but not all and that none of us is secure until all of us is secure. There's not one person in this room who, in good conscience, can say you will have the same health insurance at the same price next year.

Until everybody is in the system, to have a conversation about who we will make judgments about strikes me as inappropriate because who is most likely to be the subject of our judgment? Those the least powerless, those, you know, ones that don't have access now, those who are uninsured and walk through our doors, those who have no family that show up and advocate for them.

But once we have health security for everybody and once we have advance directives and living wills being talked about and understood for what they are, which is to try to provide this kind of guidance, then I think we will begin to have the kind of conversation you allude to.

Q If I could just follow up: If you could just explain why you and, I take it, the president will sign living wills (inaudible). What are your reasons?

MS. CLINTON: Because I think that it is the fairest and most responsible action to take on behalf of those who are going to be put in a position of being asked hard questions when a loved one is in a comatose situation, unable to speak or act for him or herself.

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I mean, you know, many of the situations I know about -- oftentimes it's agonizing for family members who are brought together because of a tragic accident or the last stages of a painful illness to know what they're supposed to do. Nobody likes talking about death. But if we do it in the context of providing guidance to help those who are left behind make the right decisions, the decisions that you would want made, it becomes an easier conversation to have.

I think it is really what we need to be doing as a nation. You know, we have this miraculous medical technology but we need now to put it into a moral and ethical and personal context so that when it happens to all of us, as it will at some point, we have some thinking about it that will help guide our decision.

Q Mrs. Clinton, (inaudible) plan has somehow proved to ability to pay income (inaudible) individual level. Why not (inaudible)?

MS. CLINTON: Well, we are doing something with Part B premiums with respect to, you know, some of the benefits that are currently in medicare. In fact, we think that that's appropriate. But I just guess I fundamentally disagree that universal health care coverage should be means tested. I think that it ought to be key to ability to pay, which is why we provide subsidies and discounts; I mean, if you want to call that means testing.

I guess you could because clearly, you know, for those who are low-wage employers and employees, we are trying to make this affordable so they can participate and contribute, and the same with people who are currently medicaid eligible. When they go into the universal system under that plan, if they work, they will contribute. We believe in having people pay their fair share.

Q You said that about younger people (inaudible) very wealthy medicare recipients who are not paying what others (inaudible) which is more than what they pay for their health care.

MS. CLINTON: But we're moving in that direction. The budget plan of last year began to increase cost in medicare for high end recipients, and the health plan does too. So I mean, we're moving in that direction. But I mean, I think you've got to recognize that there's a difference

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between trying to achieve community rating, which means that you no longer discriminate against people, which is what we have done under our existing insurance system.

The discrimination has run against the older and the sick to the benefit of the young. I think that to have insurance mean what insurance is supposed to mean in a private system, what this will, you know, largely remain, then you've got to end the discrimination.

So I don't know that as we're attempting to achieve community rating we want, in the universal system for those under 65, to start introducing new ways of making it possible to discriminate against certain members of the population. We want to get back to the old-fashioned idea of insurance which is everybody is in the community pool.

We want to end cherry picking. We want to end experience rating. We want to end lifetime limit. We want to end elimination or limitation of coverage for preexisting conditions. If you reintroduce categories that are going to be charged more based on all kinds of other factors, we're going to be right back down that slippery slope, in my view. Now, we know that rich people are going to probably buy more health care, just like they always have.

But if we've got a good floor below which nobody falls, then I think we are secure in believing that we at least have universal coverage with comprehensive benefits for everybody. And then if some person wants to have 10 plastic surgeries a year, there's no local budget or other kind of limitation on their capacity to spend their money as they choose.

Q (Inaudible)

MS. CLINTON: I think there might be some room for discussing the second but not the first. This idea that you can postpone universal coverage is troubling to me because part of the reason why we want to achieve universal coverage is to begin to control costs in the public sector. And one of the great dangers we currently face is this idea that somehow you can cap the entitlements or you can have a balanced budget amendment that will only be balanced on the backs of health care and that means on the backs of medicaid and medicare, and expect to achieve universal coverage through that route. You can't do it. You can't even achieve

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real health care reform.

What you can do is to begin increasing the downward pressure on the public program which will throw more people under the uninsured list, which will do nothing to control the cost in the private sector, which will lead to an explosion in the deficit unless we just decide we're not going to take care of people on medicaid anymore or that we're not going to try to meet our obligations under medicare.

So I think this is all of a piece. I mean, until we get universal coverage, we don't have real budgetary discipline in the federal budget. We don't have the kind of control over expenditures in state and local budgets, and we don't have the kind of focus on making our health care system more efficient than we need in order to get the whole system under better control.

But with respect to the rate of growth of premiums in the future, depending upon what the negotiations during the legislative process look like, that might be something to consider. I mean, I have said repeatedly that we think it's important to start with a tough target because if we don't, we will never get there.

And if you looked at the history of health care in this country and the amount of money that has been spent, which has very little relation to either extending coverage adequately or providing benefits, we can keep spending more and more money for less and less of what we should be buying with that money. So I think you've got to have tough budgetary targets.

But we've worked with a number of economists who have asked us to consider different rates of growth after we get the savings out of the system in the out years, and, you know, we're open to that. That's something that -- but I think everybody has to know the implications of what the impact on the deficit and the like is.

It's imperative that if we're going to look at budgetary targets, that we understand how you've got to do all of this as a whole. You cannot decrease the rate of growth in medicaid and medicare, wait for the savings to kick in, and then expect to get caught up in achieving universal coverage. So we believe all this has to be done at the same

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time in order to achieve what everybody claims are their stated goals.

Q Mrs. Clinton, do you think (inaudible) the disinformation and misinformation out there from the insurance industries?

MS. CLINTON: Oh, heavens no, but I expect we've caused them to spend a whole lot more money than they were going to spend. It's interesting to me, you know, if they've got all that money to spend on these misleading ads, I find it hard to understand how badly they're going to be hurt by changes in the insurance market.

Q (Inaudible) tone seems to vary from the tone of "come let us work together" some weeks to a more critical tone explicitly for the size of the insurance industry and pharmaceutical companies. Does that have a conscious strategy or is that just sort of what you happened to notice somebody saying (inaudible)?

MS. CLINTON: Well, I think it's more about how I assess what's going on from week to week. I mean, we absolutely mean that we intend to work with everybody, and there's a lot of division among all of these groups. I mean, I saw the press release that the Alliance for Managed Competition put out dumping on the HIAA last week. They don't agree with them.

I mean, I just think it's important to point out these differences and to make distinctions. And I think when somebody puts on \$6.5 million of advertising and it goes unanswered, that's a mistake.

Q (Inaudible)

MS. CLINTON: I don't know because if you go back and read the book which they put out, and I wish you would, called "A Mandate for Change," their chapter on health care reform says you have to reach universal coverage. So you'll have to ask them.

Q Are you disappointed in them?

MS. CLINTON: No, I'm not disappointed in them. I just think that if you go back and read what they wrote as the blueprint for their position on health care, we think

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we're right there. So I don't know quite how they got off on this track that they're on, and we hope to have some conversations with them in the next couple of days, maybe, to figure it out. But, you know, maybe they just haven't gone back and read their own book lately.

Q Mrs. Clinton, you've talked (inaudible). I'm wondering if you have (inaudible). I'm wondering if (inaudible) when your father was ill a few months ago, right before (inaudible). Did you ever invite him to go over the hospital bills and just say what would have fit under my (inaudible) benefits package and what would I have missed? Could you maybe give us your reflections on that? What was covered for him and what not?

MS. CLINTON: My father was on medicare and we're not changing the medicare system.

Q Was there any other supplementary insurances?

MS. CLINTON: Yes, they had supplemental insurance and it was mostly covered.

Q (Inaudible)

MS. CLINTON: Sure.

Q (Inaudible) government regulations?

MS. CLINTON: We'd be glad to. We'll put that together.

Q (Inaudible) is making the assumption that people's behavior will change so they'll go and get their check-ups and their annual (inaudible) mammogram (inaudible) illness or that they'll start going to the doctors, to the emergency room.

How do you know people are actually going to do that? People get really (inaudible) in their ways in dealing with the medical (inaudible). Is there any way to predict that this will really actually happen?

MS. CLINTON: Absolutely. There's a lot of evidence of it. I mean, I saw that with my own eyes. Just a few weeks ago, I went up to the south Bronx where they are running a managed medicaid system and talked with patients.

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Put yourself in the position of a medicaid recipient in the south Bronx, the poorest congressional district in America. You're told here is your medicaid card, go get your health care.

Now there are a lot of providers who won't honor medicaid cards. You've got transportation problems. You've got language problems maybe. So you end up at the emergency room of the Lincoln Hospital, which was the sort of funnel for everybody who was poor, which was much of the population.

They put in a managed care medicaid system. Everybody was told they had a doctor. They were given a 24-hour telephone number to call. They were actually given more visits than they could have afforded to have if they had gone on a fee-per-service kind of personal journey of their own. In talking to these recipients, what struck me was that for the first time, their medical care was being structured for them.

It's very difficult. I mean, it's hard for any of us sometimes to know where we're supposed to go to get what kind of care we might need or who's a good doctor if you move to a new town. For the first time, the people I talked with felt confident that their medical needs were going to be taken care of. The way that the care was being managed, they were actually getting more services than were available if they were just out there on their own.

My mother told me, you know, her daughter got sick in the middle of the night and she had a number to call. She was very proud. She pulled out her card and she said, "I can call this number. My doctor is always there." She called this doctor and he walked her through what the problems were. In the past, she would have just grabbed the baby, gone to the emergency room and waited a couple of hours and then, you know, would have gotten whatever care she got at a cost less than what was really the going rate for emergency care.

There's many examples like that all over the country. So I think if you've got the comprehensive benefits, if they are well publicized, as they will be, if people know what they're available, if many of the preventive services that we are most concerned about people getting will be free, as they are under this plan, utilization on the front end of health care will go up and on the back end should start going down. I think that there's a lot of evidence to support that.

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Q (Inaudible)

MS. CLINTON: Well, like the bills that have -- you know, like the bill in Colorado and some other places that's introducing such a bill.

Q Is that something that you would advocate?

MS. CLINTON: It's something I personally advocate, yes.

Q What about (inaudible)?

MS. CLINTON: I think we have to look at a whole range of proposals that are being actually considered and legislated in the states, and try to see what might be appropriate at the national level.

Q Ms. Clinton, one of the concerns of Children's Hospital, (inaudible), the same hospital, in fact, and (inaudible) of your plan (inaudible) providers (inaudible) birth defect situations (inaudible). Is there any rule for flexibility on that end that may be given from (inaudible)?

MS. CLINTON: I'm surprised you say that. I spoke to the pediatricians last week. We've had constant conversation with the Academy of Pediatrics and with the National Association of Children's Hospitals, and I'm not aware of those concerns. I'll have to look into them.

Q The same hospital (inaudible) will be here tomorrow complaining -- well, not complaining, raising questions about the plan and where they feel that they might have some trouble on this.

MS. CLINTON: I'll be glad to listen to their concerns. They didn't raise those with me.

Q I think you were talking about comparisons of medicare costs between San Francisco and Miami, that there shouldn't be any difference between them. Isn't it a fact that the large Miami population of the elderly who are responsible in large measure for a large medicare?

MS. CLINTON: No, because if you compare medicare costs, which is what we've done, then you're taking care of the elderly. There's no -- it's not just Miami and San

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Francisco; it's Boston and New Haven that -- you know, you could take these differences all over the country. Walter Zelman (phonetic), who is here, who has been one of the --

(End of side two of tape one.)

MS. CLINTON: -- makes this point. It basically says that some areas -- and he's a health economist at Princeton who has looked at all this data. He says there's no justification for the difference in costs in most of these regions. Yet, the medicare system, what it has done is to build in the inefficiencies. I mean, if it costs X this year and your costs keep going up, you get X-plus. But if your costs go down because you become more efficient, you get penalized.

So there has been no incentive in the existing medicare system to make the changes that would make the delivery system more effective. So we'll get you that piece because I have never quite seen it presented so clearly the way that he did.

Walter, did you want to add anything?

Q I think costs vary by nature of the population. They vary by costs of inflation in different areas. You were talking about things that are otherwise constant. The same kinds of things will cost -- the same procedures will cost much more -- the same procedures will be done three or four times (inaudible) move in one area versus another (inaudible).

MS. CLINTON: Somebody who hasn't asked a question because we're getting near the end of our time. I don't want people to be left out. Yes?

Q Mrs. Clinton, the purpose (inaudible). Yet, there has been discussion in the past of the fact that medicare is (inaudible) certain other segments that are not immediately (inaudible) sobriety (inaudible). I also wonder about supplemental insurance. You talked about allowing people to or allowing systems to compensate for benefits that cannot be provided (inaudible) through supplemental plans. Aren't you opening a door for another level of complexity (inaudible) decreasing costs, cost shared benefits? As you know, the medicare system's real (inaudible) supplemental costs (inaudible).

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MS. CLINTON: We think that's happening. I mean, the states are getting a much better handle on it. You know, that's beginning to sort of shake itself out. With this comprehensive benefits package, there will be very few needs that will be unmet.

To go back to your question, I can't think of anything that is not going to be covered except the obvious things that are left out like, you know, cosmetic surgery and, you know, maybe some extensive mental health benefits, adult dental, adult vision. Those are things that if individuals wish to buy in the open market, they're not huge expenditures on an individual basis. So we really don't see that that's going to in any way undermine the basic budgetary integrity of the comprehensive package. We've looked at that.

With respect to the supplemental market or the elderly, that's becoming better regulated and will continue to be better regulated to weed out the unscrupulous and to make sure that what people are buying is what they're getting. So I think that that -- we've looked at that. I think we've got that -- we have confidence that that will work out all right.

Q About 40 years ago on the same (inaudible) were able to see (inaudible) by presenting a lot of money and basically presenting the negative (inaudible). That seems to be (inaudible) now. One alternative that you haven't discussed is not doing something. In that respect, (inaudible). How do you get the public to focus on the positive (inaudible)?

MS. CLINTON: Well, I think that's what we're engaged in right now. We're obviously disseminating this information as broadly as possible. We're raising the level of awareness on the part of individuals. I have no doubt that the forces of the status quo will dig in their heels and do everything they can while praising the potential of reform, trying to undermine it ever being enacted.

But I think that there's going to be much more pressure for it and there's much more insecurity now because the costs are affecting everybody. I mean, this is a debate about everybody's health security, not just about a particular group or class of people. As that message really sinks in on people, I think it's going to be apparent where

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their self-interest lies.

If the forces are weighed against the form, you know, want a real batter in which their self-interest is exposed and their real agenda is made public, they'll get it because I think there's a lot at stake. We're going to make sure that people are as informed as possible.

Q Mrs. Clinton, I just wanted to clarify something, getting back to the living will. I'm just curious about something. You didn't actually say what you would specify as your wishes. I just wanted to ask you that.

MS. CLINTON: Well, I don't know yet. I'm not sure I'll ever tell you that. I'll just tell you that I've done it. I don't know that that's the kind of thing I would publicly talk about.

Q Okay, thank you.

Q Are you expecting to have to fight the doctors at some point in this? You took on the insurance industries, the pharmaceutical industry in the spring. You took after the insurers. Now are you going to have to come out hard against the doctors?

MS. CLINTON: I don't think so. I don't think so. I mean, if you looked at the major physician groups that are already supporting us, by and large, I mean the pediatricians, and the family physicians, and the general practice, and the general interns, and the OB-GYNs, and a lot of the other groups that have signed up and said that they are, you know, largely supportive of what we are doing, and they might have a particular issue or two that they would like to see changed, but, you know, they are generally in agreement.

If you even look at the issues that we've narrowed down with the AMAs, I don't think there's any reason to take on physicians or any of the other health care professionals. They all deal in universal coverage. Most of them -- in fact, I can't think of one that doesn't support the employer/employee mandate.

On the big issues, the difficult political issues they're there. They might have a wrinkle on what they think should be emphasized in a particular way, but, you know,

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that's the kind of issue we're willing to work with them on. So I don't have any problem with that.

Q (inaudible)

MS. CLINTON: Absolutely.

Q (Inaudible)

MS. CLINTON: I don't know. I might take a long trip to New Zealand. I think that this is so important. Unless the president asks me to do something else, it's what I'm going to work on. I can't think of anything more important or more rewarding to work on.

I feel like to some extent I have committed myself to all of the literally thousands of people that I have met and talked to who have shared their personal stories with me. I have their pictures running through my head all the time, and I don't think I could back out on them.

I think that they expect that the president will be able to change this system and that all of us will be better off when we do. I agree with that. So I'm going to work as hard as I can to make it happen.

Thank you all. See you all later.

* * * * *

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