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REMARKS BY THE FIRST LADY
AT THE AMERICAN SOCIETY OF MAGAZINE EDITORS

MRS. CLINTON: Thank you very much for the invitation and thank you, Ellen, for the introduction. And I'm delighted to be here. And what I would like to do is just spend a few minutes talking about health care, but to spend most of my time, and I will stay as long as I can, answering your questions.

Because I find, as I did again this morning, that there is not an issue that is of more interest or importance to people in our country. But there is also not an issue about which there is more confusion, more uncertainty, and more need for good conversation than health care and its reform.

I am -- at this point in time, after having spent -- it seems like a hundred years but only a year and a half working on health care and traveling around the country -- as convinced as I could be that we are on the brink of a historic opportunity. And it's one that is essential for us to seize for a number of reasons.

And I think if we take a step back and look at the health care system as we currently know it and what it is actually that is being proposed to be changed, then we can have a basis for a conversation and, maybe, for your questions in a few minutes.

I always start off by saying that we have the finest health care system in the world. We have the best doctors and nurses and hospitals. We certainly have the highest technology. We have the finest facilities that are available. That is not what is wrong about health care.

What is wrong and what is undermining all that is good about our health care system is the way we finance it. It is very important to separate those two out because, when people hear health care reform, they take it from the general

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immediately to the personal and specific. And they say to themselves, "Oh, my goodness, does that mean" -- fill in the blank -- "Would I lose my doctor?" "Would I not be able to go to my favorite hospital?" or "What would that mean in my life?"

What we have studied, and what anyone who has really looked at the way we finance health care has concluded, is that we are spending nearly \$900 billion on health care in America. There is too much of that money that is not going directly to anybody involved in taking care of anyone. It is money that is going into the financing of the system because of the way we have organized financing, which is undermining the potential financial stability of the entire system. Now let me just stop and explain.

If you are privately insured, as I assume all in this room are -- although some of you may not, you may have a preexisting condition or some other problem with being insured. But the vast majority of Americans who work are insured.

If you are insured privately, what does that mean? It means that you have either directly or, more likely, through your employer struck a bargain so that you pay a certain amount of money for the insurer to determine what you will be covered for and how much you will be reimbursed for in the event you are sick.

Now, how does an insurer decide who to insure? Well, an insurer, like most insurance that is offered, makes decisions by rating how likely it is that they will have to pay for you if you ever get sick. Or if you have been sick, how much a risk you pose, which would mean, in other words, how much money they would have to take out of their pocket in the event you got sick.

Now, how does an insurance company go about doing that? Well, they hire a lot of people who go out and do what is called underwriting risk. That means they take all kinds of tables and all kinds of charts and they figure out who is going to cost what and who is insurable and who is not insurable, and they offer different policies to you.

They compare those policies over years, so that if you get a little sick this year, they can charge you more next year. Then they have to have a lot of elaborate forms

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which they have you and your doctor and your nurse and your hospital fill out. And they read them very carefully because if you are diagnosed X instead of Y, they don't want to pay that, so that they want to try to argue with your doctor or your hospital to pay you less.

Now, I go through that because that is what we are trying to change. That is an enormous amount of money that we in America spend that has absolutely nothing to do about keeping you well.

And if you look at what the average cost of administration is in private insurance in America, it is on average 17 cents out of every dollar. And for some insurance policies, particularly those that insure small businesses, it is as much as 30 to 35 cents out of every dollar. That is billions of dollars if you're talking about the \$900 billion health care industry.

It is money that goes into paying people to decide who gets insured and who doesn't, how much it should cost those who get insured to be insured, to fill out forms to find out how much you should be reimbursed for, to hire people who argue with your doctor when your doctor says, "I think she needs this test."

The insurance company has somebody on the other end saying, "We're not going to pay for it." That is why we spend so much more money than any other country. There are some other things, but the primary reasons are the costs related to administering the system financially.

Now, in contrast to private insurance, for all that can be said about the problems of the Medicare system, the costs of administration in Medicare are 3 percent or less. So you have a 14 to 15 cent difference in the cost of administering Medicare compared to the cost of administering private insurance.

Now, why is that? Is private insurance much less efficient? Are government bureaucrats more efficient, more sensitive than private bureaucrats? Of course not. It's because you have a very large pool of people in Medicare, so you get a discount. You also have a defined benefit package, so you are not running around trying to compare apples to oranges with all of the costs that are related to that comparison.

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And everybody, once they reach 65, is eligible. So you don't have people being left out so that costs get shifted around so that some people are paying more and some people are paying less. It is really kind of elementary economics, that if you can buy in bulk you get a discount. If you have a standard package where you can compare so you know whether you are getting a good deal, you're likely to end up with getting a better deal.

So, the financing of health care is what's really wrong about the American health care system.

And there is a related issue to the financing in addition to the paperwork, the administration, the bureaucracy, the excess. And, that is, that if you are paying by test and procedure, which is the way we pay for medical care by and large in our country, then the more you do the more you get paid.

You may not need to do it, but if you churn it, you're going to get reimbursed for it. Which is why you have this growing antagonism between the insurance industry, which is paying the bills of the employers, and medical professionals. And why nearly every doctor I talked to is so discouraged because he is engaged in a daily battle with bureaucrats on the telephone as to what he can or cannot do for his patients.

Why? Because the only way to control costs in a system where people are insured differently for different things at different costs and where you have 40 million people left out completely, so when they get care somebody has to pay for it, which means it gets loaded onto those of us who already pay -- the only way that you can try to figure out how to keep up with that is by trying to figure out how to beat the system by trying to continue to increase the number of procedures and tests that you run.

Dr. Koop, who used to be our surgeon general, who has studied this closely, has estimated with a group of probably the best medical costs analysts that I know of in the country at Dartmouth, that we spend about \$200 billion on unnecessary tests and procedures.

So you add whatever the excess administrative cost is -- let's say it's 10 percent or 12 percent, some difference between the cost for a large pool and the cost for

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private insurance. You add to that the cost associated with unnecessary tests and procedures, often which are run as a way of trying to get paid because the arguing with the insurance company takes so much time and energy.

You know they're going to knock out something, so you have to bill more than you think you're going to get anyway. What does this have to do with keeping anybody healthy? Nothing. This is not a rational way to run any system that delivers goods and services. It is not a way that any of you would run a magazine.

What the President has argued for is a system where everybody is in, universal coverage. But that universal coverage is then obtained through the purchase of private insurance. He does not want a government health insurance plan for every American.

What he wants is everybody to be in with at least a standard benefits package. If you want more, you are free to buy more. But at least every American would have a standard benefits package which could be fairly priced based on quality and competition in the marketplace. You would be able to compare because the same services would be offered to everybody.

Now, what has happened in the last year and a half is that we've had a lot of side arguments about health care reform. We've had the same arguments that were used against social security and against Medicare, and that is, that, oh, my goodness, health care reform means that government is going to tell you who to go to, they're going to tell you you're going to have to stand in line.

Even Medicare, which is paid for by you because it is a taxpayer- financed program --

(Interruption to tape.)

-- nobody tells my mother what doctor to go to. That's her choice. This is one of those red herrings that you can read -- if you go back and you read that (inaudible) social security or Medicare.

And there is the great argument about my goodness, they'll take our choice away under any kind of reform. I would bet, without knowing any of your individual insurance

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situations, there are people in this room who in the last year have had their employer switch to HMOs or PPOs, which have limited your choice.

And some of you may have been told you can no longer see the doctor you used to see because he or she is not on the approved list. So if we do nothing, choice will continue to decrease in the face of cost pressures brought to bear on trying to get health care costs under some kind of control.

So in the next several weeks, we will have several big decisions to make. Do we want to have universal coverage, not because it's the right thing to do for the 40 million who are left out, but it's the only way to have a system where nobody who has it will lose it. And where everyone is in the system, there will be no more cost shifting, no more underwriting expenses, no more bureaucracy and paperwork associated with deciding who does and does not get insurance.

Everyone will be insured and we can spend our money on actually getting health care delivered to us. That is the real issue. And then if you believe that universal coverage is smart, both economically and morally, then how do we pay for it.

There are only three ways to pay for universal coverage. Either you do have a big tax increase and substitute that for existing insurance payments -- that's called a single-payer system -- it's what we do for people over 65 who have Medicare; or you have an individual requirement of some kind where people are told, "You have got to go into the marketplace and get your own insurance"; or we build on the system we have, which is the employer-employee shared responsibility that works for most of us.

And there are ways of protecting small business, giving them subsidies so that they don't bear the full load. But if we do not build on what we have, then we're going to continue to see an increase in the number of people who used to be insured while working, who no longer are.

And many of you in this room will see a decrease in your coverage and an increase in your personal cost because the employers alone, who are trying to insure, cannot do it if you do not have universal coverage because they cannot, in

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the long run, control their own costs.

So, from our perspective, the last year and a half, this is really part of the economic plan that the President ran on, what he believes in, and is the second part of what was achieved last summer when we finally got a responsible budget with the results that are there to be seen with all the new jobs. I guess the latest count is something like 3.8 billion with all kinds of positive economic news for a lot of people.

But if we do not control health care costs and we do not take this issue on, then all the work to control deficits, to get investment back in the economy, will begin to slow down again in a few years because, once again, health care will be driving costs in both the public and the private sector.

So I'm very hopeful that we will get a positive result out of the Congress in the next few weeks. It's going to be good for the economy and it's going to be good for individuals. And it's going to be the right thing to do and that's why we're working so hard to achieve health care reform.

And I'd be glad to answer any questions that any of you have. Thank you very much. (Applause.)

Q (Inaudible) I think everybody in this room knows of the President's pledge to veto any bill that does not have universal health coverage, but there's been a lot of talk lately about phasing in universal health.

On Good Morning, America, this morning, you said, "As soon as possible," would be acceptable. Is there a maximum amount of time that the administration will find acceptable and be able to sign the bill that has a phased-in universal provision?

MRS. CLINTON: Well, it's hard to answer that in the abstract. You would have to see what the legislative language is and what was going to be accomplished along the way. And that's why I said this morning, "As soon as possible."

I, you know, the President has said that we could live with, you know, a reasonable phase-in period, but it's

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hard to know what reasonable is when a lot of people talk about ideas that they think would be good, short of universal coverage for a certain period of time. But they don't give you the legislative language, and they don't cost them out.

Let me just mention -- let me just focus on this for a moment because it's very important. I mean, the debate is really getting down to universal versus nonuniversal in part because there are a lot of members of Congress who feel that it is just too big a political issue for them to mandate anybody to do anything.

I mean, that's what it comes down to. They don't want -- they obviously don't want the tax approach. They realize the individual mandate would be a political disaster as well as a substantive one. But they just can't bring themselves to impose any additional burdens on businesses that don't insure. So, they're looking for a way out of what they see as a political dilemma.

The problem is there isn't any good way out. Nonuniversal reforms, which are usually described as insurance reforms, where you would eliminate preexisting conditions as a bar to insurance and where you would guarantee issue so that people could move from job to job.

Those are important things to be done. But if only that is done, then what will happen is people who are sicker, who do have more costs, will be able to get into the insurance market more easily.

They will then be insured and they will bring more costs into the system, which if you don't have everybody insured, will result in raising the cost on the existing insured population, which will cost those of us who are insured and healthy more money in the short and long run and cause many people to drop insurance, which will exacerbate the uninsured problem.

That is, for example, what has happened in New York, Iowa, South Carolina: states which have tried to reform their system, short of reaching universality, and had several very unfortunate results. Number one, the number of working people who are uninsured has gone up and the cost of insurance for middle income working people has gone up.

So for people who say they want a nonuniversal

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solution, our question is, what exactly will we get for it and who will pay the price? And I would ask you all who are interested in it to look at the Catholic Health Association study which was done and released yesterday.

We didn't know they were doing it, so I have no knowledge of it other than what I've read about it. But it proved what we know to be the case, which is a nonuniversal approach will cost middle income people, those making \$100,000 or less, more money for their insurance.

In fact, the figures are striking. For a person making between \$30,000 and \$40,000, under the kind of approach that is promoted by Senator Dole and others, they will pay \$472 more for the insurance they currently have in a nonuniversal system.

In a universal system, according to Catholic Health Association, not us, they will pay \$350 less. You can go through the income scale up to \$100,000 and see how that works.

So the phase-in is something we're certainly open to. But how long that phase-in is is a very important issue because if you let the phase-in go too long before you get to universal coverage, you build in more costs in the system, which are then harder to eliminate.

Once you reach universal coverage, you start from an even higher cost level. So it's -- it's -- I mean, I know that it's hard for some members of Congress to stand up to the very vocal minority, which is less than 25 percent in every every poll that doesn't want employer mandates, but they would be doing the right thing to ask that everybody contribute. That's the only way to get to where we need to go.

Q Hi. My name is Merrill Stevens (phonetic). I'm editor of the (inaudible) Report. My audience are very grateful that you support their work. They are all very, very, very small business people and they're terrified.

They feel that employer mandate means that the few assistants that they bring on to help them, they'll have to cover them. They don't know what to do. And I would like to have you address their specific concerns because when I hear small business, a lot of times in the press it means somebody

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who has 200 employees or seven outlets or whatever, and these are cottage industries for the most part.

MRS. CLINTON: Well, several things would help them very much. One is that for the really small ones, which are basically family businesses, they would, for the first time, receive 100 percent tax deductibility for their own health insurance, something we've never done.

I mean, we treat -- you know, we say we favor entrepreneurs and small businesses, but we don't give those people the same tax advantages as we give to much bigger businesses. So that would be a huge advantage. And for those who are already insuring, they would save a lot of money from the beginning.

For those with very few employees, say one to three, which is what I'm familiar with of people who are craftsmen, sometimes part time. I mean, their part-time workers may not meet the threshold, for example, of being eligible for coverage.

But if they were to meet the threshold, we are going to be subsidizing the very smallest of businesses, and so the cost for them would be very minimal, and we're talking about much, much less than what the average minimum wage increase has been over the last 20 years.

And, you know, I hear the same arguments because they are the same arguments. You know, small businesses are always very sensitive and nervous about this. But if you go back and read, every time anybody proposes a minimum wage increase, there was always opposition. Business always said it was going to cost millions of jobs, it's going to drive us out of business. There is no evidence that that happens.

And I personally read every review I could find of every analysis that's been done of what the minimum wage has done. And there was the very -- you know, there is a very poignant aspect of this to me because right now those people you represent and you communicate with are the ones who are most often disadvantaged by the current insurance market. They couldn't get insurance if they wanted it.

They're not members of any large groups. They are the most discriminated against. Their cost, as I said earlier, 30 percent or higher if they were to go into the

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insurance market. We would be making insurance not only guaranteed for them but affordable, and everybody would be in the same boat.

I mean, the way it is now, you've got businesses one next to each other on main street. One might insure, the other doesn't. When an employee of the business that doesn't insure gets sick and goes to the hospital, the company and the individual who does insure pays for that. We all eventually pay for it.

There is no free medical care in America. People do not get a free ride. They may not personally pay for it, but we pay for it either through higher premiums or through taxes.

So your small crafts people are paying taxes. They are paying to keep a system that is much too expensive, getting more and more expensive. If we change the system, insurance will be affordable and a lot of the costs that are currently being borne disproportionately, I would argue, by small business, to keep Medicaid, for example, going, would not be as burdensome because we are going to eliminate Medicaid, which is a wasteful and much too expensive program.

So there is a lot to this. And the problem with most small businesses is that they look at the existing insurance market and they say, "We could never afford this." We're not talking about the existing one; we're talking about getting the price very low and then subsidizing the smallest of businesses. Because the people we're most concerned about are the ones with fewer than 25 employees.

Q (Inaudible.) Your support for abortion (inaudible).

MRS. CLINTON: You know, I think that our position has always been clear. That pregnancy related services, including medically necessary or appropriate abortions, should be part of the benefits package and part of overall women's health. And we also believe that most insurance policies cover that now. So we didn't want to do something that would take away coverage that most people have already.

But you are right. I mean, this, like all of the issues, are going to be decided in the Congress. And, you know, at this point, I don't know on a whole range of issues

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exactly where the Congress is because they don't know. I mean, they're still trying to get focused themselves.

You know, we will continue to press for it, but it's one of those issues that's going to be decided in both houses of the Congress. And people who are feeling strongly about it should be sure that their voices get heard because it's going to be a real battle.

Q (Inaudible.) Can you be more specific on how exactly the people who are unable to afford it now, and I understand there will be savings in the entire system, but for the, say, mother under the poverty line and the children, how do you envision that this is going to work for them in terms of getting insurance and paying for it?

MRS. CLINTON: Well, if she's under the poverty line, she's already taken care of. So let's -- that's another point I want to make is that, right now, if you are on welfare, if you're in jail or you work for the federal government, you have guaranteed health insurance. And if you are rich and can buy it. That's about it. And so for people who are on poverty, they're going to continue to be subsidized the way they are now.

I mean, hopefully, welfare reform, which we've also got on the agenda, will get a lot of people off of welfare who are only there because they get health benefits that they don't get if they go to minimum wage. The real people I'm concerned about are the people who are just at or above poverty who are working, who are really being disadvantaged in this system.

And a lot of the single mothers -- that I take behind your question -- who get up and go to work every day instead of staying on welfare, have absolutely no health benefits. And one of the great myths, and this is really heartbreaking for me, is we have increased the number of the uninsured in the last three years by 3 million. We've gone from 37 to 40 million.

Eighty-five percent of those people are working people. And I think there's an idea in America that all these uninsured, they must just be sitting around, you know, driving welfare Cadillacs and just having a good old time and expecting us to take care of them. That's a whole lot of people, 40 million people, most of whom work and pay taxes.

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Those are the people, and the people who are at risk in any income category, either because they have a preexisting condition, they're between jobs, whatever their problem is -- every one of the bills or approaches that is not universal penalizes those people because what they do is to say, "Well, we'll take care of the poor. In fact, we'll take care of a few more of the poor. We'll subsidize up to 150, 185 percent of poverty." So we're going to take care of people up to what, \$16,000 a year, something like that.

Well, there are a whole lot of people who are making \$50,000 and \$40,000 and \$30,000 who are not financially secure and don't have health care. What has happened in the states that have subsidized the poor and put in insurance reforms is that the poor have, all of a sudden, got health care. And they go into the system where we would want them to go into the system.

But because they're in the system and there's no universal requirement that everybody be in the system, they then put extra burdens, because they're often sicker because they haven't had adequate medical care, on the insurance system, which then increases the costs for people who are not subsidized.

So in a lot of the states we've had -- you can have these charts that take Iowa or South Carolina or Oregon. All have subsidized the poor, and the number of people who work, who need insurance or used to have insurance but no longer do, has gone up.

Now, here's how we can take care of that. But we can only really take care of it if we have universal coverage. If everybody is in the system, you stop what is called cost shifting. Cost shifting occurs when someone gets medical care and cannot pay for it or cannot pay fully for it.

As I said, there is no free medical care. So somebody pays for that and you pay for it. The cost gets shifted onto people who are insured and onto the government. So you pay through your private insurance or you pay through taxes.

Now, why is that important? Well, it's important because, if you continue to have opportunities to cost shift, you can never get costs under control because there's always somewhere else to put it. It's like a shell game. It's like

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grabbing a balloon at one end and it pops up somewhere else.

If everybody is in the system, there isn't any way to shift those costs. And you can begin -- like having a giant prepaid system, in a sense, you can begin to control costs. Now, if you do that, you quickly eliminate the billions of dollars that are spent on insurance practices that keep people out of insurance. And you begin to be able to manage costs because more people get preventive care instead of expensive care at the end of their illness.

And you are also able to take the dollars that are in the system from the new people that are required to be in it and you can spread those around. So you've got new money coming in while you're getting costs down.

And that's the other big myth. People have said, "Oh, my goodness. You're going to ration care." We already ration care. We ration care in every city in America every day. Because if you don't have money or you don't have enough money, you go to the end of the line.

And I can tell you countless stories and you probably know some of your own. But if you have everybody in the system, then you've got a large pool of money, in fact, larger than we spend now in the short run. So where you don't ration care but you can begin to rationalize it in the sense that you can begin to manage the costs better.

We spend enough money right now to take care of every American well if we eliminated waste, unnecessary tests and procedures, insurance administrative and bureaucracy costs. We have enough money right now, but we don't spend it right.

So with new money coming in and controlling costs, those are the shorthand ways of explaining how we're going to be able to take care of people because people are going to be paying something for it. And this is not a free ride. I mean, even people on welfare, under the President's approach, would have to pay something.

Even if it was just a dollar for a visit or 50 cents or a quarter when they went to the doctor, they would have to pay something because they would have to be responsible. And so, you know, there's going to be more than enough money, but, hopefully, the money is going to be better

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managed.

And let me just end that with one quick story. If you look at the hospitals in New York City, or if you look at the hospitals in any state, you take one procedure that I know something about, the coronary bypass, you can find that it costs anywhere from \$20,000 to \$90,000 in the state of Pennsylvania, for example.

Well, how do I know this? Because the state went and they looked at records and they figured out how much everybody charged for the very same operation. They then looked at outcome. Well, did the people who got the \$90,000 operation, did they get better faster? No, they didn't. There was no correlation between cost and quality and outcome.

A lot of people, including some of us in this room, think, well, you know, gee, if your doctor drives a Rolls Royce he must be a better doctor. Right? There's no relationship. What there is is a relationship between how efficient you are in delivering the service and the quality that comes out.

And so, for example, if you have, in the state of Pennsylvania, a decision made that, you know, we can't spend \$90,000 on these things. So we should pay on average \$40,000. If somebody wants to go and pay \$90,000 with their own dollars, that's fine. You would actually give more people more coronary bypasses at less money than we do now.

So there is a lot to be done in just being sensible about how we deliver health care in America, which, until now, we haven't really had any incentive to do because we've just basically been writing a blank check year in and year out.

Q (Inaudible) from Newsweek. Your comments about the bite that insurance and administration takes out of every health care dollar, about the price of cost shifting and the need for universal coverage, all make an excellent case for a single-payer system. Why did the administration reject that approach so early on?

MRS. CLINTON: Well, I think, for two reasons, one substantive and one political. The substantive reason is that the President became convinced as a governor, and being

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on the receiving end of constantly increasing Medicaid costs and constantly increasing state's share for employee health plans, that what we needed was some competition in a marketplace that actually worked for consumers as opposed to those who are profiting from the system.

And the way to do that was to try to get some competition into the health care system where you had people competing on cost and quality instead of the bureaucracy and the confusion that exists in the underwriting system.

Because if -- when you looked at single-payer systems, they are very good at delivering health care and have been, up until recently, in controlling costs across the board. But there are danger signals in the best of the single-payer systems because many of them are realizing that if you only have one payment system and one delivery system there is no incentive to try to continue to control costs.

Everything becomes a political decision. There's no real marketplace competitive incentives. And so from a substantive perspective it looked like a better idea to try to get everybody in the system with guaranteed private insurance and then to give incentives to private insurers and providers to be more efficient.

Because, you know, somebody in Minnesota might learn something that would work better than somebody in Florida, for example. So he wanted to keep that element of competition in the system.

And, actually, in the last year and a half, I've had visits from probably six or seven health ministers from single-payer systems who talked to us about how they could maybe introduce some competition into their single-payer systems. So there is a lot to be learned coming in from both directions.

But the second issue was political, and that is, that, you know, it is very difficult to persuade many Americans that a single-payer system would work in their best interests.

In fact, one of the most astonishing experiences I've had is I've traveled around and people come up to me all the time and they'll say something like, "Keep the government out of health care." And I'll say, "Well, I'm not sure

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exactly what you mean. How do you get insured?"

And nine out of ten of the people who say this to me say, "Through Medicare." People in America have no idea what Medicare is. So they, therefore, think that single-payer is, you know, the first step toward socialism.

To try to make that argument against such a misunderstanding of the way our own system works in the Congress seems too big a hill to climb. So the substantive and the political were both at work, which is why the President's approach would guarantee states that wanted to go single-payer to be able to do so.

Because on a state level, over an extended period of time, you could deal with a lot of the arguments that come up against single-payer. And many of the states along the Canadian border said they wanted that option because that may be the way that they go. So that's the reason that we decided that this approach, which was kind of an American solution to an American problem, seemed better.

Q I'm Barbara Tober (phonetic) from Bride's Magazine and, as you know, Betsy McCoy, who is now running for lieutenant governor, at the Manhattan Institute did an analysis of your original health care program. I wondered if you felt that she -- her analysis had been helpful and (inaudible) how many adjustments have come along the way. I don't ask you to quantify them, but I'm curious.

MRS. CLINTON: My memory of that was that her piece was factually inaccurate in a number of very important ways that really undercut the analysis she was trying to make. I think there were a couple of points she and other people made which have been listened to. And that is, that people, going back to the single-payer system, didn't even like the idea of large alliances within states. That bothered a lot of people.

So those have been basically done away with, and there will be voluntary cooperative buying groups that people will be part of. And it's a continuing educational effort to point out that the President favors guaranteed private insurance, not government insurance.

And the fact that some people misunderstood that has given us cause to say it over and over again because we don't want to be misunderstood. We don't mind if people disagree with us. We just like them to get their facts

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straight before they do, so we can have an honest conversation about it.

So, you know, that's really all I remember from that. I don't have any other comments on it.

(End of speech.)

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