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001. paper	Health Care Briefing with the First Lady and Editors-in-Chief, Women's Magazines; RE: private info [partial] (8 pages)	05/24/1994	P6/b(6)
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Women's Magazine Editors

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May 24, 1994

HEALTH CARE BRIEFING WITH THE FIRST LADY
AND
EDITORS-IN-CHIEF, WOMEN'S MAGAZINES
NEW YORK CITY

MRS. CLINTON: -- health care reform because not only have we mostly been under-served by the medical system in the past, but we make most of the decisions.

And part of what I want to see happen is that health benefits for women are enhanced and women are empowered to take advantage of those benefits. And they feel more of a sense of ownership over their health.

So part of what we are trying to do is to lay out some checklists about what we should look for. And this first one is obviously a checklist.

Then there is a little, short memo about what kinds of issues are particularly important for women, and how we can assess the debate as it moves through Congress to determine whether or not women are getting what they need.

Then there is a little memo we put together about questions and answers that are really some of the questions that people ask, and how we try to answer them. Because there is a lot of misinformation out there.

And then we've got the five biggest lies, because we find that they have taken on a life of their own. And we just wanted you to have that information.

And then just some backup facts which most of you I know probably have already talked about and have in your magazines.

Then there is an interesting little article that is at the very end, by a woman who writes about what will happen if we don't reform health care. Because I honestly believe, and I think there is a lot of support for this belief, that the worst choice we could make is to do nothing.

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Because if we do nothing, the system that serves most of us very well, leaves out many people, but still has quality and has what we need when we are in dire straits, will be under continuing pressure. And lots of trends are going in the wrong direction when we look at what is likely to happen in the future.

And then there is just some additional information in here that may be of benefit to you and your writers as you follow this.

But the important thing, particularly for me personally -- and I would guess for all of you, and particularly for your readers -- is these two issues that I alluded to. How do we change the system to be more woman friendly, which it has not been.

And then how do we help women take more responsibility and control over their own health care situations.

The articles that you publish every month are really in many ways the most effective way of conveying those two points.

I was stunned when I started this work, 15 months or so ago when I first started looking at everything, to realize how disadvantaged women had been. Everything from learning to my total astonishment that the first breast cancer clinical trials were done on men.

I read it over and over again, and I started calling people. I said, you know, this has got to be a joke. You stuck something in my briefing that just is so absurd. And it was true.

To the kind of short shrift that women's health concerns, until very recently, have been given in both the clinical arena as well as the research arena.

I have a woman doctor, a woman internist. She is a very matter-of-fact person and not prone to exaggeration at all. So after I took on this assignment, I was in for my annual checkup. And I asked her if she minded if I asked her something. And she said, "Well, no, of course not. What is it?"

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And I said, "I really want you to just level with me. As a woman physician, do you feel that women patients are given the same kind of treatment and consideration by the whole system as male patients?"

And she said, "No. And I see it every single day with my own patients the way that I have to fight to get them treatments, the way I have to fight to get a specialist to take them seriously." She said, "I see it every single day." Since I trust my doctor, I consider that great validation as a part of my own personal fact-finding.

But it's not any individual's responsibility. It is the way the system has been designed and driven decisions up until now.

The five things we want to see enacted -- and we have lots of room for dealing with the details -- is, we want universal coverage. If we do not have universal coverage, and we mean universal coverage, not something which calls itself that, the people who will most likely be left out are women and children. They will be left to fall between the cracks of the existing systems which are the private insurance systems, workplace based and the government programs.

One of your key points, I think, is to watch universal coverage, how it's defined, and whether it will really cover women. As part of that, what is the benefits package going to be? Is it going to be gender neutral, in which case women lose?

Because if it doesn't do things like cover mammograms and PAP smears and prenatal care and well-child care, then we still have the system skewed. Because those are the kinds of problems that are women's problems.

And other problems like heart disease and cancer, which are serious, and cut across both genders, have to be dealt with. But we have to understand that if we don't have better preventive care for women, we don't get ahead of the curve on their health concerns.

The second thing is we have to change the insurance system. If we don't get rid of preexisting conditions as an exclusion to health care, we are going to find ourselves right back where we start from no matter what other changes

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we make.

Again, preexisting conditions fall disproportionately heavily on women. Not just because women themselves have such condition, but because women are the primary caretakers of people with such conditions. Children born with congenital problems, husbands who lose their jobs and have a disease that they can't get covered for. It is the women who then bear the responsibility, largely, to keep it all together.

Third thing is we've got to make sure we preserve the choice of doctor. Most doctors are chosen by women. It is the mothers and wives who drive medical decisions. I don't think I ever talk to my husband about what pediatrician I was going to take Chelsea to. You talk to other mothers. You find out who they think is a good choice. And that's who you end up going to unless you are related to one.

And the same with your husbands. Usually it's -- if their family is anything like mine, it's you urging your husband to go get an exam, and go see somebody he knows, and get something taken care of.

Women make the decisions. And we want to put that choice in the hands of consumers which will be predominantly a choice made by women.

And the fourth point I would make is Medicare needs to be preserved and strengthened. Medicare has a much heavier case load of women, because we live longer, than of men. As Medicare has been under cost pressures, and services have been cut back, and some physicians now won't even take Medicare, that is falling disproportionately on women.

I am now starting to hear from hospitals and doctors who are seeing women, who are Medicare eligible, in emergency rooms because nobody else will see them.

Going along with preserving Medicare, we need to get support for prescription drugs. Another problem that is -- again, because we live longer -- one that is peculiarly hard for us.

But then the other thing is we need to begin to have a sensible long-term care system. Not only for older Americans, but for disabled Americans.

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Because what happens now is -- I see it all the time, I assume you see it, and you certainly hear about it from readers -- families aren't free to make the choice to keep their relative at home because they don't get any support for it. Unless they can afford it themselves, they have to look for an institution oftentimes.

We need more options. We need to support home health care. We need to support community-base care. And we need to support respite care. Again, an issue that's predominantly a women's issue.

I have now talked to countless women who are caring for children with severe disabilities and for spouses with Alzheimers and with other kinds of chronic conditions. They are not asking for a lot of help. But they are asking for a little bit of help so that they can keep doing what they are doing. I think this is going to be an issue that is just on the age curve.

I don't think you all can write enough about long-term care, and about the cost to women, and about the choices women are confronting. And it's particularly tough for those of us in the sandwich generation who are seeing our parents age and become ill and still caring and worried about our children.

And then the final point is how we finance it. That's what the big battle in Congress is about right now. We think we ought to guarantee health benefits at work, and we ought to do it in a way that is fair to small business and provide subsidies.

But if we don't do it at work, then you will see what is happening where we have an increasing number of uninsured working Americans, most of whom are women. And most of those are single mothers or women who have other responsibilities.

There was a little article in the New York Times by Bob Herbert, the last day or so, talking about women who are on the edge of welfare, who are trying to work, who can't get health benefits.

So we put women in this position of saying to them, we want you to work, we want you to take responsibility, but go take a job where you're not going to get any health

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benefits.

Whereas they go to work, they get money taken out of their paycheck to pay for Medicare, which is a government-funded program, and they get money taken out of their paycheck to pay for welfare mothers to have health benefits they don't get themselves.

So there are about 20 to 25 million women and their children in that category of people who are getting up every day, going to work, and being disadvantaged because they don't have health benefits.

So those are some of the ways these big issues impact, from our perspective, more on women. And I just wanted to kind of lay that out, and then to have a chance to answer any questions or hear from all of you about how you see this issue and what you think we should do.

Q I thought it would be great to go (inaudible) yourself and find out --

(Tape interruption.)

Q Would you just really simplify the health care plan, what is it that we need to work for.

MRS. CLINTON: I sure will. I think what we need is a federal law that says everybody is entitled to have health insurance at their workplace, if they are working, under the following formula:

The formula will differ. if you work for a Fortune 500 company, it might be a little different than if you work for a mom and pop grocer. But the basic principle is everybody gets insured through their workplace.

If you are not working, then we provide subsidy for you like we do now with people who aren't working. But we will actually spend less on that because more people will be insured in part through their workplace.

And people who are self-employed, who can't afford insurance now, will get the same tax benefits as people who have companies. So if you are a self-employed painter, you get 100 percent tax deductibility. So everybody gets insured through their workplace.

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Then, what you do, the money gets pooled together into what we would argue would be purchasing co-ops like buyers clubs, discount clubs. And then insurance companies have to come, and doctors' groups have to come and say here is the health plan we would like to sell you. You make the choice.

That's exactly what happens now with the Federal Government. The way the Federal Government gives health insurance to my husband and to members of Congress, is, the Federal Government as the employer, contributes 75 percent. Federal employees contribute 25 percent.

Then the Federal Government doesn't tell you who your doctor is. They don't tell you what health plan to have. They go out into the marketplace and they say, okay, Blue Cross, do you want to try to get the business of President and Mrs. Clinton? Okay, Hospital X, you send your plan in.

Every year you sit down and you look at all the plans and you make your choice. Your employer doesn't make it. You make it.

So this year my husband and I sign up for one of the Blue Cross plans. Our 25 percent of the cost goes in, and the Federal Government pays the rest. There are private doctors, private hospitals. It's an insurance policy.

But because there are nine million federal employees, we get great rates. I mean, if you have had friends who work for the Federal Government, they have told you for years you get better coverage, you get more services, and you get lower cost. Because when you are buying for nine million you can drive a harder bargain than if you are buying for five or 50.

If you are buying in New York, you are part of some big purchasing co-op, and you are buying for two or three or four million or seven million, you get lower rates.

That's really how we see the system working. So it keeps the same doctors, same hospitals, same kinds of arrangements that you are used to. But we finance it in a smarter way to get more dollars. We take the insurance companies out as the middle men.

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We tell the insurance companies they can't layer on all the administrative costs, so they are going to have to get their prices down. And we start being able to have the same health care but for less money. That's really the bottom line. It's like the federal plan that now exists for federal employees.

Does that make sense?

Q Yes. I mean, for everybody, then. Not just --

MRS. CLINTON: Yes, right.

Q Can you help me with how much it is going to cost extra?

MRS. CLINTON: If you are well insured, it should not cost extra. You should get the same or better benefits for the same or less money.

Q And why would it cost the government extra to provide this?

MRS. CLINTON: It shouldn't cost that much extra. It should cost, we think, somewhere between 15 and 30 billion to get the system started. If the 40 million who are uninsured all pay something, you've got billions of dollars going into the system that aren't there now.

If you've got everybody in the system, then, what happens now with people left out of the system or being under-insured, is when you go to the hospital they charge you more because they pad your bill to pay for the woman who came in after you, who has no insurance, or whose insurance has a \$5,000 deductible.

So you will no longer have to be paying what amounts to a surcharge for the uninsured because they are going to be paying something for themselves. And the government is no longer going to have to be spending billions of dollars on Medicaid because we are going to do away with Medicaid.

A lot of people, who are eligible for Medicaid, work, but don't make enough money to afford insurance. So they are going to have to be paying something. We are going to do away with Medicaid. And we get everybody into the same

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health system, but everybody has different choices. You still choose your doctors, et cetera.

For me, what is really important about this kind of change, in terms of cost to the Federal Government, is the Federal Government now makes up the difference. We pay all this money to hospitals that have a lot of charity care.

When everybody is paying, the Federal Government doesn't have to pay that much. So the money it would have paid to hospitals, goes instead to subsidize poor people to pay for their insurance. Because our basic idea is everybody should pay something.

Maybe they can only pay \$100 a month, or \$50 a month, or \$20 a month. But they should pay something. They should not think the medical system is a total free ride. So that's where the money comes from.

Q One of the biggest concerns people talk to me about is the choice issue. That seems to be a perception.

What do you think was most instrumental in that developing of perception of that? And what simple language can you use to help people understand that they will have a choice?

MRS. CLINTON: I think the most -- probably the most effective device were the Harry and Louise ads, I think. Because they were very well done. And for, I guess two months, they talked about how the Clintons were going to take away your choice of doctor.

And then they were supplemented by a much harder, much more right-wing message that is on the radio now, and maybe you have seen, about how we are going to socialize medicine. And a picture of a mother with her child who is sick, and you call a number, and they say "The government doctor is out. Call back tomorrow." Really hard-edged, scary stuff.

And I don't know if you have seen any of the direct-mail campaign that have gone on. But they are frightening. It's funny because I've gotten to know about it because of older women who have written to me and said, "Please explain this to me."

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These letters come to them in very official-looking brown envelopes, and there have been literally millions mailed. And it says, "This is government property. Do not tamper." Women open it up because they think it's like their Social Security form or something like that.

And then it says in big, "The Clintons are trying to take away your doctor. They are trying to make you go to a government doctor. They are trying to make you stand in long lines. They are trying to prevent you from having your health care."

So there's been a very pervasive campaign. Some of it very visible like the TV ads. Some of it more like a stealth campaign.

Part of what we've tried to do is to keep saying over and over again it's not true, and to have others write back.

But once there is a bill in Congress and you can actually see that it's not true, then we are going to have a much bigger campaign to point out that these people were misleading and scaring people.

Actually, if you go back and read the coverage -- and maybe some of your magazines did articles. The ones that are old enough did articles on Social Security, and it did articles on Medicare. The debate leading up to Social Security and Medicare use the same language. Because I have gone back and read the news articles.

Socialism. The AMA fought Medicare for a long time. The head of the AMA hired Madison Square Garden and had a big campaign about how this was going to end medicine as you knew it.

So a lot of the arguments have been the same arguments. And we just have to recognize that and be prepared to take it on. But I think the time will be more when there is an actual bill that people can read. It's a little hard talking about abstract. Because we say one thing, and somebody else says something else.

Q As the revenues get driven down through the cooperative buying, and theoretically some of the revenues increase for (inaudible) hospitals, and even some charity

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patients who now actually have dollars behind their visits, I know one of the things that the hospitals remain concerned about, the teaching hospitals, is that the overhead cost of the medical school education do not seem to be able to be met.

So that when you talk about the cost of a type of health care -- I am mentioning for Helen -- she is picking up not just the cost of the charity patient, but the cost of training the medical student. And the internists who will not be taking in Medicare, or don't want to take too many of them, is because the revenue, the reimbursements, aren't covering their costs.

So what I have seen happen, long before anything is getting through Congress, the health care program (inaudible) is changing here. The insurance companies have gone more in groups. Sometimes you can change your doctor, sometimes you can't, because your doctor is in a particular group that your company has suggested that they are going to join.

But there is an enormous battle now brewing between the major hospitals and the major medical schools. And they are fighting for territory, and they are killing each other.

MRS. CLINTON: Right.

Q I am wondering what -- since the administration has been fostering medical research and medical education as well, how are they going to negotiate this?

MRS. CLINTON: I am really glad you ask that because what you have just point out is what is kind of going on under the surface. We haven't passed a bill, we have no reform. And I am very worried about what's happening to our medical system. This is one of the reasons why my husband wanted to try to stop these trends.

If we are not careful, our major medical schools, which are the real guts of our training and research program in this country, are really going to be in financial peril because they rely very much on Medicare. Because Medicare is the way the Federal Government supports training positions. That's where the money comes from.

They do 50 percent of the charity care in this country because usually people are taken to emergency room of

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a major trauma center that's usually associated with the teaching hospital, all that.

And a lot of the big hospital chains, the big for-profit chains, are trying to buy up little hospitals and doctor practices and basically corner the market, and not take charity care, and not do teaching responsibilities.

Here's how we think we need to combat that. If you have universal coverage, as you said, you put our teaching hospitals on a stronger ground. We don't think Medicare should be the only source of payments to our teaching hospitals. We do think all of us should bear part of that responsibility.

And part of what we propose in health reform is for what's called an all-payer account so that when I pay for my insurance there is a bit of a surcharge on there, and it goes to research, and it goes to academic training. Because if we don't have good research and academic training, the whole system down the road is not going to be effective.

We also think it's imperative that individuals get the choice of who they go to, and that doctors get the choice of who they join the practice with.

And you might have seen in the New York Times today a very interesting article about the AMA taking on the big insurance companies.

And I share -- because I have said to the AMA, and I have said to the major doctors' groups over and over again, "We are not your enemy. Your enemy, if there is an enemy, are the big insurance companies that are basically trying to turn you all into employees." They want doctors punching the clock. I think the AMA has finally figured that out. At least this article seems to suggest that.

If we can get the money into the teaching hospitals, if we can get the choice of provider and the provider's choice into the law, so that insurance companies and large for-profit chains can't control doctors, then I think we've got a good chance of stopping the trends that you just described. Otherwise I am very concerned about it.

I think we could see four or five major for-profit hospital chains monopolizing most of the health care in this

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country in five to seven years if we don't have a reform system. Because they are just gobbling up hospitals and shutting them down.

Q But before this conversation of health care chain started, why does it all, must it all totally be changed? Is there not a base that remains there and start to tinker with or change? Why does it have to be an overall change?

MRS. CLINTON: Actually, the change we are proposing is not that dramatic. It's a federal framework. And really the only things that would be different, if we got what we wanted, was every American to be guaranteed health care, which would actually increase business for doctors and hospitals. Because you would now have people going in for preventive care and doing things they couldn't afford to do otherwise. And you would get your benefits at work.

What will change is not how we deliver health care, but how we finance health care. And that's where I think the change needs to be. I have said over and over again, we have the finest doctors and the finest hospitals in the world. But we have the stupidest financing system in the world. And it's stupid on nearly every level.

It's stupid on the level of the individual doctor's office. Most doctors now are spending, if they are in private practice, between 40 and 50 percent of their income on overhead. And this overhead that is not in large measure related to patient care.

It is hiring more bookkeepers and clerical help and people to call up insurance companies to fight with them about whether they can get a test or get reimbursed.

We will actually be freeing up billions of dollars that could be used for that doctor to hire another nurse or to hire another doctor.

Hospitals in the last ten years have hired four bookkeepers for every doctor they have been able to put on staff. If we eliminate all that, then doctors and nurses can go back to doing what they were trained to do, taking care of patients instead of what they now do, which is filling out forms that have nothing to do with health care; that have to do with how we finance health care.

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One of our big lies, we think, is the way that the opponents of health care try to paint this as this huge sweeping change. Because we are trying to change them. I'll be very honest with you, I don't want insurance companies making money by going down this row and saying, all right, you have to pay this amount.

But you once had this disease, so you've got to pay double that. And we are not going to insure you at all. And you, who are paying for it, have to pay for the time they spent deciding that neither Lyn or Susan could get insurance at the same rate you did.

That's how insurance companies make their money, by eliminating us from coverage and by making it harder and harder for us to get health care. And they are interfering with doctors, and they are undermining hospital financial well-being. That's really where the opposition is coming from. Because we want to change how we finance it.

Does that make sense?

Q It makes sense sort of. But the only thing I would like to ask is why are doctors so concerned, then? They feel that they are about to lose their relationship and their connection, really, to the patient. And that an incredible bureaucracy -- we were hearing this morning at home -- incredible bureaucracy is going to be layered. You used the word "layered" before. It's not a layering.

MRS. CLINTON: I think for the same reason I -- Helen's husband is also a doctor. For the same reason that Helen pointed out.

First of all, what's happening to doctors right now is that they are losing their autonomy. They are being pushed further and further into an employee status by insurance companies that they pay their bills and all of that. So that's caused a lot of discomfort.

Change has not been their friend the way they view it. They feel like they are kind of being pushed further and further against the wall.

So along we come, and we say, look, we want to change the health care system. They hear "change," then they hear a very well organized attack on what we are proposing

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which oftentimes doesn't bear any relationship to what we have said.

But if I am talking to a doctor who has only heard what somebody has told him about what we are proposing, but who already knows that the changes he is living with have not been all that good for him and his patients, that raises a lot of anxiety. I understand that completely.

And all I can do is to keep trying to talk to as many doctors and doctors' groups as possible. Because when we have sessions like this, they say, "Well, that's not what I thought you meant. People didn't tell us that. I saw this TV program, and somebody said it was going to be this big bureaucracy."

I ask doctors who are concerned: "How much money do you think the insurance companies that pay your bills through the health system now, what percentage of their income is spent on administrative cost as opposed to paying you for your services or other health care services?"

Doctors guess 10 percent, 15 percent. It's between 20 and 26 percent. That's how much the insurance overhead is.

So then I ask doctors, "How much have you increased your costs in the last ten years to deal with insurance overhead?" I have yet to talk to somebody who hasn't said, "Look, I am raising it all the time." And I say, "Do you think this is a good trend?" And they say, "No, I hate it."

I said, "Well, what we are trying to do is to eliminate all of that. We are trying to eliminate the paperwork, we are trying to eliminate the bureaucracy that already exists. We are trying to give you the freedom to go back to practicing medicine without calling up somebody and saying, 'Can I do this?'"

And I'll just end with this one story. This one doctor was having this conversation there. He said, "I'm going to tell you what I don't want to have happen. I was in my office a few weeks ago and" -- this is what he said. He said, "I have this girl who works for me. She was arguing with an insurance company person about whether or not I could get reimbursed for a test I wanted to run on one of my patients."

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He said, "So I finally walked over and I said I want to talk to that person. So I picked up the phone and I said, 'This is Dr. So-and-so. Who am I talking to?' And this girl said, you know, Jane Smith or something.

The doctor said, "Jane, how old are you?" And Jane was like 23. And the doctor said, "Jane, how much education do you have?" And Jane had been to a vocational school for two years. And the doctor said, "Jane, how are you making this decision that I cannot run this test on my patient?"

And Jane explained she was looking at a chart, and she was matching what the coverage of this woman's policy was, and how many times this doctor had gotten reimbursed, and she was doing a calculation, and that was the bottom line.

And the doctor said, "Jane, I am the doctor. I have gone to" -- and then he recited all of his many credentials and his years of study. And he said, "Jane, I am going to run this test because in my judgment my patient needs it. And if you want to try to deny it, go ahead. But I am going to fight you. This is where I am drawing the line."

This doctor should not have to do this. What doctors fear is that that will get worse, not better. And what we are trying to do is eliminate all of that.

If insurance companies are not fighting over how much coverage they can give you, and how much to pay for it, but everybody gets a good set of benefits, then if you want more you go into the marketplace and buy a supplemental policy, there are no more arguments.

You don't have to employ all those people. You don't have to argue with the insurance company. You go down to one form, one form that gets sent in. We will save so much money, and doctors will have so much authority back, which right now they are losing.

And I have a lot of sympathy for doctors who say to me, yeah, right, I am from the government, I am going to help you. I understand that. But we really think we can eliminate the worst hassles of their lives. That's what the AMA article was about today in the Times.

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The AMA is finally getting it that their real enemy is not what we are trying to do to them, but what insurance companies are doing to them every single day. And that's what I hope I can get more doctors to focus on. Because even if they don't agree with everything we are trying to do, the general direction we are trying to take them is better than what's going to happen to them if we don't change.

Q Why is there such a fear, that I am hearing, of this incredible bureaucracy? I mean, you don't do medicine by bureaucracy.

MRS. CLINTON: Well, the reason is -- I have to say that it's because there's been a very effective campaign which has said over and over again, the government bureaucracy.

But tell your husband this. Ask him, as many hassles as he has with Medicare -- and every doctor I know has hassles with Medicare. We are going to try to eliminate those, too. Here is the comparison: Medicare, which covers millions and millions of Americans, has an administrative cost of 2.6 percent. That means more than 97 percent of the dollars we spend on Medicare goes to direct services.

The average insurance company, between 20 and 26 percent. That's where the bureaucracy is. The bureaucracy is in the hundreds and hundreds of insurance companies who have bookkeepers and insurance review agents and claims adjustors and utilization review people, hundreds and thousands of them all lined up to prevent your husband and any other doctor from getting the reimbursement he deserves to have.

So even if you compare the existing government system we have now, which is Medicare, we save a whole lot more money delivering services through that than we do through the private system. And we could actually do better, and increase the rates in Medicare, if we didn't have so much cost-shifting going on in the private sector. Because they have to keep trying to make more money off of the increased cost from the insurance system.

It's complicated, but it's the financing system that's the problem. Not the health care system.

Q Two things. One of the reasons people think

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there is a bureaucracy is because of the alliances --

MRS. CLINTON: Yes.

Q -- that you went in with. And it looks like now that these alliances may not be --

MRS. CLINTON: Right.

Q -- part of the (inaudible).

My first question is, what do you think is going to replace that?

MRS. CLINTON: We made a mistake. We should never have called them alliances because that sounds bureaucratic. We had called them purchasing co-ops all the way through, which is what I told Helen they really were. People pool their money. They don't have government doctors and everything. We just get a better deal.

But I was convinced nobody in New York knew what a co-op was. Okay, well, we'll use alliance then. We shouldn't have done it. We should have thought of a new name. We should have called them discount health stores.

The alliances serve two functions. They serve to pool our money so we get better deals. And they serve to keep the insurance companies honest so that everybody would get the same health care plans to choose from. So that you could compare apples to apples. Now it's very hard to do that.

So if we don't use alliances as we originally proposed them, then we've got to figure out a way to perform those two functions. How do we get more bang for the dollar, how do we get that market power against the insurance companies, and how do we figure out how to enforce community rating and make sure people get treated fairly.

I know there are a lot of good ideas floating around about that. So as long as those functions are fulfilled, it doesn't matter what they are called.

You can even have a lot of different alliances as long as they all have to offer the same kinds of benefits, the same kinds of choices.

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Let's go back to the federal plan. I live in Washington. So, as the dependent of a federal employee, I get all these choices. But if I lived in Alaska, I get a lot of choices. So as long as we get the functions performed, I don't mind if the vehicle is changed. But the functions have to be there and met,

Q It seems to me the readers I talk to, and in my constituency, women generally are for universal coverage. They are for insuring -- they are for employment-based insurance as it now exists.

But the finance question, which is extremely complicated, is difficult to simplify, is part of the problem of the choice. Because they already know their plans are limited, their choice is limited, limited strictly on a cost basis.

MRS. CLINTON: Right.

Q So it seems to me that the finance issue is the key issue --

MRS. CLINTON: That's right.

Q -- to everybody in terms of -- and especially when you have both employment and big business not yet (inaudible), it seems to me, on this issue. Some are and some aren't.

And you've got the doctors who are (inaudible) this issue. The consumer --

MRS. CLINTON: Is confused.

Q -- is confused.

MRS. CLINTON: I think that's absolutely right. But I also think that part of the problem has been that we have been forced to talk, while the Congress has been working about principles and abstractions. And the other side, which has been building its case against change, has been able to raise all the worst scenarios, the bureaucracy, the no-choice, and all that.

Once we have a bill, we then will have the opportunity to launch a very aggressive campaign about what

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it actually means, and to point out that on the choice issue, right now in America fewer than half of us, who are insured any longer, have any real choice.

We are told if you don't go into this plan -- I don't know if it has happened at your magazines yet -- but if you don't go into this plan and use these doctors, we are not paying for you. Or else we will pay up to a certain point and you have to pay all the rest.

As we sit here, choice is disappearing. So once we get a real bill that in black and white says we are going to really fight to preserve choice, then we can get out there and through the media talk about it. And people can see then what the real decision is.

It's interesting. We think choice ought to belong to the individual. Big business thinks they ought to be able to keep the choice. Because no matter how good a deal we think we can cut with these great big buying groups, they think they can cut an even cheaper deal for themselves.

So they don't want you and me to have a choice. They want to continue making that choice for us. So that's one of the reasons why they are split. We think you can get the same and better cost benefits if each one of us makes the choice.

Once we get a bill, then we can draw the lines. And then if you are working for a large employer who is fighting us on this, we can organize you all to say, wait a minute, we want this choice. Why do you want to keep it? Or at least, if you are going to try to keep the choice, we ought to require that you offer more than one plan so that I have some choice.

We can begin to get into that level and people will be able to relate to that much better. At least that's what I am hoping.

A friend of mine said one time, if Franklin Roosevelt had to walk around and sell Social Security by saying I've got this new deal for you; you pay in money while you are working, and then when you retire, you'll get some money back, except if you haven't worked four quarters, or actuarially if you are not yet 65, or if your spouse dies.

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We have changed the expectation about how much information people want. And it is just much harder to sell something in today's world where you are on information overload, and where most of us don't understand a lot of the complexity of it, and you have to take certain things on faith as they did when they passed Social Security.

Then you tinker with it, and you fix it. And when it looks like it is running out of money, you figure out how to put more money in it, but you get it off and running.

We just have a higher hurdle to get over before we get to that point.

Q I have a question that deals with that financing (inaudible) problem in a way (inaudible) ultimately. And that is how consumer expectations have to change (inaudible) get for our money. And also (inaudible) the desire for the numerous tests that might detect cancer in a younger woman, but those things cost money.

And it seems to me we are missing an opportunity to talk about the big question. There is going to be some (inaudible) we have to be realistic how much we are going to spend.

MRS. CLINTON: That's one of the most important issues about how we take responsibility for ourselves and how we educate ourselves so that we know what is and is not appropriate and realistic.

I guess I would answer it in this way: It's very hard to have that conversation when you have millions of people who are left out of the system altogether. You need to get everybody in the system so then you have a rational conversation.

And every day I am reminded about how we ration care in this country. We ration it on the basis of whether you can pay for it or not. C. Everett Koop and I have travelled around the country and he has said over and over again, and sometimes he tells doctors' groups this, and they don't believe him.

But you can't argue with Dr. Koop because he knows everything. He has said if you are uninsured in this country you have a three-time greater chance of dying from the same

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ailment than if you are insured. And that's true both because you don't get the preventive care you need. And it's true that once you get into the hospital you don't get everything you need.

To me, in order to have a conversation about these hard choices, first, everybody has got to feel that they are secure enough.

I tell you the only place I know where some of these discussions are going on on a broad basis, and that's Hawaii. And it's not an accident because Hawaii has the only system that is universal in our whole country.

And in Hawaii there are actually more doctor visits per patient than there are in this country. But the doctor visits are less expensive because people go more frequently, so they get problems taken care of before they get worse.

So if you get to universality, and we get everybody in the system, then several things start to happen. We also have malpractice reform, so that doctors are able to be protected if they make what they consider reasonable clinical judgments.

If they follow whatever the clinical practice standards are, then, if they haven't run 100 tests, but they ran the 12 that were required, they are not going to get sued for not running the other 88. That begins a whole different dialogue.

A lot of doctors do things because they are afraid they are going to get sued. And a lot of patients demand things they shouldn't get. So doctors give in because of that fear.

So you add the universality, and you add the clinical practice judgments, the malpractice reform, and you could begin to get an environment in which we could start to have these conversations.

I think you have to do a lot to promote living wills. And I hope everyone of you will in the next months talk about how both President Nixon and Mrs. Onassis had living wills. And tell your readers what living wills are, and how they work.

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And try to find some real life experiences of the children of people who can tell you how much better they felt because they knew what their mother or father wanted than to be sitting in the hospital corridors arguing about mother would have wanted this, or mother would have wanted that.

So that takes it to the next level, the end-of-life level, so that we get more people making those judgments early. This is a wonderful thing that President Nixon and Mrs. Onassis did because they showed us how to die. That sounds funny, but -- Jackie could have stayed in that hospital for weeks, maybe months. President Nixon could have done the same thing.

There is a wonderful lesson in there about what it means to come to terms with your life at the end.

And, then, if you have a good benefits package, which stresses preventive care, you do a lot of patient education. And you try to begin to change behavior. People start taking care of themselves earlier so that they are more active in their own care. And they have more of a sense of what is appropriate medical care.

And the final thing is that if you change the financing of the system -- and I want to get back to Lyn's point and Grace's point and Helen's point. Look at the bind we put doctors in right now. Most medical care is paid for on a piece-work basis.

If you run a test or procedure, you get paid. If you don't run it, you don't get paid. And most insurance policies, and most even of the government policies, the most important thing you might do for a patient is sit and listen to them for 30 minutes and give them some advice. But you can't bill for that.

And so what happens is that a lot of the cost of our medical system -- and Dr. Koop has said we have about \$200 billion worth of unnecessary tests and procedures. Now, that is not because we have dishonest hospital administrators or doctors and nurses. It's because that's what the system pushes us to do.

So if you begin to change the way we finance care, and you get more doctors practicing like they practice at Mayo's, where if a surgeon refers a patient to a radiologist,

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he doesn't take money out of his own pocket because he is on a very good salary. So he doesn't get paid on a piece-work basis.

So you've got one of the finest medical institutions in the world where they can all collaborate because they are all being paid out of a common fund as opposed to competing with one another.

All those factors, if we could get those at work, then we can start dealing with the hard issues. And a lot of them will just kind of take care of themselves.

Q It's so true, as you said, about women being under-served and put in a (inaudible) that's dramatically (inaudible). Black women and Hispanic women for the most part feel more comfortable dealing with physicians who look like them.

There is a great concern that African American and Hispanic physicians are not being invited into, and are actually being discouraged from joining a lot of the HMOs, and are not being received well by some of the insurance companies.

So there really needs to be -- have you looked at that at all --

MRS. CLINTON: Very closely.

Q -- to see the requirements? You have to include that in some --

MRS. CLINTON: It's a very serious problem. And it's a combination of factors. A lot of minority physicians are in solo practice or in very small groups. A lot of them in under-served areas with very high levels of health problems. So a lot of their patients are sicker than patients in suburban, more affluent settings. So that many of those doctors have a much more expensive caseload than other doctors.

So one of the reasons they are being excluded from HMOs is because they are taking care of people who are often sicker. They are often people who don't get preventive care, they show up when they are really sick, and they have about ten things wrong with them instead of one thing.

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So these doctors are often being discriminated against for doing what doctors should do, which is taking care of very sick people.

In our proposal we have very strong anti-discrimination rules that -- if an HMO has some legitimate reason, that is absolutely unarguable, to exclude a physician, that's one thing. But very often they just exclude on the basis of where you practice and what kind of patients you have because they don't want to pay for them. And we have eliminated that in the proposals that we have made.

We also want to do what the AMA asks for in this article today which is give the doctors the right to apply to practice in these different organizations. And let them -- if they are willing to take the prices that are offered, they ought to be able to practice.

So if they want to be part of an HMO that pays \$20 a visit, that should be their right, if they are willing to abide by the rules. Instead of what happens now where they are not even invited to participate.

And then the third thing is we want to put more money and support into under-served rural and urban areas and to give loan forgiveness and capital formation loan programs to physicians, both black and Hispanic, as well as white, if they are willing to practice in areas that need them. And we think we can then both recruit and retain more physicians.

So we have looked very carefully at this, and we are going to try also to increase the supply of such physicians by increasing the financial help from such physicians to go to medical school.

Q There is one other little piece of this that concerns both black and Hispanic, and mainly African-American physicians because they have been practicing for a long time in this country. And some of them are really the only health care providers to very poor African-American people who are living in urban areas. And sometimes don't charge these people anything but very little.

Some of the older physicians are not board certified because it was very expensive when they were coming out of medical school, and had these huge bills, and couldn't

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afford to do it or because they felt it wasn't important because most of them were practicing in the communities.

Now it's going to be impossible to get into any of the plans, the HMOs or the insurance companies, if you are not board certified. We are talking about physicians who might be in their early sixties or seventies.

Has that been looked at all? Has any of these physicians spoken to you?

MRS. CLINTON: Yes, they have. There are different ways of working that out. I have spoken with some of the members of Congress who are concerned about this as well.

One of the ways, in addition to the anti-discrimination and the like, is that we've got to start thinking about how to organize communities to be their own health plans.

Like when I was up at North General Hospital in Harlem, I told them what I told the Truman Medical Center in Kansas City. That facility, and the doctors affiliated with it, have a long tradition of taking care of the people in that community. They ought to form their own health plan. So that under our plan they would be able to submit that choice to the people who live there.

I believe, as you said in the beginning, people will want to choose doctors and hospitals they are already familiar with. Because they are treated well there five years ago, and they want to go back.

What I am trying to encourage, so that the doctors you are talking about would be part of a community-based health plan. They wouldn't have to apply to some HMO downtown. And then they could go and basically have that health plan made available in the community. I think they would get lots of people who would want to be part of it.

Q The issue of domestic violence and substance abuse seem to be disproportionately affect health care in this country. Can you fix one social problem without treating the others? I know you have talked about this for a long time. How do you approach those two issues?

MRS. CLINTON: I think the fix is a long way off,

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but I at least think we are beginning to deal with it honestly in trying to go down the right road. I am so pleased that we beat the NRA. I hope nobody is a big NRA fan in here. We beat the NRA twice in six months. I think that's a big step forward.

I think the crime bill has a lot in it, including some specific things about police support for domestic violence. We have got to move on all of these fronts at one time.

And in the benefits package we have proposed there is a really good start on substance abuse.

It is so difficult to look at the broad range of social problems we have and feel that you can have any comprehensive approach to them. But I think you can take a step back and see the pieces that we are trying to put together.

Everything from an investment tax credit for working poor people to the National Service, to send kids to college, to the Brady Bill, and the SALT weapons ban, and health care, and welfare reform, they are all pieces of trying to get at parts of this problem that we are all struggling with.

And then I think on top of the programs that we are pushing through, you have to have some over-arching themes that particularly are aimed at women to take responsibility for their own lives. Don't be a victim. Don't give in to despair and all the things that go on. Get treatment if you've got a drug problem, once there is treatment out there to get.

That's the big question. We are doing all of these things because we think they will help us strengthen our country and rebuild community and solve these problems. We are a generation or two away being able to see the kind of results we want. But we can't just sit here and let it go on.

We can't let it get -- it's gotten to the point now where we are living with such a level of violence and such a level of meanness, mean-spiritedness, and a kind of cynicism that I haven't seen for 30 years.

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We think all these things are going to help. But you've got to operate on the programmatic policy level, you've got to operate on the big value, big picture, change your own life.

When I went to South Africa -- I was talking to some people earlier about this. The personal highlight for me was Mandela saying that he invited three of his former jailers to come to his inaugural. That was such a statement about what it takes to make change. But you've got to start from the inside out.

Every one of us has people we need to forgive sometimes 100 times a day. Every one of us has to be an agent for reconciliation. You really could see how emanating from this one man's journey and anguish came the whole miracle of the transformation of that country. So when I think about how our problems are much less than theirs, that's really a big part of the message.

And what you all do in the stories that you tell about women who have made life-affirming choices and transform their lives, I really think that is exactly the message that you need to keep getting out there while we try to change conditions so that, yes, there are drug treatment centers; yes, there are more police on the streets; yes, we get the assault weapons off the streets.

We do our part on the governmental level, but everybody is going to have to do her own part internally.

Q Let me tell you what concerns me. You said that when you first began looking into this issue you were stunned -- I think that was the word you used --

MRS. CLINTON: Right.

Q -- to learn how much the health system in this country disadvantages women.

MRS. CLINTON: Right.

Q I don't think that message has come through at all. I don't think women have any idea of the many, many ways in which it is women who will pay, women who will pay, women who will pay, women who will pay.

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Recently I was so encouraged, cheered to see the cooperation and united front of women in the Senate and women in Congress. Couldn't they be encouraged -- can't somebody turn this thing into -- make it apparent what a woman's issue it is? We all know cancer was a woman's issue.

MRS. CLINTON: I think that's a really good suggestion because I know that the women in the House and Senate and I -- in fact, we are doing something tomorrow. We are doing something. We are doing a woman's health media event at the National Press Club, which is mostly the daily print reporters, I guess some TV and radio people.

Q Are you doing this?

MRS. CLINTON: Yes, and we are doing this. But that is something we have talked a lot about. I have met with the Women's Caucus numerous times. We have talked about how we can do that. And we are beginning to try to break through on it.

It's so funny in this country, when you say things like that you are accused of being too dramatic or of engaging in exaggeration. But the fact is it's true. And we have had several good sessions. Some of your magazines have carried some good panels and some good sessions talking about how this is a women's health problem.

But I think we just need to keep doing it over and over again, and maybe in a slightly louder voice than we have. And I'll try to start that tomorrow because we have got a good opportunity tomorrow.

Q I am glad you (inaudible).

MRS. CLINTON: Good, good.

Q I'd like to know your ideal timetable for going out or the passage of the bill. I think a lot of people are very confused. Two weeks ago Ted Kennedy came up with another projection for the bill. People don't know what it is anymore.

MRS. CLINTON: Right.

Q Because there was this feedback from the Clinton administration on the Kennedy bill. Do you see this

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happening in the fall, or do you think it's going to take until 1995?

MRS. CLINTON: Oh, I see it happening this year. Remember that old saying, there are two things you should not watch, sausage being made and bills being legislated? It is really true. It's hard to take even when you are involved in it and optimistic about it.

I feel really good about where we are. What we have done to the Congress is to put them on a faster timetable than they have ever been on.

I had a member of Congress say to me the other day, "You and your husband, you think we can do a health care bill in less than two years. It took seven years to do Brady. It took five years to" -- he goes on and on, this long litany.

And I said, "Well, yes, but you guys are going to have this for 60 years, ever since" --

(End tape 1, side 1.)

MRS. CLINTON: -- needs that have to be met. But then when they come out, then they will be in some way melded together. In the House it will probably be through the Rules Committee or the House leadership. In the Senate it will be through some kind of a consensus building effort on the part of the two major committees and the leadership.

And then you will have bills, and you will then start seeing people organize for and against them, and amendments, and all of that.

But this has been a remarkably accelerated timetable. I think it's going to happen though. I think we will get a bill by the fall. Yes, I really do. Now, how that bill will actually be implemented, and what the phasing will be, that's going to be all hammered out.

June and July are the critical months. Senator Kennedy was on a track to get his bill out on Friday. But with Jackie's death, he didn't meet -- last Friday he didn't meet yesterday. So I don't know whether he feels he can get it out before their Memorial Day recess. They have a two-week recess coming up.

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I haven't had recesses since I was in grade school, but I am now learning about recesses again.

So he will either get his bill out right before he leaves or right after he gets back. And I think Chairman Rostenkowski and the Ways and Means Committee is moving his bill along. Senator Moynihan has said he will have a bill in mid to late June out of the Finance Committee.

So all of this is converging. And you'll see the dynamics begin to change. A lot of it has been behind the scenes and you only can hear about it through leaks and what somebody says to somebody. We'll get it out on the floor, and then you have all these organized interests lining up one way or the other. So it will be a hot and hectic summer, is my prediction.

Q So August it will get on the floor, you think?

MRS. CLINTON: Maybe July. I think July is a good possibility to get to the floor. What we would hope is that they would have a bill by the August recess, which is about the second week in August?

Then you have to have a conference committee to work out the differences between the House and the Senate. But I am very optimistic.

Q So if one was giving practical information, they will vote before they go back to the election --

MRS. CLINTON: We hope.

Q You think they will vote sometime in October? I see this essay is really if they don't vote at all (inaudible). Do you think they will constantly be polling their own constituents to see if they should vote before the election? Will that be the real juggling act to see if they will go back to their voters having voted on this bill?

MRS. CLINTON: Yes. I think that's a big part of it. I sure do.

I think also a lot of it will depend upon how much heat they are getting and from whom. If they only hear from the small business lobby and the insurance industry, then the bill will be one way. If they also hear from doctors and

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nurses and consumers the bill will be tilted another way. So the battle will be really joined once we see what the bills are as they come out of these various committees.

Q (Inaudible) monthly magazines to write about this for the September-October issue, one really has to start right now so in a way well-informed people sort of know the bill and the opposition points of view.

The Republicans will present a bill also --

MRS. CLINTON: Probably, yes.

Q Mandela's jailer retired -- one of them retired when he was gone. It wasn't -- he didn't like his work, not because they became such good friends. When Mandela left he retired.

MRS. CLINTON: It's an incredible story.

But I think your magazine can continue to talk about these big picture issues. Because no matter what the shape of the bill, consumers need to be more empowered. They need to make better decisions. Doctors need to be able to get back to doing their work as doctors and not being paper-pushers. Nurses need to be at the bedside, not at the computer terminal.

So there's lot of big issues that you can keep writing about no matter what happens with health reform. The other thing is if we get a bill this year, then we've got to work on implementation. The current design is for each state to kind of proceed at its own pace.

Look at California. The California Medical Association has endorsed the President's bill. That's the biggest medical association in the country. And that gets back to Grace's point.

Those doctors have really studied it, and they haven't been as influenced by the advertising partly because so many of them are already practicing managed care settings and they know that it's not like they are being led to believe around the country. So they are ready to go.

Then to take a state like Texas where more than 25 percent are uninsured. Where you do start. You've got one

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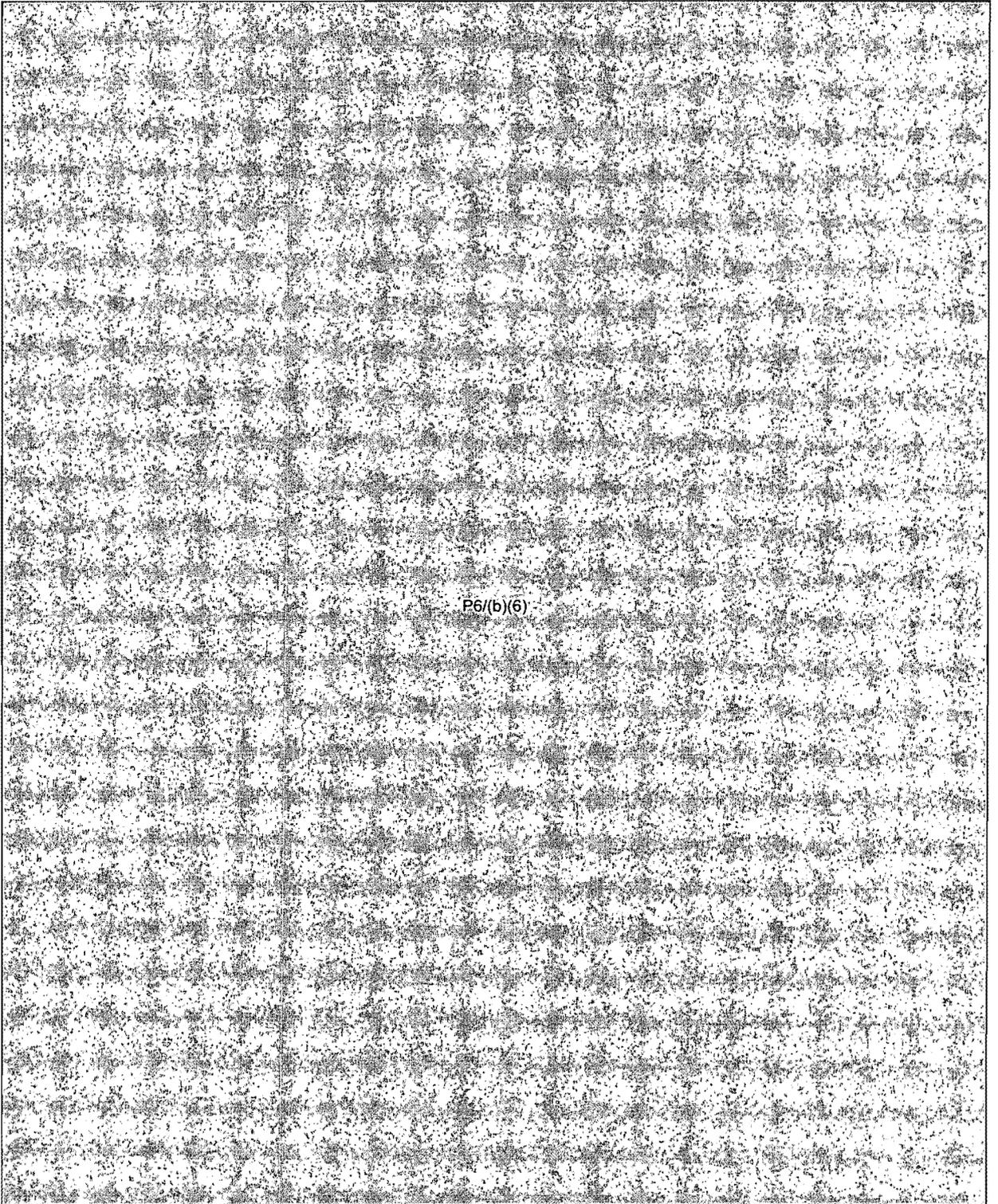
out of every four Texans who doesn't have any insurance. So the difference in states is so dramatic. Different states will be kind of rolled in based on how progressive they already are, how well organized they already are. That will be a big difference, too.

I have just been told I am going to have to wrap up. Could I just take five minutes to ask all of you something? And then if you have more questions, if you will write them out or fax them to me, we will get answers for you.

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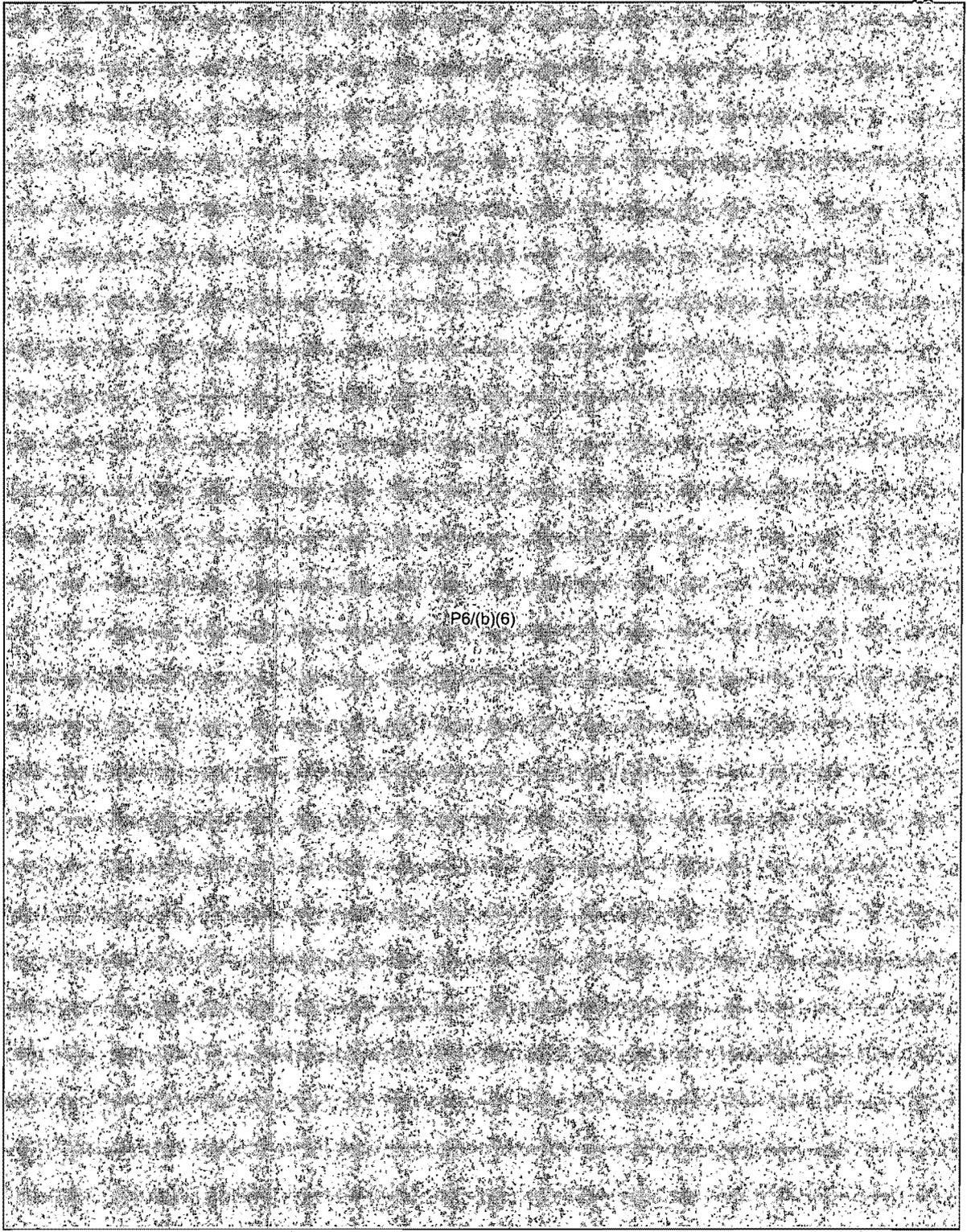


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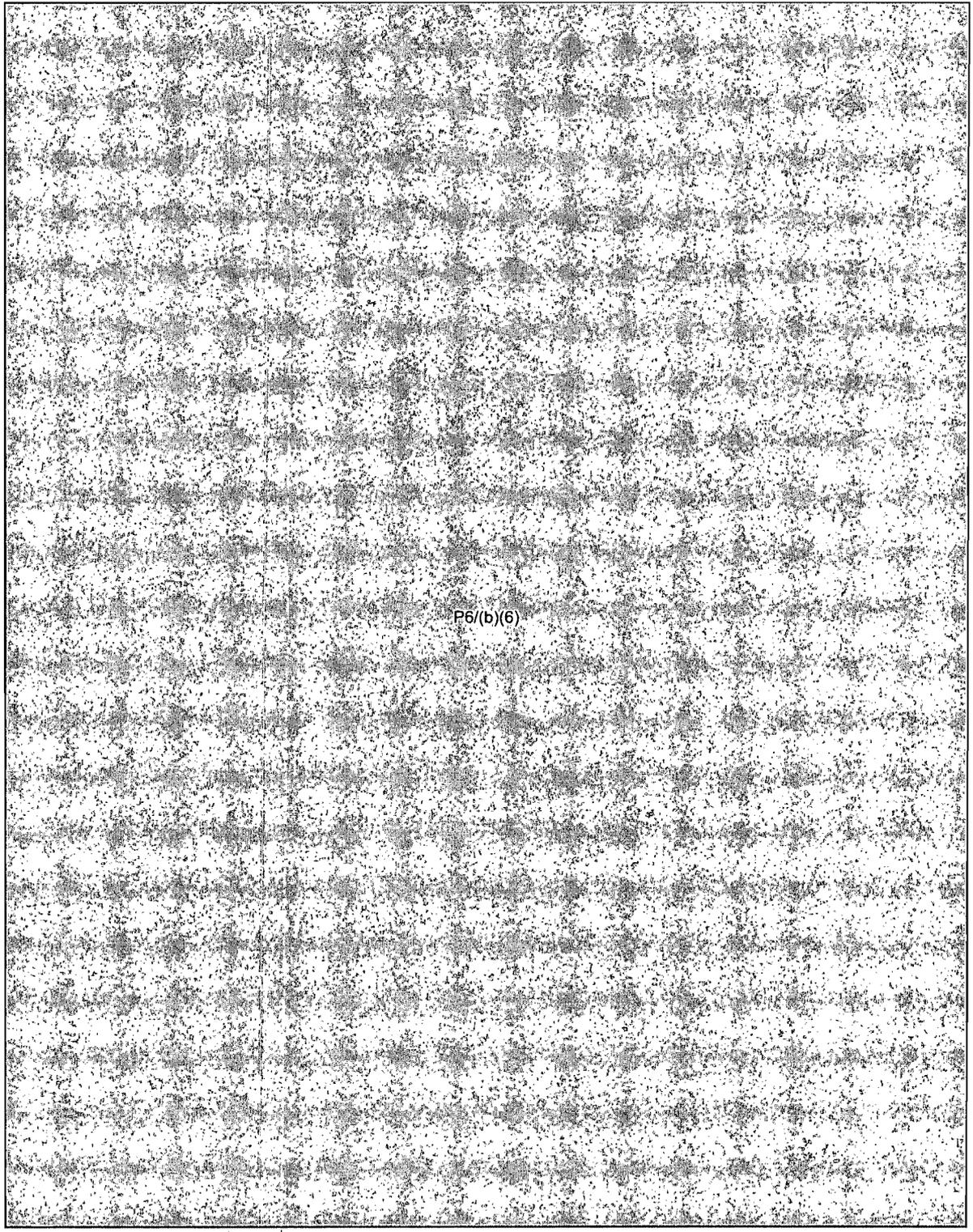
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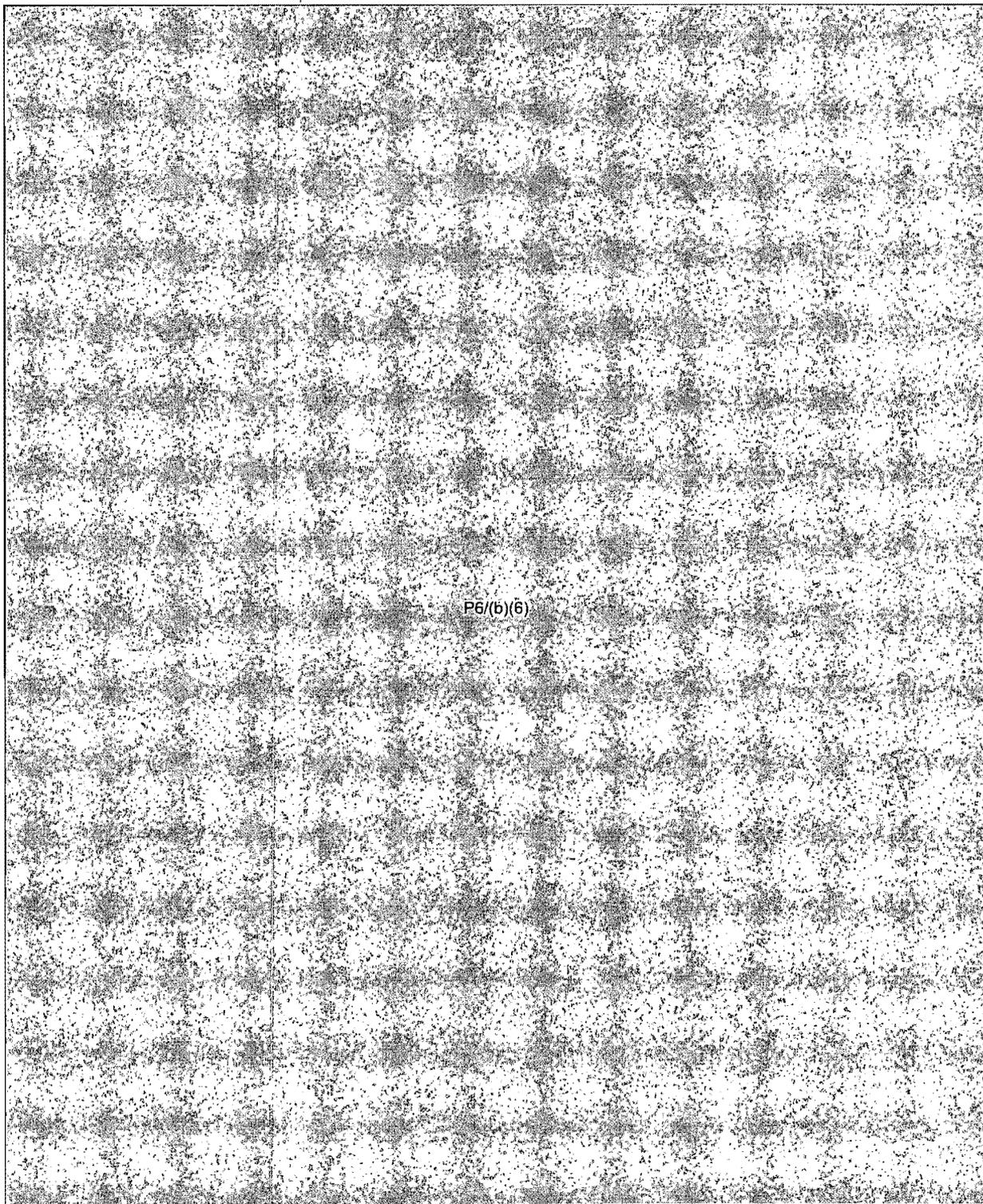
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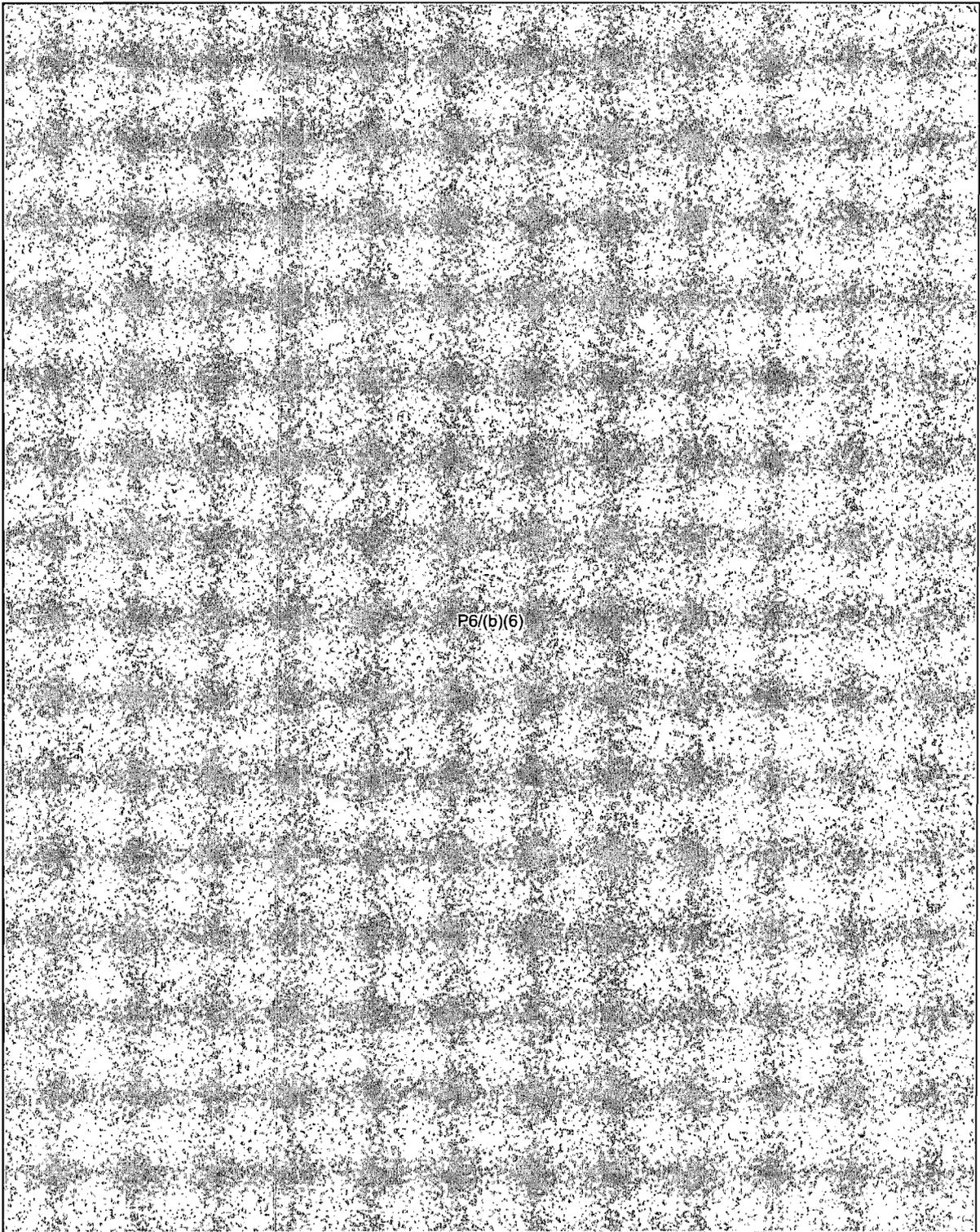
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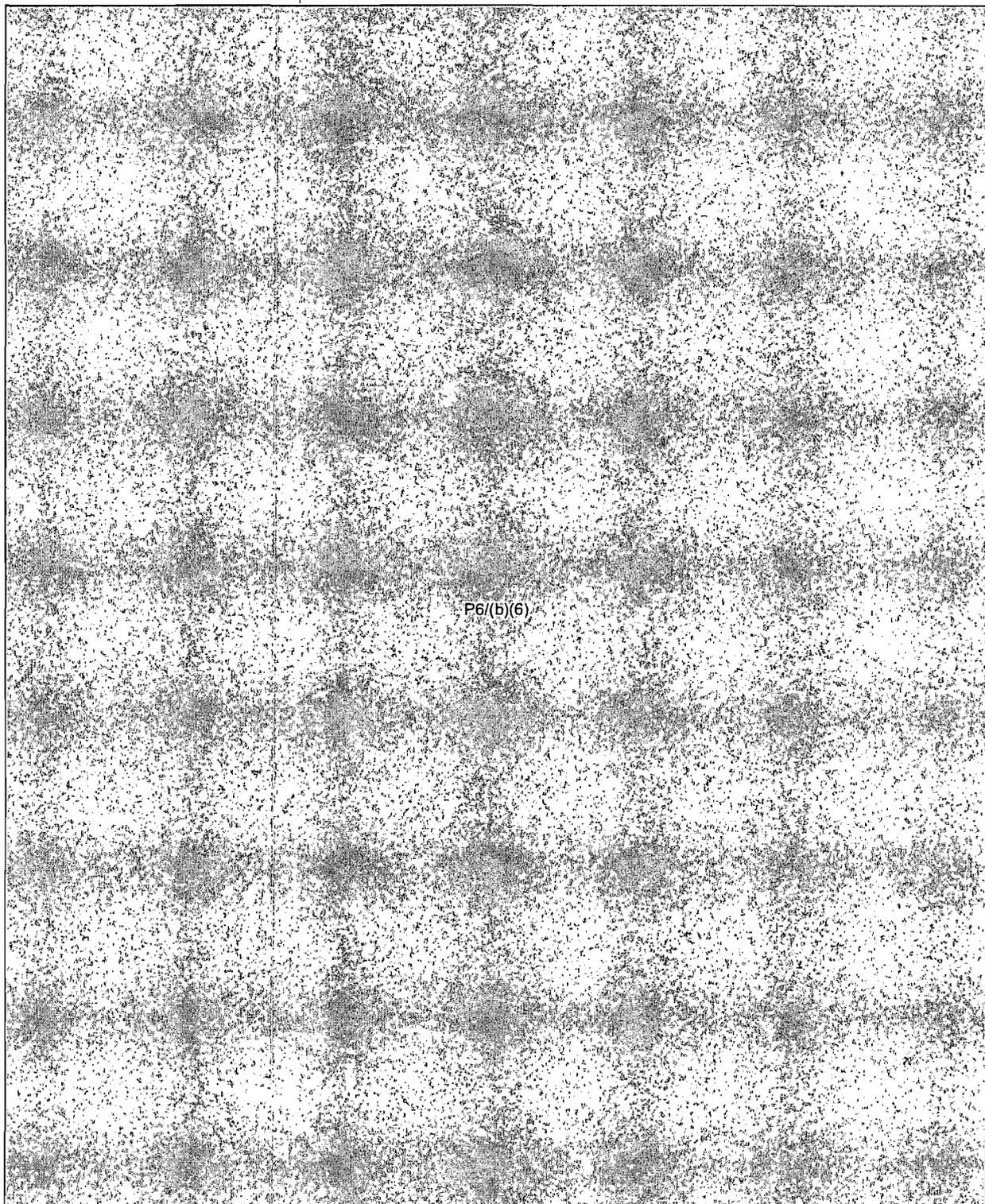
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P6(b)(6)

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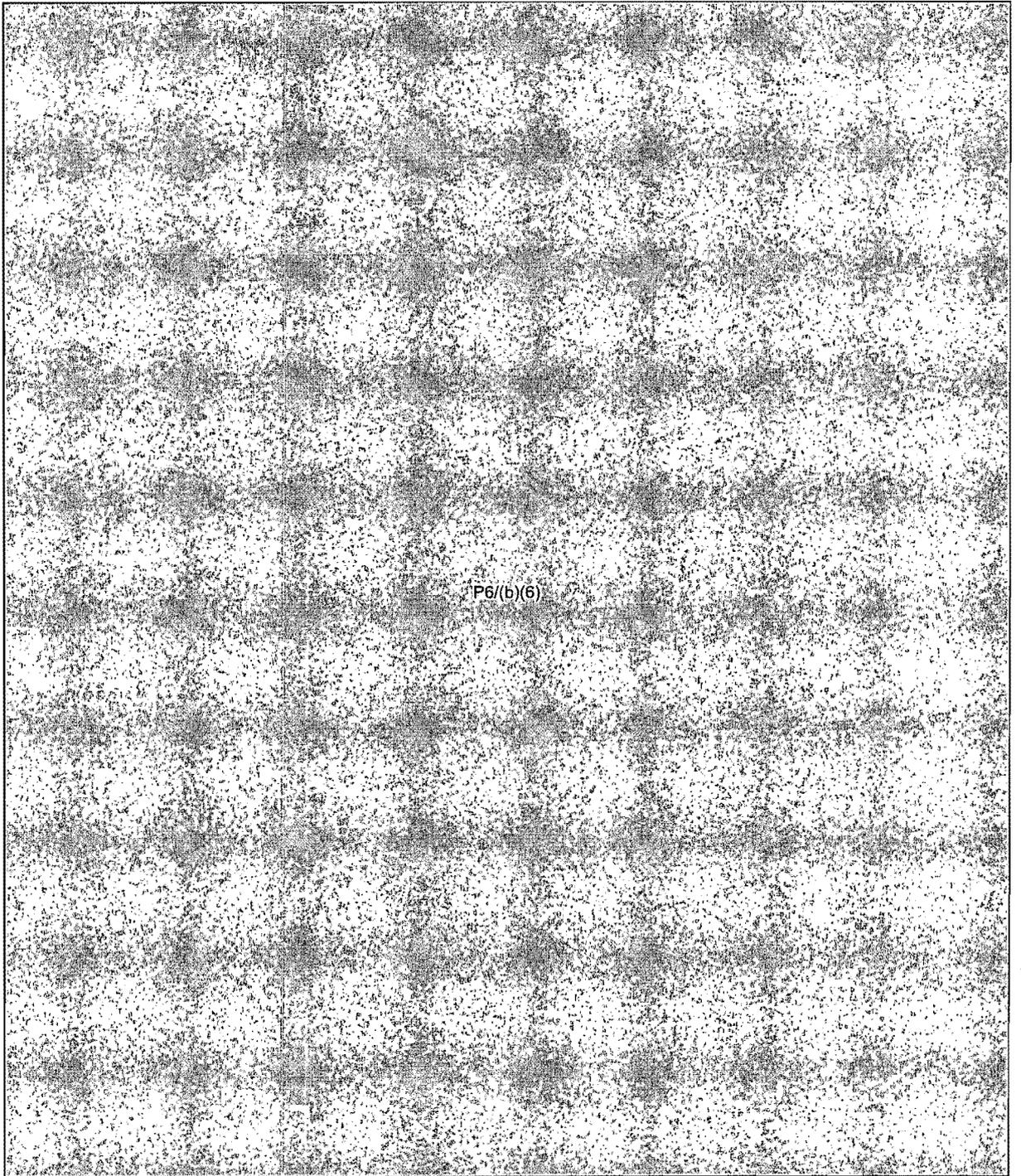
[001]



P6(b)(6)

MORE

[001]



P6/(b)(6)

* * * * *