Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	[handwritten note on back of speech] (1 page)	n.d.	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 20035

FOLDER TITLE:
HRC Remarks II [1]

2013-0534-S
ry1571

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript May 7, 1993

REMARKS OF THE FIRST LADY
TO THE BUSINESS COUNCIL

Williamsburg, Virginia

MRS. CLINTON: Thank you very much. I am delighted to be here and have this opportunity to visit with you. I know you've already had a number of very substantive and useful presentations about health care. And I'm looking forward to the opportunity to hear your questions and be able to do my best to try to describe where the administration is in this process.

I wanted to say just a key word about the process and -- (inaudible) -- especially to this group. The process that the President put into motion in order to seek out and find the best possible approaches to dealing with our health care crisis, because it is a crisis, has been unprecedented. It struck the President as a bit odd that it would be viewed in Washington and somewhat unusual to try to bring together in one effort people who cross all kinds of bureaucratic and other lines to work on behalf of a common agenda.

But apparently, as I was told the other day, there hasn't been anything quite like this effort since the planning of the invasion of Normandy. And I think that's a sad commentary to some extent on our domestic agenda in which we have allowed ourselves to be viewing these problems that are national problems through the prism of various bureaucratic agencies, various special interests, and losing sight of what the national common interest should be.

To that end the process has, first of all, tried to pull together from within the federal government itself those people with expertise, and then to go out and seek advice from some of the people you've already heard this morning, but many many others who have brought particular points of view to bear.

I'd like to give you just one idea of how difficult this has been and why it is so imperative that we follow through on what we have started. When I began this process, I learned very quickly that within the federal government itself there were at least five

major agencies using different economic models based on different economic assumptions to drive different kinds of cost projections with respect to health care. And there were many other less important agencies who had pieces of health care who themselves were engaged in comparable effort; with the result that if one turns to the federal government and says, what would this proposed benefit package cost? One would receive, as I did, answers that varied in cost between $500 and $600, which on aggregate when one is looking at an entire nation, is an extraordinary amount of money.

We therefore concluded before we could go forward with the kind of intensive policy debate that this issue required, we first had to do everything we could to get the numbers right. Now, that may sound like an elementary conclusion to you, but it apparently was rather revolutionary in Washington.

And we put into place a process that has now been going on for three months, where we got for the very first time all of the actuaries and all of the economists from within the federal government who have influenced health care policy over the last 30 years, but who had never been convened together. And we began forcing them as best we could to deal with one another, to examine each other's economic models and assumptions, and to go through a process that would give us the best possible numbers.

In addition, we convened a panel of nongovernmental, outside actuaries and economists who deal with health care and some of whom have been consultants to or in the employ of some of the businesses in this room, to second-guess and double-check the federal process. I cannot tell you how complicated it has been to reach some consensus among the government employees themselves about this issue. But I have said from the very beginning we would not go forward with policy proposals until we had agreements on numbers. And we will have the best numbers that the government has ever had before we do so. And we are close to a revolution of this, because we are now running various iterations based on the agreed-upon model.

But I wanted to start by giving you some sense of what the President has been up against in trying to harness even the resources of the federal government to speak with one voice about what the health care crisis is costing us, what the projected costs will be for the kind of policy recommendations that he favors, and what these savings will be to try to reach some net figures that we could consider credible.

In addition to the kind of hard work that underlies this process, there has been an extraordinary amount of consultation. Many of you in this room either through your individual capacity or through your corporation or through associations with which your

corporations is associated, have been part of the more than 1,000 meetings that have been held between interested parties and persons and members of this health care task force.

That process of consultation will not only continue but intensify over the next weeks as we get to the point of hammering out the policy recommendations based upon what we believe will be the best available numbers to share with you.

In addition to the analytical and evaluative and consultative process that has gone on within the task force, we have also worked very hard to begin a substantial public education effort; because one of the principal difficulties we face is that the American public is aware in a personal way of their health care situation, but is not aware in the aggregate of what our health care choices have meant to our economy, to our quality of life, to our future stability. And so we are working very hard to reach out to enable people to be participants in a very broad conversation about what is the state of health care today; what is the real cost; and what future policy changes will mean for them personally.

I think that it is also a real difficulty for us is that even sophisticated decision-makers in their own areas often have overlooked the real impact that the rising and in some respects uncontrolled health care costs have had on their business interests and on the long-term growth prospects for -- (inaudible).

Many of you have had an occasion to hear presentations about the impact that health care costs have had on the deficit. But I want to underline this, because particularly important to this group, that we have worked very hard in the last several months to put together a credible deficit reduction proposal -- the first that our country has really undertaken seriously in several decades. But it is also clear that given the growth of health care costs in the federal budget that even were we to adopt the President's proposals, which, of course, I hope we will, it will create $500 million of savings in the deficit over the next years; that within five years the deficit will continue to rise because we will failed to deal with the principal driver of the rising deficit, which is health care costs.

And I think that the interrelationship between our economic fortune and the deficit reduction that is necessary for us to regain economic and financial stability for the long-term must always be talked about in the same breath as health care reform. We have to make it clear to businesses of all sizes as well as to individual citizens what is at stake in this health care reform effort.

So we are attempting then to do a number of things at once. We're attempting to educate ourselves, educate the American public, come up with a credible set of cost and savings projections, and create a policy that will reassure the American people that they will continue to have access to the best possible health care. They will be secure in their access, but there will be changes in the way health care is delivered so that we can begin to try to discipline the health care system and its costs that will eventually benefit all of us.

So those are the kinds of multiple goals often times difficult to describe but always -- (inaudible) -- that are driving this process.

And my final word on an introductory basis is this: There are many good ideas about how to reform the health care system. And you have heard from two of the leading advocates for the need for change. You just heard from Dr. *Dreyheart and *Entopin. What the process the President has begun, is attempting to do, is to put together a workable solution that draws from a number of recommended proposals that will be understandable to the American people and will result in the changes we are seeking.

There will be plenty of opportunities for people to argue over the details. But I hope that as we argue over the details, we keep in mind the overriding imperative to change what we are doing now and to do so with the goals of controlling costs; providing universal access, because access and cost containment are inseparable; and to retain and improve quality.

If we keep those overriding objectives in mind, I'm confident that we can work out the details. We want you to be involved in helping us work out these details, because there are a number of issues on which your experience, both in the corporate world and as reluctant but necessary managers of health care, can be extremely beneficial.

But there is not any -- (inaudible) -- way to do this. There is not any easy to do this. There is not any universally acceptable way to do this that is real. There are lots of folks on the sidelines who are promising to be able to deliver on health care reform with no pain and no change. This amounts to one of the most important restructurings that you will ever be part of. If done right, which I'm confident it can be, it will also be the most important role that any of us will play in ensuring the long-term economic and social well-being of this country.

Thank you all very much. (Applause.)

I would love to be able to answer your questions or to describe further what we are thinking about, if any of you want to

pose a question. And I would appreciate it if you identify yourselves, if that would be all right.

Q On the premise that disease prevention is one way to improve the cost efficiency of the system, do you have any encouragement in terms of your deliberation that delivery system as it relates, for example, to immunization or to delivery of services to rural areas can be improved under the auspices of the plan that you're working on?

MRS. CLINTON: Yes, sir. Let me tell you where we believe we can make a big difference, because we are not just changing the way we finance health care, because the changes there are not going to be all that significant; we are mostly concerned with changing how we deliver health care, because we think for both quality and cost reasons that is the key.

We are looking to have the kind of standard uniform benefit package that Dr. *Entopin referred to at the end of his remarks, which will heavily emphasize primary and preventive health care; because we have had it backwards for so long now. We will pay for your hospitalization for cancer, and we will not pay for your pap smear or mammogram. We will pay for your being the victim of the increasing number of measles epidemic in our country, be we won't in our insurance system pay for much of the well child care and the immunizations that would hopefully prevent that more costly experience.

So in the benefit package that will be proposed by the President, primary and preventive health care will be a part of it. We think if we can begin to provide that primary care and begin to encourage more people to utilize it, because it is now reimbursable, we will in that way alone begin to lower a lot of the costs of acute care.

In addition, in rural areas, we believe that the kind of integrated delivery network of care that will be the result of the proposal that the President will make, will benefit rural areas particularly. There are many people in rural areas who do not have adequate access to health care at this time. We need to provide that access in two ways: We need to increase the number of practitioners and facilities; we need to change a lot of the rules that will enable us to do that; and we need to hook in rural providers into integrated delivery systems so that they are part of providing care on a continuum to residents of rural areas.

Let me just give you a few examples. We have had for the last year a system through Medicare, which has subsidized the graduate medical education of specialists. It is not, therefore,

surprising that the specialists are now outnumbering by a substantial majority primary and preventive health care physicians. We need to change those incentives so that we can provide more of the kind of personnel that are required not just in rural areas but across the nation.

We also need to encourage the use of other medical care professionals, like nurse practitioners and physicians assistants. They are particularly important in rural areas, but there is also a role for them elsewhere. In order to do that, we have to do things like change the anticompetitive statutes of a number of states that have tried to keep many practices and procedures for the sole -- (inaudible) -- of physicians; or even if given the opportunity, to people who are under the direct control of physicians. We have to change the way we think about who can deliver primary and preventive health care.

We need to make better use of technology. We are now running from good experiments around the country where you have small hospitals in rural areas hooked up with interactive video in more sophisticated medical centers that provide better health care.

So there are a number of ways that we think by changing the delivery system so that rural areas are part of the same system and the physicians and other practitioners in those areas are not out there on their own, and the reimbursement for services is not heavily skewed against rural areas as it is in many ways now, that we will create a better supply of medical care in those rural areas and begin to deal with a lot of the access problems that currently exist.

Q -- (inaudible) --

MRS. CLINTON: Yes, sir. In fact, regulatory reform and administrative reform are at the key of the cost savings that we think are within the system. I believe that it is a fair estimate to say that 20 to 25 percent of the costs that we currently have within the system could be better allocated, as well as eliminated.

Much of that is because of the point you make. We have over the last years, but particularly within the last 10 years, particularly within the Medicare and Medicaid system, have created a regulatory model in which checkers checked checkers, in which there is constant second-guessing about decisions that are made which have no value added to the delivery of health care or as the outcome of that delivery.

We believe that we will have to do two things simultaneously -- well, actually a million things simultaneously -- but two big things simultaneously. As we move on cost containment

and universal access, we will be moving on eliminating a lot of the unnecessary regulation and paperwork and administrative bureaucracy that is now eating up a large portion of our health care dollars. There is no doubt that if we move, for example, as we intend to do, to a streamlined reimbursement system, that fuses, we hope, one form, but certainly very few forms, that we will save an enormous amount of doctor and other practitioner time as well as money.

The average physician is actually spending somewhere between 30 and 50 percent, depending upon the nature of his practice, on his income, on the kind of support services that consist of filling out forms, arguing with insurance companies over who pays for what, making sure that the proper kind of reimbursement protocols are met -- from the both private and the public third payers. That has to be gone. And it is one of our most important goals.

Now, the cost savings that that will generate will come over time. It will not be immediate. But we really believe that if we focus on that, we will be successful in saving billions of dollars.

And the other point I would make about the regulatory reform issue is that part of the reason we have -- engage in so much regulation over the past years is because there is this sense among all of us, whether we are private payers or public payers to the health care system, that there is a lot of unnecessary costs and flaws and abuses going on.

And there is now a growing realization as for the reasons why. And one can see it anytime one looks at a hospital bill. I saw it graphically illustrated the other day when someone sent me a bill for a relative's stay in the hospital and showed me the comparable cost in the marketplace of some of the items that were being billed for. And we all know about the $50 Tylenol. Well, we also know about the latex gloves, which you can go and -- (inaudible) -- wholesale and buy for $28. But if they're used when you're a patient in the hospital you'll be billed for maybe $100. Or for the foam rubber mattress that you can go and buy at some outlet for maybe $100, but you'll be billed $1,100.

Why is that happening? Is every hospital administrator in America a crook? No, of course, not. The reason it is happening is because we have so much uncompensated and undercompensated care being delivered in hospitals that you and I and our insurance companies are therefore billed, and the Medicare system is therefore billed, to be able to pick up the slack. That difference between the $100 and the $1,100 for the foam mattress pays for somebody showing up who is uninsured at the emergency room and being treated for

something they should have been treated for all along at much less cost to the primary and preventive health care system.

So we have to begin to rid ourselves of the regulation that has attempted to try to control this unsuccessfully and move toward much more administrative simplification, which I think is going to be the primary goal -- (inaudible) -- administrate the changes -- (inaudible).

Q -- (inaudible) --

MRS. CLINTON: My answer is yes, I believe more is necessary. And I don't know whether it will have as significant an impact as some people argue it will. We have looked exhaustively at every study that has been engaged in. And as Robert Reischauer, the head of the Congressional Budget Office, testified in Congress recently, the -- (inaudible) -- for saving are in the ballpark. I mean, you've got a low of $2 billion, which are studies that are obviously favored by -- (inaudible); and you have a high of $40 billion, which are studies obviously favored by physicians.

The truth is somewhere in the middle. I don't know that we will ever know where it is. But the facts are that for whatever reason and for whatever combination of factors, the medical malpractice system has had an impact, an adverse impact, on the cost of practicing certain kinds of medicine, absolutely. Obstetricians are often viewed as the primary victims of this, and have had an impact -- again, incalculable -- on the proliferation of checks and procedures.

There is, however, a much more important reason for the proliferation of tests and procedures, and that is the whole fee-for-service system where we pay on the basis of tests and procedures. When you are in the Medicare system, you get paid on the basis of how many tests and procedures you run, not on how well you treat this single human being and what kind of outcome you get.

So what role the malpractice system plays in increasing defensive medicine is -- again, I cannot tell you exactly. But we do need malpractice reform in order to weed out whatever that cost is. And we intend to come forward with that.

Q I'd like to ask a question about a more narrow area, specifically the diseases of alcoholism and chemical dependency. In the last three years as a result of the application of -- or maybe misapplication of managed care -- people are being denied the ability to go for treatment for these diseases. The net result is 40 percent of the rehabilitation beds in this country have

been closed in the last -- months. How does your benefit package deal with these important diseases?

MRS. CLINTON: That's an excellent question. And I have to say, this is a prefatory remark. Alcohol and drug abuse are not only problems in and of themselves, they are contributing in underlying cost problems within the entire system. I became interested in this when I began to look at lengths of stay in hospitals and compare like kinds of injuries among the same kind of people -- a, you have two four-year-old white males had been burned severely, go into the hospital; where there is an underlying alcohol problem it takes 10 to 12 days longer for the treatment to be effectual. So we are therefore, in effect, paying more for the underlying alcohol problem, even though we're treating a burn problem.

So this issue is not just an alcohol, drug issue, it is a much deeper and more -- (inaudible) -- health care problem. We intend in the comprehensive benefit package to provide for mental health treatments and substance abuse treatment. We are very conscious of the experience that a number of the corporations in this room have had in trying to monitor effective mental health and substance abuse treatment. But we believe that providing it as a comprehensive benefit will create a bigger and more effective market than we have currently have.

When Mrs. Betty Ford came to visit me recently to talk about the Betty Ford Clinic, she brought with her documentation showing that the cost of the Betty Ford Clinic, which is generally acknowledged as a very successful treatment center, is substantially less than many other treatment centers that don't have the same kind of positive outcome. And yet many people because of the celebrity connotations associated with that, would assume otherwise. And there has been very little base information on which to make good management decisions about the kinds of programs that really work effectively.

And I would just throw in an additional point here. We also need to be looking at ways that we can deal with some of the hard-core problems represented by the severely addicted and severely mentally ill. And here is a perfect example of why it is important for us to move in a comprehensive way at once, if one looks at the mentally ill community.

Twenty-five or more years ago, actually in the late 1960s; I think it was a combination of a Johnson-Nixon policy -- we made the decision to deinstitutionalize the severely mentally ill. And we were going to have home-based and community-based care for them. We did the first part of this, and we never did the second.

The results are lying on the streets and in the parks of every one of our cities.

We, therefore, need to think clearly about how to deal with these severe problems in an effective way. And we are looking at the creative ideas of such things as treatment with conditions, so that people who receive treatment and then fail to follow through, we will have to look at more -- perhaps more restricted confinement, where if they are a danger to themselves and others, or where they could possibly are public health dangers, such as the growing tuberculosis epidemic.

So I hope that if we move forward in this policy debate, substance abuse and the mentally ill will be seen as part of the comprehensive problem that needs to be resolved.

Q Mrs. Clinton, building on that, you mentioned that there's -- (inaudible). How much is the President's proposal going to cost? What do your models say, and how do you propose or how will he propose to allocate those funds?

MRS. CLINTON: Well, I assume since I'm talking to a group of business executives and off the record, unlike talking to people on Capitol Hill and off the record -- (laughter) -- and what I say to you will not be immediately told to the press because I want to be as straightforward as I can in this process. I am learning that that is a very difficult matter. (Laughter.)

And -- (inaudible) -- to my experience, because the other day in a bipartisan meeting that was an exceptionally good meeting where there was a lot of good give and take and a great deal of honesty on all sides, I explained where we are in this cost issue, and one participant in the minority, but with his own agenda -- (inaudible) -- contact and carried off his particular point into the sunset. It's a real shame. I just -- (inaudible) -- as I come from a primarily private sector experience, I wish you all would just take a minute and imagine what it is like to try to make important decisions with people peering over your shoulders who are running their own agendas, and may therefore not keep in confidence whatever you tell them from minute to minute. It makes public life very challenging.

So what I would like to say, given those ground rules is that we don't have a final number, as I said in my very opening remarks. And I'm not going public with any numbers until I can absolutely defend them and not be ticked off by somebody saying you forgot assumption 942, which throws you off by $10 billion.

We see two things happening simultaneously. If you look at how we achieve universal access and cost containment at the same time, there are very few options available to us. We can either move towards an entirely government-funded system -- and I know there are some among you that advocated a large VAT in order to achieve that government-funded system, in part because you believed that you would be better off competitively if you were out of the health care business. But if you look at what it would cost to replace all of the dollars currently spent in the private sector to support health care in this country, the amount of a VAT would be extremely large. There is some variation as to how large. Some people say a 17 percent progressive VAT that would eliminate food and rent and utilities would be required. Others say if it were progressive, it would have to be 22 percent -- within 17 to 22 percent range. A regressive VAT that included food, rent, and utilities would perhaps be in the 8 to 10 percent range.

That is one alternative. There is another alternative which is a government-financed system that keeps some private base, but adds a VAT. And people have come forward with a proposal for that, which is approximately a 7 percent employer-paid roll with a 7 percent VAT to try to get the equivalent dollars.

The President has rejected both of those for policy reasons, for substantive reasons and for political reasons. It just seems that it is very difficult to describe to the American people why we would need a huge general tax increase to fund our health care system in a more effective way when we believe there is a tremendous amount of money within it that can be better utilized in ways which can be eliminated.

So if we're not going to move toward a general government-financed tax-based system, then we have the various alternatives that fall under the broad rubric of a premium approach, whether it is a pure premium in which there is some kind of mandate for insurance obligation on the individual and the employer, whether it is a premium as a percentage of payroll, there are a number of possibilities there.

And then there -- our third alternative, which we do not believe will solve our problems, which talk in terms of mandating the individual, either through a medical IRA or some other means, to go out and get his or her own insurance. We do not believe that will adequately address cost shifting and achieve universal access which will therefore further exacerbate the kind of cost shifting that is currently going on.

If you look at the kind of benefit package that we think is reasonable, it is not the top-dollar benefit package, but it is

equivalent to what most Americans now have in their insurance packages. We think that if you had a combination -- not new taxes, but a combination of public and private sector investments and the private sector would be both employer and employee, and the public sector would be both significant front-end savings and some additional revenues, most likely from a cigarette-alcohol tax combination, because of their direction relation to health care costs -- that the whole package of investments would be about $100 billion. And that is not $100 billion in new taxes, but it is $100 billion in new funding that would go into the system.

At the same time, we believe there is approximately $100 billion in public and private savings that would be -- (inaudible) -- realized almost immediately. So what we are attempting to be able to do to show you and to show your colleagues around the country is that for most of the businesses in this room, and maybe all of the businesses in this room, we believe that within a relatively short period of time, your real costs of health care would decrease. We believe we would stop your escalating costs and begin to decrease the costs that you currently pay.

One model that we are looking at is a model in which we do require all employers of whatever size to participate through an employer contribution and the acquisition of health care for all their employees and require all employees to make a contribution.

If we phase in what we believe will be the decreases that many of you will realize with the new requirements on the smaller businesses, we think we would get to a level of -- (inaudible) -- in terms of a premium-based payroll percentage that would be about 7 to 8 percent of payroll. I bet there are not many of you in this room that are paying only 7 or 8 percent of payroll for health care right now. We know that some of the car companies are at 20 percent of payroll. And we know that some of the older manufacturing industries are at 15, 16 percent of payroll. And many of the rest of you are at 10 to 12 percent of payroll.

There are large sectors of the economy that utilize large numbers of first-time workers that are not at 7 percent of payroll; as well as small businesses that currently do not make a contribution.

In addition to health care reform, however, we think you will not only get savings because everyone will finally be contributing, which will stop the cost shifting, stop requiring you to run health care businesses on the side to try to keep your costs down, but we also intend to fold into health care reform the health care portion of workers compensation and automobile insurance. If you add to what you are currently paying for health care, your

workers comp -- (inaudible) -- your auto insurance-health care costs, I think we will be able to show you that it will be greatly to your economic advantage to support the kind of plan we are putting together.

Most small businesses currently provide some kind of insurance. The number is about two-thirds. And one of the points we have begun to make to the small business community is that the small business that is currently providing health care, it sits on some main street in Norfolk or Newport News, next door to a small business that does not. It's subsidizing the next door business, because the health care payments that the first make keep the hospital in the town open, keep the physicians employed in a direct way. And those services are available to the employees of his neighbor and perhaps competitor. It has been an extraordinarily unfair competitive advantage for businesses with whom you compete or even smaller businesses that you have been paying for their health care. Often times not only for their employees health care, but for the owners health care as well.

What we are also hoping to be able to do is through a phase-in that will commence as soon as we would be able to pass this legislation, be able to move on a lot of these administrative fronts that you have asked about before.

I cannot give you this exact number until the end of next week when we finish all of our economic work, but we really believe that the gross investments will be offset by savings of an equivalent amount. Now, that will require action by the government as well as the private sector. So let me just give you two more quick examples to illustrate my point.

Medicaid currently provides health care for two categories of people generally: there is the Medicaid disabled population. Those are people with chronic disabilities under 65, often confined to a nursing home. And there are the Medicaid-funded nursing home patients. And we have some fairly good evidence, we think now, that the right kind of managed care will benefit the Medicaid disabled and -- (inaudible) -- less money, because there has been some very good models that have shown how we can achieve better quality care at less cost with that population.

The other category that is primarily children, if one compares what we pay for the Medicaid child health care, with either an insured child or an uninsured child who seeks comparable care, we pay a lot more for the Medicaid child care. There are a number of reasons but the principal reason usually is because they seek care from the most expensive source. The emergency room is the family's doctor.

By bringing Medicaid immediately into this comprehensive system and imposing the same kind of competitive discipline that we think will work with the rest of the system on that population so that they are part of integrated delivery networks, they are eligible to get access to a primary preventative health care physician, we will save an enormous amount of money that you will no longer have to subsidize, both directly through taxes and indirectly through your insurance premiums.

And a second quick example is that if one looks at Medicare, Medicare has done through regulation a job over the last several years of trying to control prices. One of the results of their attempt has been that volume has increased to a great extent. If we leave Medicare outside this system completely, where it is not -- not a part of the comprehensive health care reform, we will not get an end to kind of cost savings from the entire system that we want. So we will eventually, we hope, be able to move toward phasing in Medicare as well. And once everybody is in the system with their various payment sources, we think the total cost of the system will not only stabilize at the frightening figure of 14 percent GDP, which it currently is, and not go with the 19 percent projected for the year 2000, but begin to decrease. And so that is where we are coming from and looking at an employer-based system building on what we have but with that kind of approach that we think will save all of you money.

Q -- (inaudible) -- it's been suggested by some that during the transition period, and where we are today -- (inaudible) -- some form of inner price control would be required. Can you comment on that?

MRS. CLINTON: Yes, sir. We have struggled with this issue. And I don't know any easy way to get to a conclusion on it. But let me just outline some of the issues we have tried to think through.

As we transition to a new system, we, every month, lose ground because costs continue to escalate and eat up more and more of our disposable income. And if there were a way to wave a magic wand and have the health care providers, and those within the health care economy, voluntarily -- and mean it -- voluntarily impose discipline on themselves to control prices, it would be one of the greatest gifts -- and I would argue, and I don't want to sound like a -- (inaudible) -- but I would argue a very patriotic thing to do at this point in our country's history.

And as you know, from -- (inaudible) -- prospective, several major institutions have come forward with just such a

proposal that the administration is looking at very carefully; because it would be our preference to avoid price control if we can do so. But we also know that in addition to the responsible members of the health care industry, there are many who do not air that -- (inaudible) -- and will be intent upon pushing the system to the limits because they are afraid of the new discipline that any reform would impose.

So we are considering looking at voluntary price freezes with legislative stand-by authority that could be triggered. The only reason we would do so is to try to stabilize the system where it is now; to try to send a message to the American people that not only the President is concerned about this but even the responsible people within the health care industry are concerned about this. They all know what a crisis it is. And these will be sun-setted or lifted as soon as we have made a substantial enough transition to this new system that we think will work. That is -- (inaudible) -- the administration is thinking about.

There are those in Congress, as the majority of the American people, who believe that price controls are the answer to health care reform. That is how they view it. They believe that everybody's made a tremendous amount of money off of the system in the last years.

And so there is a tremendous political pressure to impose price controls and do so as the answer to health care. The President obviously doesn't buy that. But some effort to try to stabilize prices while we move toward a new system, hopefully in a truly effective voluntary way, may be sought.

Q The good news is that in the first quarter we are seeing a dramatic reduction in our suppliers, both pharmaceutical and surgical supply; 89 percent -- (inaudible) -- year-to-year price increasing. I'm confident that the labor-intensive health care provider side of the -- (inaudible) -- of health care system that we can also bring down labor costs two to three to four percent year-to-year increasing. My big concern is how we win with voluntary or mandated global budgets if over 50 percent of our business will be frozen for up to two years as Congress is passing -- the House has -- on the Medicare portion. It's just impossible to do, you can -- (inaudible).

MRS. CLINTON: Let me say two things about that. And I don't mean this to be critical but just as a comment. It's an interesting comment on the market that any sector of the economy can drop prices so dramatically in such a short period of time. I think that that is a very salientary point to keep in mind, which is why I think some kind of voluntary action is entirely within the realm of

the economically feasible for most sectors of the health care economy.

Secondly, global budgeting, as the administration considers it, is a fail-safe mechanism. If a competitive market really works so that suppliers and deliverers of health care truly are competing and don't have the kind of range of options to be able to pick and choose their prices without much fear of any accountability because they have no discipline then imposed upon them in the marketplace, then we won't need budgets.

I don't think the country, though, can take the chance that that will work immediately. We have a lot of cultural and attitudinal changes that have to take place in this entire system starting with the individual and going up institutionals.

So I believe that a budgeting system that sets targets and gives a realistic view to the entire country of how much this country is willing to spend on health care, which is allocated in at the state level, will have varying effects on individual hospitals depending upon where they stand currently within their own budget disciplines.

I can't answer what the exact impact of freezing GRGs and some of the other Medicare changes that the President is proposing will be in the short run, but we hope that we will begin to be able to move away from a lot of that regulation so that hospitals and doctors together will make the right decisions for patients. But we think that there has to be some sense of a budget within which those decisions should be made; that until the market in this sector of the economy -- and from my prospective, the market hasn't worked either in health care or in higher education financing or in a lot of other surface areas, effectively -- so until we can get more effective market mechanisms that work in this industry that had been immune from the market, I don't see how we can count on the people who are currently within it even effectively dealing with the changes in the absence of a discipline of a budget. So that's where we are.

Thank you.

END

Draft Talking Points on Managed Competition and the Administration's Approach to Health Care Reform

Our approach to health care reform is unique. It may not exactly fit the "managed competition" label, just as it doesn't fit "pay or play" or "single payer".

Our approach is a hybrid: it takes what's best from different reform approaches and melds them in a way that makes the most sense for Americans.

The President's framework for health care reform is clear: he wants a privately-run health care system, he wants people to be able to choose their own doctor or health plan, he wants a system that controls costs and covers all Americans, and he wants a system that offers the highest quality medical care. Within that framework, there's a lot about the "managed competition" approach that's appealing: "Managed competition" preserves and promotes the private, competitive system, and lets people have more say in making choices about their health care.

But it's also true that "managed competition" may not work everywhere: any health care solution for America has to work in all of America: rural areas and inner city areas as well as elsewhere.

Some managed competition purists believe that with a system of managed competition there's no need to set a budget: the market alone will work to bring health care costs under control. They may well be right. But the President's not willing to ask the American people to wait and see. Setting a budget gives us the peace of mind that health care costs will be predictable and controllable, no matter what.

The appeals of a single-payer approach are the cost-containment principles, the simplified paperwork and the benefits package guaranteed all Americans.

The problem with the single-payer approach is that it relies on dismantling much of the current system-- good and bad together.

Our approach will adhere to the single-payer principles of reduced bureaucracy, cost containment and guaranteed coverage, but it will do it by building on what works in today's system.

The appeal of the "pay or play" approach is that it tells employers that they have a responsibility to provide health insurance for their workers. The problem with that approach is it doesn't guarantee that costs are brought in line.

Our approach will say to employers: you have a responsibility to help your workers get coverage, but we'll take responsibility to see to it that your premiums are fair and predictable.

The President is committed to forging a health care program that is uniquely American-- one that is rooted in the private sector, builds on the existing employer-based system, and guarantees all Americans the right to choose the doctor.

TALKING POINTS ON HEALTH CARE TASKFORCE
AND THE "TOLLGATE" POLICY DEVELOPMENT PROCESS

WHAT THE TASK FORCE IS . . .

President Clinton established the Task Force on National Health Care Reform to develop a proposal that would bring spiralling health care costs under control and give American families the peace of mind and security they deserve. The President gave his Task Force a clear charge: by building on the work of the campaign and the transition, and incorporating suggestions and advice from all corners, prepare health care reform legislation that he can submit to Congress within 100 days. President Clinton's Joint Address to Congress emphasized that Washington can delay no longer: the American people demand health care reform now.

Demonstrating his level of commitment to solving this complex problem, the President appointed First Lady Hillary Rodham Clinton to chair the Task Force. As President Clinton said, the First Lady is not only experienced but is capable and effective at bringing people together around complex and difficult issues to hammer out consensus and get things done.

The Task Force also includes representation from the highest levels of the government -- including the Secretaries of Health and Human Services, Labor, Treasury, Commerce, Defense, and Veterans Affairs -- as well as senior White House officials.

POLICY DEVELOPMENT: THE "TOLLGATE" PROCESS . . .

The overall policy development effort of the Task Force is being coordinated by the President's Senior Adviser for Policy Development, Ira Magaziner, and is based on the "Tollgate" system -- a research and decision-making process commonly used in the business world for large-scale projects that need to be completed quickly. To advise the Task Force, Mr. Magaziner has formed over 25 working groups. These working groups, which are divided into health policy subject areas, will guide their research efforts through a series of tests, or "tollgates", before a comprehensive set of options is presented to the President for consideration.

The first series of tollgates -- the broadening phase -- require the working groups to put all serious options "on the table" -- ensuring that all issues are considered, all questions are discussed, and that the correct methodology is being used. The next phase of the tollgate process narrows this broad group of options and makes draft recommendations, which will later be synthesized into a comprehensive set of proposals for the President. At that point, auditors will check to ensure that all cost and savings projections are sound, and that all legal concerns are addressed.

AN INCLUSIVE PROCESS . . .

The President and First Lady feel strongly that this be an open and inclusive process, and have structured the system to encourage participation from all levels of government, all segments of the health care industry and the business community, and the American people.

Over 400 people -- including officials from various agencies, Congressional staff, health care experts, and White House personnel -- are directly involved in developing policy within the working groups.

In an attempt to make health care reform respond to the concerns of both those who receive health care and those who provide health care, there are doctors, nurses, social workers, and hospital administrators working on -- and often leading -- many of the working groups. In addition, diverse panels of consumers and health care professionals will be brought in regularly from around the country to advise the working groups as they develop their recommendations.

Representatives from several White House departments -- including Congressional Relations, Inter-Governmental Affairs, and the Public Liaison's Office -- are actively reaching out for advice from members of Congress, state and local governments, organized health care interest groups, representatives from small and large businesses, and the American people. All groups have been encouraged to submit written proposals and many are being brought into the White House to meet personally with the First Lady, Mr. Magaziner, and other working group members.

In addition, the Task Force operates a round-the-clock "War Room" -- which receives the thousands of speaking requests, policy papers, letters and phone calls from Americans concerned about solving our health care problems. And whether it be a hospital administrator's treatise on malpractice reforms or a widow's handwritten letter expressing outrage at her skyrocketing prescription drug costs, each inquiry is taken seriously, channeled to the appropriate working group, and given immediate consideration.

The First Lady has been travelling throughout the nation talking to the American people about their health care concerns and their suggestions on how to reform the system. She has accepted several invitations to participate in roundtable discussions that will be held throughout the country in the next month -- where she can listen to the recommendations of all the people -- consumers, providers, and special interests -- who are eager to contribute to the Task Force as it develops its proposal for comprehensive health care reform.

DRAFT

HEALTH CARE TALKING POINTS

Summary

Americans are getting killed by skyrocketing health care costs. What you're charged for health care is rising four times faster than your wages. That doesn't make sense -- and it threatens your family's future and every business, large and small.

President Clinton is committed to fundamentally reforming our nation's health care system. The Clinton plan will make sure that what you're charged for health care stops rising faster than your income and provide security to every American family. We'll maintain the highest quality medical care in the world, and preserve your choices.

Powerful lobbies and special interests are already lining up to defeat our program. They oppose change because they benefit from today's profitable system. But we are committed to breaking the gridlock.

It won't be easy and it won't happen overnight. But we will stand with you and take on the special interests. No American will feel secure again until we bring health care costs under control -- and make it possible for your family to get ahead again.

Goals

The Clinton health plan will:

1) Make sure that what you're charged for health care stops rising faster than your income.
2) Root out fraud and overcharges.
3) Provide security and peace of mind, so that you don't lose your insurance or get denied coverage because you're sick.
4) Maintain the highest quality medical care in the world, and preserve your health care choices.
5) Simplify the system.

TALKING POINTS ON HEALTH CARE TASKFORCE
AND THE "TOLLGATE" POLICY DEVELOPMENT PROCESS

WHAT THE TASK FORCE IS . . .

President Clinton established the Task Force on National Health Care Reform to develop a proposal that would bring spiralling health care costs under control and provide American families with the peace of mind and security they deserve. The President gave his Task Force a clear charge: building on the work of the campaign and the transition, and incorporating suggestions and advice from all corners, prepare health care reform legislation that he can submit to Congress within 100 days of his inauguration. President Clinton's Joint Address to Congress emphasized that Washington can delay no longer: the American people demand health care reform now.

Demonstrating his level of commitment to solving this complex problem, the President appointed First Lady Hillary Rodham Clinton to chair the Task Force. As President Clinton said, the First Lady is both experienced and effective at bringing people together around complex and difficult issues to hammer out consensus and get things done.

The Task Force also includes representation from the highest levels of the government -- including the Secretaries of Health and Human Services, Labor, Treasury, Commerce, Defense, and Veterans Affairs -- as well as senior White House officials.

POLICY DEVELOPMENT: THE "TOLLGATE" PROCESS . . .

The overall policy development effort of the Task Force is being coordinated by the President's Senior Adviser for Policy Development, Ira Magaziner, and is based on the "Tollgate" system -- a research and decision-making process commonly used in the business world for large-scale projects that need to be completed quickly. To advise the Task Force, Mr. Magaziner has formed over 25 working groups. These working groups, which are divided into health policy subject areas, will guide their research efforts through a series of tests, or "tollgates", before a comprehensive set of options is presented to the President for consideration.

The first series of tollgates -- the broadening phase -- require the working groups to put all serious options "on the table", ensuring that all issues are considered, all questions are discussed, and that the correct methodology is being used. The next phase of the tollgate process narrows this broad group of options and makes draft recommendations which will later be synthesized into a comprehensive set of proposals for the President. At that point, financial auditors will check to be sure that all cost and savings projections are sound, and lawyers will ensure that all legal concerns are addressed.

AN INCLUSIVE PROCESS . . .

The President and First Lady feel strongly that this be an open and inclusive process, and have structured the system to encourage participation from all levels of government, all segments of the health care industry, the business community and the American people.

Over 400 people -- including officials from various agencies, Congressional staff, health care experts, and White House personnel -- are directly involved in developing policy within the working groups.

In an attempt to make health care reform respond to the concerns of both those who receive health care and those who provide health care, there are doctors, nurses, social workers, and hospital administrators working on -- and often leading -- many of the working groups. In addition, diverse panels of consumers and health care professionals will be brought in regularly from around the country to advise the working groups as they develop their recommendations.

Representatives from several White House departments -- including Congressional Relations, Inter-Governmental Affairs, and the Public Liaison's Office -- are actively reaching out for advice from members of Congress, state and local governments, organized health care interest groups, representatives from small and large businesses, and the American people. All groups have been encouraged to submit written proposals and many are being brought into the White House to meet personally with the First Lady, Mr. Magaziner, and other working group members.

In addition, the Task Force operates a round-the-clock "War Room" -- which receives the thousands of speaking requests, policy papers, letters and phone calls from Americans concerned about solving our health care problem. And whether it be a hospital administrator's treatise on malpractice reforms or a widow's handwritten letter expressing outrage at her skyrocketing prescription costs, each inquiry is taken seriously, channeled to the appropriate working group and given immediate consideration.

The First Lady has been travelling throughout the nation talking to the American people about their health care concerns and suggestions on how to reform the system. She has accepted several invitations to participate in roundtable discussions that will be held throughout the country in the next month -- where she can listen to the recommendations of all the people -- consumers, providers, special interests -- who are eager to contribute to the Task Force as it develops its proposal for comprehensive health care reform.

DRAFT VIDEO SCRIPT

Hello, this is Hillary Clinton.

I want to thank you for letting me speak with you about an issue that is central to our children's future and critical in our fight to restore this nation's economy: solving our nation's health care crisis. Our message to you is simple: It's time to bring about fundamental change, control our nation's soaring health care costs and provide security for American families.

Since we first came to Washington, I've been chairing the President's Task Force on National Health Care Reform, and every day I have been lucky enough to hear from people all over the country. But I think the person who best summed up the situation we face was a doctor I met recently at St. Agnes Hospital in Philadelphia. He said to me: "You know the saying, 'If it ain't broke, don't fix it.' Well, Mrs. Clinton, the system's broke, and it's time to fix it."

Since January, the Health Care Task Force and the hundreds of people who are advising it have been working round-the-clock to come up with a comprehensive health care reform package. We've brought in people from all over the government and experts from around the country in an unprecedented effort to solve this complex challenge. We've met with groups from all over the country representing different perspectives on health care. From nurses to hospital administrators, from academic experts to

businesspeople, we have reached out in an effort to get the best advice we can.

The President also asked people to write and tell us their concerns and opinions about health care, and the response has been just incredible. Let me read you part of a letter from a woman in Warren, Michigan: "I am a middle class American with a husband and three children," she wrote. "My family ran upon rough times 2 years ago when my husband lost his job [after] 7 years with the same company...We aren't eligible for State funded programs and can't afford the price of the insurance premiums, so as a result, we do without. I hope and pray that a solution to this problem will come about soon."

Another woman -- from Apple Valley, California -- wrote to tell us that she and her husband can't afford to buy the antibiotics their children need. So they drive to Tijuana, Mexico to get them instead. These are middle-class Americans who just want decent care at reasonable prices. And they deserve nothing less.

As we work to develop our plan, we're taking into account the concerns of those families from Michigan and California -- and the points of view of every American and every group involved in making health care reform work. The small businessperson who creates jobs and wants to cover his employees but struggles with premiums that rise at thirty percent <u>each year</u>. The older American caught between a fixed income and prescription drug

prices that are out of reach. And the parents of four who can't switch jobs because they're afraid of losing coverage.

For those people and the groups who have been fighting for health reform for years, this is not the time for yet another study or report. As President Clinton said in his February address to the joint session of Congress, it is time for action. Later this spring, my husband will present Congress with a comprehensive health care reform package based on the recommendations of the Task Force. And he intends to pass the reform all at once -- not in bits and pieces.

With your support, we will bring about real change. But let me say up front: we are going to preserve American medical care at its best -- the superior technology our doctors need and the flexibility that our nation demands. We will maintain the highest quality medical care in the world and the individual's right to choose a doctor.

But there's also a lot you won't see in our new system. You won't see the patchwork of forms that frustrate patients and make doctors spend more time with paper than people. You won't see prescription drugs that cost three times more than they would overseas. You won't see the phrase "pre-existing condition" on any insurance form and you won't hear of people who lose their jobs and can't find coverage. And you'll see the last of the headlines that say, "Health care costs rising at record rates."

These kinds of fundamental changes won't be easy. Believe me, I've learned since I started working on this issue -- there are powerful special interests who profit from the status quo. And high-priced lobbyists who get paid to keep everything the same. They're already lining up to block the change.

But with your help, we can break the gridlock. The American people want fundamental change. People need a health care system that controls costs and provides security to families. And I know the American people share the urgency that I feel -- the sense that we must act now.

Since the time when Franklin Roosevelt was President, each generation has struggled to create an affordable system of health care that covers all Americans. Many groups involved in today's effort have been involved before and may wonder why this time will be any different. The difference will be the American people -- and their unprecedented demand for fundamental reform.

We face a historic opportunity -- and we must seize the moment. I ask you to join me in working for fundamental change in America's health care system: to lead this nation toward quality, affordable care for all Americans.

Thank you all very much.

PHOTOCOPY
PRESERVATION

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	[handwritten note on back of speech] (1 page)	n.d.	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 20035

FOLDER TITLE:
HRC Remarks II [1]

2013-0534-S
ry1571

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 10, 1993

REMARKS BY THE FIRST LADY
TO CATHOLIC HEALTH ASSOCIATION
VIA SATELLITE

MRS. CLINTON: (In progress) Millions of other Americans are gripped by fear that at any time they could lose their benefits. And every year, two million Americans do lose them. They may lose them for a month or two or six months or a year before they find a way back on some insurance roll. And they usually pay a lot more to be insured again. Still, every month, 100,000 Americans fall off the health insurance rolls. Others stay in jobs that they want to leave because they can't take the risk of being uninsured. And many families find they can't get coverage for the very problem they need care for, because that illness is stamped a "preexisting condition."

Americans who work for a living, who pay the bills and take care of raising their families should not be burdened by the insecurity of not knowing whether they will have health insurance. Security is what this health care debate is all about.

Once the new health care plan is up and running, everyone will get a health security card which will guarantee all Americans access to a comprehensive package of benefits, no matter where they work, where they live, and whether or not they've ever been sick before. Security, no matter what, is the first condition.

MORE

Second, we're going to work together to make sure that health care costs are brought under control. You see every day what happens when health care is priced out of the reach of many Americans. It forces you to absorb more red ink, and many other segments of the health care system to shift costs, and all of us bear the burden. Left unchecked, health care costs will continue to hurt our families, bankrupt businesses, and drive the federal deficit to ever greater heights.

Our reforms will rein in health care costs through several measures. We will strip away the incentives from rewarding doctors who do more tests and procedures, and instead will create a system that encourages cost-effective, high quality care where a doctor and a patient can again be at the center of the relationship and where decisions can be made not on how something will be reimbursed, but what a doctor believes is best for a patient. We will reduce the bureaucracy and micromanagement that bloats our health care system and that so many of you have complained about because it adds unnecessary costs.

Finally, we will say to all health care institutions and providers, just as you recommended in your proposal, we must live within a budget, and we must reallocate our health care resources within that budget away from paperwork, administration, insurance costs, into what matters most, caring for people. We're going to ask everybody -- workers, employers, providers, doctors, nurses, hospitals -- to chip in and do their part for health care. And to the drug companies that charge two and three times in America what they charge overseas, we're going to say, bring your prices down. It's only fair.

I can remember so well sitting in the St. Vincent's waiting area and talking with a friend of mine who's a physician there who told me that every day he discharges somebody from the hospital who needs continuing prescription medication to stabilize a condition. And every day there is at least one patient whom he knows cannot afford the drugs he prescribes. And so what often happens is that patient decides not to take those expensive drugs, or to self-medicate. Instead of the four a day required, maybe only one to stretch them a little further. And, sure enough, it's not too long before that patient ends up back in the hospital, costing all of us even more.

To the businesses who don't cover their workers today, yet take advantage of your hospitals and, therefore, drive up the costs for the businesses who do cover their workers, we're going to say it's time for everyone in America to take responsibility. It's only fair that we all pay our fair share.

MORE

To the individuals who think they can get by without coverage and have that terrible accident or that unpredicted illness and end up in the emergency room or in the ICU and, therefore, we all pay the bill, we're going to say, you, too, must do your part. If you can afford it, or whatever you can afford, you must contribute. It's only fair. We will all benefit if we all take responsibility for our health and for each other.

Third, our reform will reduce the waste that eats up our health care dollars now -- and so much of your time. Another key component of reform will be a wholesale reduction in the frustrating and wasteful paperwork that eats up the health care system. You all know very well what the load is like, and when you look at the number of rules, the volumes of regulations, the stacks upon stacks of forms, you have to ask yourself, where did all this bureaucracy come from?

The short answer is it comes from everywhere. It comes from private insurers, it comes from government. Forms were created to make sure that the most vulnerable people were getting proper care. Then more forms were created to make sure doctors and hospitals didn't perform unnecessary tests and procedures. Then the insurance companies have their own sets of rules for doctors and nurses to follow, so they create their own forms. And as the number of health insurance companies grew -- today there are more than 1,500 -- so did the number of forms. The result: Instead of a system where forms enforce the rules, we have a system ruled by the forms.

Patients don't know how to read their bills or make sense of their insurance policies, and worry they'll be left hanging because they didn't understand the fine print. Doctors and nurses, especially nurses, spend as much time dotting Is and crossing Ts as they do taking temperatures and carrying for patients. One of the nurses I spoke with told us she entered nursing because she wanted to care for people. She said that if she had wanted to be an accountant, she would have gone to work for an accounting firm.

And for every new doctor an average hospital hires, it hires four new administrators. It's a bad case of the tail wagging the dog. And we're going to take that administrative mess we now have and clean it up for you and for everyone. We'll see a health care system that is made easy. One insurance form for everybody. A quality check form -- no hidden fine print. And we're going to reduce the paperwork and streamline the regulations. Doctors and nurses will be able finally to do what they were trained to do. At the same time, we will maintain and enhance the quality of American health care by measuring quality based on results, not based on micromanagement and forms.

Fourth, this reform will make a serious start at addressing the growing long-term care problems our country faces. Now, many will argue we should put off consideration of this issue. While it would be too costly to try to meet all of America's long-term care needs at once, it would be irresponsible for us not to make a start, to try to get ahead of the aging curve. Today there are too few options for people hoping to stay at home and out of institutions, and too little help for families doing their best to care for ailing relatives. Individuals and their families, as you know, are often bankrupted by the cost of long-term care, or at least forced to spend themselves into poverty and turn their backs on their older relatives. They can't get help until they have almost nothing left.

The system is complex and disjointed and it fragments the care people receive. If the long-term care system is left unchanged all that will only get worse.

Most of you know Monsignor Charles Fahey. Monsignor Fahey served on our working group on ethics, the group charged with making sure that the system we develop is driven by fundamental values, shared responsibilities, social justice. Monsignor Fahey has confronted the fragmentation and backward incentives of our long-term care system firsthand. He took a month off this year to care for both his parents, seriously ill, in order to keep them out of a hospital or a nursing home. As he struggled to nurse his parents back to health in ways that met their needs and maintained their dignity, he took on a system that looked at the moving parts but never at the whole person. As the Monsignor put it, "We've got a system that cares for the eye or the foot or the nose, but never for Charlie or Elizabeth."

Our reform will reverse the incentives and expand the options for care at home and improve coordination of services. Another example from my visit to St. Agnes: That hospital, as many of your does, runs an adult day care center. And what they found is that they couldn't get reimbursed on even a sliding scale to help keep their patients and their families from the neighborhood at home. And so what often happened is that, although nursing home care was so much more expensive, the $35 a day for adult day care in a hospital setting was beyond the financial reach of so many families that they went ahead, met the Medicaid requirements and, very regretfully, put their relative in a nursing home.

It wasn't the choice they wanted and it cost us more money. How much more sensible we will be if the St. Agneses and the St. Vincents and the other hospitals in your association are able to

reach out and help families make this connection to be able to serve their older relatives.

We'll make a serious start on improving long-term care coverage for the elderly and disabled Americans by expanding home and community-based care. People with severe disabilities will have access to a broad array of services, coordinated by a case manager, tailored to individual needs. By expanding the availability of home and community-based care, we will give seniors and disabled citizens who can't manage on their own the opportunity to remain in their community for as long as possible.

Lastly, we will improve the availability of health care in the areas that have been traditionally underserved -- rural communities, urban centers and other parts of the country where a health care card alone will mean little to people unless we guarantee that services will be there for them.

Americans everywhere need to know there will be a doctor and a health facility available to them. This is a problem that the Catholic Health Association knows very well because your members have helped to address the problem in many rural and urban poor areas. I am especially proud that one work of the Catholic health care providers in Arkansas was recognized this year, and I'm speaking about the wonderful work in caring for the needy by the St. Elizabeth Health Center in Gould, Arkansas, which serves a community that other health care providers have abandoned.

For the 1,500 residents of a community like Gould out in the country, the nearest doctor was out of reach. Many people didn't have transportation and couldn't reach even the facilities 18 miles away. But about three years ago St. Elizabeth's set itself up in an old police station and it's been filling the critical health void in that community ever since.

The President's plan will bolster these efforts by targeting funds for areas that are now undeserved. And the plan will strengthen the health care infrastructure in these areas by linking community based centers to other hospitals and providers and will provide incentives for the national health service corps and other programs to encourage doctors to practice in remote parts of our country.

This plan will make sure that all America is cared for, just as you've recommended, with integrated delivery networks where all of our providers, doctors and nurses and others will be connected up to give care in areas that traditionally have been overlooked. We've gotten away from that. We've watched bureaucracies and

paperwork and red tape distance us from the human caring that needs to be at the root of any health care system.

We can't wave a magic wand and reverse time, but we can try to reconnect. I know that CHA members try every day to inject that extra bit of humanity and caring into the system. That's the kind of effort that can make all the difference at those moments when we find ourselves, as I have, dependent on each other.

This is what I hope: that in a few years we will not only have a streamlined more efficient system, that we will not only have a better distribution of health care professionals and have more primary and preventive health care physicians and nurse practitioners and physician's assistants, that we will not only have better access, but we'll feel better about ourselves and about each other. We won't just be healthier, although that's a tremendous goal in itself, but we'll all be part of a community of caring again.

Thank you very much for being part of that community now, for thinking hard about how we can expand it to every American, and by standing behind the reforms that need to be made. Thank you all again.

END

THE WHITE HOUSE

Office of the Press Secretary

~~Internal Transcript~~ For Immediate Release

April 16, 1993

REMARKS BY THE FIRST LADY
AT HEALTH CARE BRIEFING

Lincoln, Nebraska

MRS. CLINTON: Thank you very much. It is a great delight for me to be here. I am especially pleased to be with your Senator, whom I have known for a number of years since he served as your governor when my husband was also a governor, and have admired and respected his commitment and concerns on issues; but, particularly, his concern and commitment to the issue of health care in this country.

I don't quite know how to take the Navy Seal analogy. (Laughter.) It is a little bit too apt, too close to home. But throughout this process, when I have been treading through very choppy and dangerous waters, Bob Kerrey has given good advice and good counsel and, I think, made my task much easier by the fact that he has been there before. And I am personally very grateful for his lifelong commitment to doing what he believes is right and, particularly, his willingness to put himself on the line in the last couple of years on behalf of better health care for all Americans.

It's a real tribute, Bob. (Applause.)

I'm also pleased to be here with Governor and Mrs. Nelson. They have become friends of my husband's and mine. I always enjoy being with them, and I always learn something. I learned just a few minutes ago about how the Governor is not only enormously popular in this state for a lot of very obvious and strong reasons, but how he handles the bane of all people in political life, and that is the unfair, unjust, inaccurate reporting that goes on from coast to coast, north to south, east to west. (Applause.) And he has given me some tips that I think I'll start putting into effect. I'm not going to share them with you right now. (Laughter.) But I'm very grateful to the Governor.

And I'm also pleased to be here with another governor whom you'll hear from in a few minutes: Governor Howard Dean from Vermont is a practicing physician as well as the governor of his

state, and has been intimately involved with the work of the President's task force. And it's a remarkable combination to have someone who sees this complex issue from the ground up as a practicing physician whose wife is also a practicing physician, and from the policy perspective of a governor's office. And I know that you will find Governor Dean's remarks as useful and provocative, as I always do, and am delighted to be here with him.

Those of you who are here are obviously concerned about the subject of this conference and wanting to know more about it. I assume from the great size of this crowd there are people from all walks of life and from very differing perspectives -- people who deliver health care, people who receive it, people who study about it, people who are concerned as citizens, as parents, as members of the community that you live in.

That is a very good sign. Because part of what we have tried to accomplish in the last several months is exactly the sort of conversation that this conference represents and which your presence exemplifies. We have to be willing to strip away the years and years of papering over the problems in our health care system, of denying the reality that was all about us and impinging upon us and be honest with one another. That is where we have to start. We have to be willing to talk about our problems, put aside our own personal interests, our own prejudices, our own experiences insofar as that is humanly possible.

Physicians and nurses and patients and insurers, business people of all sizes, working people -- all of us must recognize we are all part of the problem and we will all have to be part of a solution if it is going to work for America.

Starting from that premise, let me share with you some of the facts that have made it impossible to ignore this problem any longer, and which prompted the President to commit himself as he has to trying to make our country provide quality, affordable health care to all Americans.

First of all, there is a lot that is right about our health care system. No one can deny that. We are always proud of the accomplishments and achievements within the various sectors of our health care community. We are secure in the knowledge that we have among the best health care in the entire world, and in many, many respects the very best. And we want to do all we can to make sure that our children and our grandchildren will be able to say that as well.

What is happening, however, is that beneath that statement of fact, there are many other facts that now are breaking

through the surface that we have to deal with as well. The security that many of us have come to take for granted -- that the doctor, the nurse, the hospital would be there for us in time of care and need -- the fact that so many of us have relied on the kind of care that we have grown accustomed to and that we feel comfortable with, as we look around our country today, that fundamental, personal security can no longer be taken for granted.

Instead, what we find is not only skyrocketing costs, but the effects of those costs. We find the growing numbers of people who work hard for a living who do not have access to health care. We find that more than 100,000 Americans move into the ranks of the uninsured each month. And more than half of the uninsured in 1990 were full-time workers and their families, and the rest were part-time workers, seasonal workers, people who worked.

Now, that's the kind of statement that, taken in a vacuum, sounds frightening. But if you're not in that group, you wonder to yourself: Well, that's not me and that's not those whom I know. But it could be. Because now more than ever, Americans worry about losing the insurance that they have, that they have taken for granted.

I wish all of you could have come with me on the visits I've been privileged to make around the country, talking to people about health care. It is very hard to explain, as I tried to explain to a group of working people in New Orleans a month ago why they, who had worked for the same employer, some of them for 20 years and 30 years, did not have insurance, could not afford it for them or their families, but lived down the block from people who were poor enough and not working that they were eligible for Medicaid.

It was very difficult for me to look at the woman who worked in the clerical office of that small steel company who could not afford insurance, her company could not afford, they believed, to offer any help to her in purchasing that insurance, but she tried to take care of herself. She was a single woman who had raised a child, and she went every year to have a physical exam. She tried to read what she needed to read, to eat the right things. She said to me she even tried to start exercising a few years ago and tried to walk every day.

But when she went for her physical exam, her doctor found a lump in her breast and referred her to a surgeon. And then when she kept that appointment with the surgeon, she reported to me that following the appointment the surgeon said, you know, if you had insurance, I would biopsy that. But since you don't, we will just watch it for a while.

It's very hard to look in the eyes of working Americans, people who are really at the backbone of this country and always have been, and to know that some, by the grace of their employer, have an insurance, and some do not. Some women can be referred to a surgeon for a biopsy and some will just have that lump watched.

Or to listen to a veteran in that same group who had worked in that same business for many years but who wasn't eligible for VA benefits because he didn't have a service-connected disability and he was working and wasn't poor enough to access the VA system. So, again, without insurance the emergency room was his physician. And he talked about how he hated to go to the emergency room because it was always so expensive. He tried not to go, but the times that he did have to go often he couldn't pay the bill he was presented. And he felt bad about that as well.

So, there is, beneath the security that many of us still feel, because we can afford insurance, we are lucky enough to work for someone who helps us pay for that insurance, there are millions and growing numbers reaching millions more of Americans who are not so lucky. I call that the "there-but-for-the-grace-of-God-go-I" group, because many of us are one job away, one layoff away from not being able to afford insurance ourselves.

And then there are so many others who are in the position of being self-employed. Many of the farmers and ranchers in this state are like the ones that I met in Iowa when I sat for over an hour and listened to four farm families talk to me about how they could not afford insurance. And these were people who put literally the food on our table. And what they did was despite the fact it made no sense by any accounting measure, they just squeezed every possible dollar out of everything else so that they paid for those very expensive single-family policies that they were able to access.

Or they even went through their local farm bureau; but because it wasn't a very big policy or they had a preexisting condition, they were still paying more and more every year with the cost continuing to escalate.

And I sat there in the living room of this farmhouse thinking to myself: Why on Earth would we want, literally, to drive out of business, which is what we are doing, farm families and ranch families who are still among the most productive workers in our entire country? Why would we want our government to look at their balance sheet when they come in for some kind of loan from some government-supported program and have the government representative say, you know, you're not really in a good position to borrow as much money as you want because your assets are obviously highly mortgaged. You can't really afford much but if you cut out your monthly health

insurance, we think we can make this work for you? Why are we doing that to ourselves, why are we doing that to the people who work for us?

We also know that in addition to the 37 to 40 million Americans who are uninsured, to the group of Americans who are paying for insurance at extremely high rates for a variety of reasons such as preexisting conditions, there are 22 million more Americans who do have insurance but whose insurance is the barest bones insurance that often when the catastrophe strikes, the accident occurs, the illness worsens, they find they are not covered for all that they expected.

I always wonder when people start playing with the numbers, when they say, well, this is really just a problem of the uninsured if they have not talked to same people I've talked to, if they haven't talked and looked into the faces of people who are uninsured, who are barely insured, who are insured at extraordinary costs that never seem to reach an endpoint. And then if they don't talk with the rest of us who worry that it could happen to us next.

If we do nothing, if we just say to ourselves: this is such a complicated problem, we really don't think we will ever come up with a comprehensive solution to solve all of the aspects of it, then here is what we can look forward to. Experts estimate that the annual cost of health care for an American family will more than double by the end of the decade to approximately $14,000 per family. Workers will lose about $655 in income each year if health care costs are allowed to continue to eat up wage increases.

So, if we just keep our focus on the individual and on the household and think about what is at stake, we can see how big an issue this is for most Americans. But it is not just an individual and family issue, it is also a business issue. And it is a business issue in a number of respects. Right now, two-thirds of small businesses do provide their employees with health insurance. Many small businesses do so at great cost and at sacrifice. And about the most poignant meetings that I think I have personally had in the last months have been with small business owners who have told me in great detail the struggle they have gone through to try to continue to insure their two or five or nine or 10 employees.

Some have been able to continue to meet those costs by doing all kinds of things. Certainly, by doing the obvious of increasing co-pays and deductibles and all. Some by taking members of their families off the health insurance and putting them on another health insurance that another member of a family had. There have been enormous efforts made by so many small businesses who do provide insurance to keep doing so.

For many others, they have not been able to. And I can recall, particularly, sitting in a small restaurant in a suburb of Boston talking to a group of small business people who told me in excruciating detail the struggles they had undertaken to try to provide and continue health insurance.

One man who owns a small family bowling alley has one employee. That one employee had a son with a serious illness and the illness was one that was difficult to continue to insure for and the costs continued to go up. And the owner looked at me with tears in his eyes and he said, look at the choice I'm asked to make. This man has worked with me like a member of my family. And now I'm either going to have to make a decision to just cut him and his family off of health insurance or to tell him to see if there's any other place he can go to work where he might get it, but I've checked for him and I don't think that's possible. Or to continue to try to pay the insurance when we don't make all that much money. What am I supposed to do?

The human side of the business story is one that is filled with tales like that. There's another side as well. And that is that small businesses because they are small pay premiums that are one-third higher on average than large employers and those premiums have continued to increase 50 percent faster than premiums for larger employers.

So, it's a never-ending cycle. It's not enough just to make it one year. Given the history we've had in the last several, it keeps getting worse. There's also a competitiveness issue here with business. Our large businesses very often have a tradition of insuring their workers; and not only workers but their retirees. As a result, they have paid out millions and by now billions of dollars in both premium and costs that they will never recover in terms of investing in more jobs and opportunities for Americans.

In 1990, for example, General Motors spent $3.2 billion in medical coverage for its 1.9 million employees and retirees -- $3.2 billion. This was more money than the company spent on steel to build new cars.

Health care costs add $1,100 to the price of every car made in America. How can we expect to revitalize the manufacturing sector of this country if we basically have told our large employers: Fight the global economic battles with two arms tied behind your back. So it is not just the human side when it comes to business, insurance, and health care costs, it is a question that every American needs to be aware of because it impacts on our quality of life and the economy of this country.

In addition though to business, we have government. But governmental costs for health care are the primary reason behind the increase in the government deficit. I want to stress this point because so many people when we hear about the enormous deficit that has swallowed up so much of the investment potential in this country, it is such a big number, it has grown so much in the last 10 years that it's almost hard even to grasp.

But right now we are currently spending 14 percent of every dollar that your country produces -- and that's referred to as the Gross Domestic Product -- 14 cents out of every dollar is spent on health care in this country and the government's share of that is growing faster than the private sector's share of it. If we continue at the same rate of growth, then we are likely to see that in seven years almost one dollar out of every five dollars earned by Americans will go to health care spending, and more than half of the increase in federal revenues that we hope to see in the next four years because of economic growth will be absorbed by health care cost increases.

If we do not deal with the costs of health care in the federal and the state and the local government budgets, we will bankrupt cities and counties and states. They may never go to a bankruptcy court because we don't have a system big enough even to comprehend that. But they will continue to do what they have done for the last years -- run enormous deficits which will never ever quite get closed and the federal government will be in a position, as it has been in the last years, of pretending that there is an answer to a budget deficit that grows by leaps and bounds because we will not face up to the role that health care costs play in keeping that growth accelerated.

When my husband made his announcements about what he wanted to do with the budget, and he spoke to the Joint Session of Congress, he made it very clear that what we were facing was a budget deficit that had to be addressed on several fronts at once -- had to be addressed by cutting spending, which is being done dramatically and honestly for the first time in a very long time. But it also had to be addressed by reining in health care costs in both the public and the private sector.

Now, these are the facts that, no matter how much we would like to deny them and wish they would go away, are really framing the debates about what we should do in health care. And you have heard in this conference, and will continue to hear, from people who have spent a lot of time thinking about the best answers.

What the President did when he established the Health Care Task Force was to say, look at everything everywhere that might

work. Make sure every issue that has an impact on health care, its cost, its quality, its availability, is pulled out to the light of day and evaluated.

To that end, hundreds and hundreds of Americans have been spending countless hours trying to make sure that the President's charge to them has been met. People from all over the country, all walks of life, more than a hundred medical practitioners, nurses, others who are on the front lines of health care, many people who have studied the issue from a different perspective, whether it be the VA's problems or the Indian Health Services problems; and countless others have given of their time and energy to be consulted with on an ongoing basis.

And one thing that is clear from having looked at the extraordinary range of issues is that any attempt to try to rein in our health care costs cannot just attack one part of the problem. To do that would be leaving opportunities for explosions of costs and continuing growth in other parts of the system. So the President has called for recommendations of a comprehensive approach to try to reform the health care system, put it on a sound financial footing for the future, retain the qualities of choice and opportunities that currently exist, and be sure that all Americans have access to health care.

And to that end, a number of different programs and potential models have been examined in an effort to come up with an American solution to an American problem, to make sure that what was proposed would provide flexibility to states like Nebraska or Vermont, because the people in different localities might need different approaches if they were to solve their own health care problems.

The costs associated with trying to provide a comprehensive solution are ones that we have to also be honest about. We believe that there is money in the system now that can be reallocated and used to meet a new system's more realistic requirements. We believe there is money to be saved in ridding the system of unnecessary paperwork and bureaucracy and red tape and micromanagement that has stood in the way of delivering health care. We believe that insurance companies like the great one that is headquartered here can help a great deal by coming up with uniform reporting forms and making it possible to move toward a computer-based information system that would save in the future billions of dollars.

We also believe that changes have to be made in our laws as they currently exist -- laws like antitrust laws that prohibit physicians or hospitals from cooperating instead of competing. There

are communities in this country that tried to bring their hospitals together so that they could work out sharing arrangements of expensive equipment like MRIs or CAT scans. And we're told that if all the hospital administrators met in the same room, they would violate the antitrust laws. So instead, they all went out and bought their own machines. And that's one of the reasons Tylenols cost $50 when you go to the hospital, because you have to amortize the costs of those machines. You have to make them pay for themselves, even though the volume demand may not warrant it.

So there are so many issues to be looked at, all of which are being considered, evaluated, and serving to make recommendations for the President.

But I want to say something very clearly about the principles that need to underlie whatever the President proposes. The first principle has to be that Americans will be secure in knowing they will have access to quality, affordable health care, no matter who they are, no matter where they live, and no matter what their health status is. They also have to be given the security that the costs that they pay for health insurance will not continue to skyrocket, but instead, will be controlled in some way by the marketplace so that they will understand that they can budget for that, businesses can budget for it, that will not be hit by surprises on a yearly basis, and not be able to deal with the costs.

We also have to recognize that there are values in our health care system that we need to promote and some we need to introduce. Individuals will have to be more responsible for their own health care. They will have to behave in ways that will promote health care. Now, how can we do that? We can't write a law that says go out and be responsible and take better care of your health, but we can put incentives into our system to try to promote certain kinds of behavior and discourage others.

We also need to value the full range of health care professionals. We have subsidized through the Medicare system the creation of many subspecialties in medicine. Those are important. But we have now 70 percent of our physicians who are specialists and only 30 percent who are generalists. You cannot run a system of health care that will tend to the primary and preventive health care needs of Americans when only 30 percent of the physicians currently in practice and only 15 percent of those attending medical school now will be there to provide primary and preventive health care. So the incentives that have traditionally gone into medical education to promote specialists now have to go into medical education to promote generalists.

We also need to expand the work force composition in health care. We need more nurse midwives, we need more nurse practitioners and other advanced practice nurses. We have to have a health care profession that reflects the broadbased needs of Americans.

So the kinds of values that we are struggling with, the kinds of issues that you live with, whether you're in a household or as an individual or in a business or part of the health care system, are all being looked at so that we can come up with answers to what we think will be the best American response.

Now, how will this program affect your life? We hope it will not change much about how you actually access and receive medical care. We do hope that you will have a card which is your passport, as Senator Kerrey has said, to health care in America. We hope that you will continue to have choice in the doctors and other health care professionals whom you choose to go to receive care. And we hope that the states will be willing to take on a lot of the responsibility for making sure that the system actually fits the needs of the real people in a region.

Before coming out here, I was privileged to meet with representatives of the Lancaster County Medical Society and the local public health and social services offices and representatives from the state who have innovated a program here in this county to be able to care for Medicaid recipients by using private physicians through a referral system run by the public health system.

That is the kind of partnership and cooperation that we have to have if we're going to have a true comprehensive system that provides a continuum of care.

I like the word "cooperation" when I think about the health care system in the future. We have spent too much time in the past arguing and fighting over shrinking dollars that are creating barriers to access instead of expanding opportunities and removing those barriers.

When the President comes forward with his proposal, it will be based on extensive and lengthy and thoughtful suggestions from literally hundreds of thousands of Americans. But we will need you to take a hard look at it and to continue the process of consultation and suggestion through your senator, through your governor, because there is no magic bullet out there. There isn't any one simple model that can take care of Alliance and Broken Bow and Omaha and Lincoln, or Little Rock and Los Angeles. We need a national system with state and local opportunities to make sure that differences can be adequately met.

We're looking for a chance not only to change our health care system, but to reassert some fundamental values in this country that have been forgotten -- values like individual responsibility, values like community. We want to restore some of the compassion and caring that we took for granted when I was growing up and which have been lost, not just because of the pressures of change in our society, but because of big institutions and bureaucracies and the distance that they create between people.

When I was meeting with the Lancaster County Medical Society representatives and the other folks, they told me that one of the reasons that this innovative Medicaid treatment program worked is because the people behind it had been humanized. Private physicians could see real faces of real people. Social workers paid calls on physicians and on patients. People began to help one another and once again to identify with each other as human beings, not as numbers, not as insureds, not as providers, but as people.

This is an incredible challenge and opportunity for our country. It's not going to be easy. It's not going to be done overnight. But it has the promise, not only of providing health care in an affordable, quality way to all Americans, but reasserting some of the common values about what it means to be members of a community where people are joined together in caring and commitment. Because we all have a stake in the future, and the surest way for us to realize a better future is through cooperation and a commitment to making a health care system that really works so that Americans can once again be secure.

Thank you very much. (Applause.)

END

SRN Comments

What is the health care task force?

The President created the Task Force on National Health Care Reform on January 25, 1993. The Task Force's mission is to recommend to the President as promptly as possible a proposal for comprehensive health care reform legislation to be enacted by Congress.

The Task Force is chaired by Hillary Rodham Clinton, the First Lady. The other members of the Task Force are the Secretaries of the Treasury, Defense, Commerce, Labor, Health and Human Services, and Veterans Affairs; the Director of the Office of Management and Budget; the Assistants to the President for Domestic Policy and Economic Policy; the Chair of the Council of Economic Advisors; and the Senior Advisor to the President for Policy Development.

Who are the 400 people we keep hearing about?

Ira Magaziner, the President's Senior Advisor for Policy Development, is leading an interdepartmental working group that is gathering information concerning the impact of existing health care policies and delivery services, and possible alternatives to those policies. The working groups are reaching out to literally hundreds [thousands?] of individuals and groups to ensure that a full range of alternatives is considered. The information that is gathered and analyzed by the working group will be used, in turn, by the Task Force in formulating its recommendations to the President.

Only the Task Force will have authority to forward recommendations to the President, and only the Task Force will provide advice to the President. The interdepartmental working group is not charged with responsibility for making, and will not make, recommendations to the President or directly advise him.

Only federal employees serve as members of the interdepartmental working group, including more than 90 Congressional staffers.

Are you sure that all of the members of the working group are federal government employees? Aren't some contractors and consultants?

We have been careful to ensure that all members of the working group are federal employees. These federal employees fall into two category. The first category includes full-time, permanent employees, who work for the Executive Office of the President, for federal agencies, for Members of Congress or for Senate or House committees.

These federal employees have been informed that they are subject to the conflict of interest provisions set forth in 18 U.S.C. § 202-209; the Standards of Ethical Conduct for Employees of the Executive Branch; and all related ethics laws and regulations.

The second category of federal employees serving as members of the working group includes "special government employees" who have been employed by an agency or the Executive Office of the President for less than 130 days in a 365-day period, either with or without compensation. These special government employees have been informed that throughout the period of their special employment, they are subject to a limited version of the conflict of interest provisions set forth in 18 U.S.C. I 202-209; the Standards of Ethical Conduct for Employees of the Executive Branch; and all related ethics laws and regulations. These special government employees have also been informed that they are required to abide by limitations on public speaking and by applicable post-employment restrictions.

Finally, the working group has also retained a wide range of consultants, who attend working group meetings on an intermittent basis, either with or without compensation. These consultants have not had any supervisory role or decision-making authority in connection with the consulting services they have provided to the working group, but instead provide information and opinion to the working group members. These consultants have been informed that in connection with their services to the working group, they too are subject to a limited version of the conflict of interest provisions set forth in 18 U.S.C. §§ 201-208; the Standards of Ethical Conduct for Employees of the Executive Branch; and all related ethics laws and regulations. These consultants come from a wide range of backgrounds, including physicians, nurses, health and political economists, sociologists, human resource management experts, health educators, health administrators, public health experts, health researchers and policy analysts.

Aren't these all just White House staff?

No. The full-time employees who are serving on the working group have been provided by the White House, members of Congress, and several agencies, including the Department of Health and Human Services, the Office of Management and budget, the Department of Defense, the Department of Veterans Affairs, the Department of Labor, the Department of Commerce, the Department of the Treasury, and the Council of Economic Advisors. The employees are working on the task force as part of their regular jobs at their home agencies. Health care policy and finance experts from each agency are working together -- this is far more efficient that having each agency work in this area on its own. This is a novel

approach. Through this working group, the staffs of different agencies are working together to present ideas and proposals to a Task Force made up of the Cabinet Secretaries of the agencies involved.

The "special government employees" serving on the working group have been retained, and provided to the interdepartmental working group, by the White House and several agencies, including the Department of Health and Human Services, the Department of Defense, and the Office of Management and Budget.

Can we see a list of the staff of the working group?

[to be added]

Who pays for the 400+ staff?

The full-time employees serving as members of the working group have their salaries paid by the agency that employs them.

Those "special government employees" and consultants receiving compensation for their services to the working group are being paid by the agency that retained them. All decisions to hire special government employees or to retain consultants have been made by the office or agency that has hired or retained the individual involved.

What will the Task Force cost?

The Task Force's Charter, filed with the GSA and the Library of Congress on March 17, states that the Task Force's cost is expected to be below $100,000.

As to the working group, each agency involved keeps its own budget. And each has appropriations that are directed to policy research and development, which is what these staff are doing. The cost to each agency depends on the number of staff each agency has provided to the working group, as well as the contributions the agency will make to common costs. It is difficult at this time to estimate the total costs of this health care reform effort. Most of the costs are in staff time. Overall, HHS will be contributing the most because of its primary role and interest in health care reform, and because that department has provided the most staff to the effort.

What about the Court decision? What did it mean?

The judge held, first, that the advisory committee act does not apply in any respect to the interdepartmental working group. Second, the judge held that it would be unconstitutional for the advisory committee act to apply to

the task force itself whenever the task force is advising the President or formulating advice for the President. Finally, the judge simply held that the advisory committee act does apply to the Task Force when it is gathering or receiving information -- but the Task Force was already planning to hold an open meeting and to give timely notice of that meeting. So this doesn't really change anything that was planned.

In fact, the Court made clear that everything the working group has done to date is legal, and that everything the task force and working group plan to do in the coming weeks will also be legal.

Will we get to see all of the documents that the working group uses?

The judge's decision does not affect the working groups at all. But the product that the working group presents to the Task Force will be made public, as will the final recommendations presented by the Task Force to the President. Of course, the President's proposed legislation will be submitted to Congress.

OVERVIEW OF HEALTH REFORM

ALL AMERICANS ARE GUARANTEED:

- COMPREHENSIVE BENEFITS
- SECURITY AND PORTABILITY OF COVERAGE
- CHOICE OF PLANS AND PROVIDERS
- HIGH QUALITY CARE

FEDERAL GOVERNMENT WILL:

- DEFINE BENEFITS
- DEVELOP QUALITY, ACCESS, INSURANCE STANDARDS
- REFORM MALPRACTICE
- ESTABLISH FRAMEWORK FOR STATE-RUN SYSTEMS
- SET BUDGETS

STATES WILL:

- SET UP ALLIANCES TO REPLACE FRAGMENTED INSURANCE MARKET
- GUARANTEE AFFORDABLE COVERAGE THROUGHOUT STATE
- ENFORCE QUALITY, ACCESS AND INSURANCE STANDARDS
- ENFORCE BUDGETS

HEALTH ALLIANCES WILL:

- ENSURE AVAILABILITY OF VARIETY OF HEALTH PLANS
- NEGOTIATE PREMIUMS WITH HEALTH PLANS
- MANAGE ENROLLMENT
- PROVIDE CONSUMER EDUCATION AND PROTECTION

HEALTH PLANS WILL:

- ACCEPT ALL APPLICANTS AT COMMUNITY RATE
- PROVIDE GUARANTEED BENEFITS WITHIN AGREED-UPON RATE

(1)

Talk to Children's Hospitals Groups

The First Lady regrets very much that her father's illness prohibits her from being here with you today. I know you all join me in wishing her well. Mrs. Clinton was looking forward to being here with you. As many of you know, the roots of her twenty year commitment to children and families in large part can be traced to the time she spent at the Yale New Haven Hospital and Child Study Center. She believes, as I do, that your work is critically important.

The National Commission on Children was charged with assessing the status of children and families in the United States and with shaping policies to improve conditions among them. Our mission was to design an action agenda for the 1990s and to build the necessary public commitment and sense of common purpose to see it implemented. (Beyond Rhetoric Page viii)

Nothing could be higher on that agenda than reforming our present health care system so that it works -- really works for children and families. American families deserve not to worry about their health care. They deserve peace of mind.

Yesterday over sixty groups sat with the Vice President and members of the President's Health Care Task Force for a little over thirteen hours. The more than 400 hundred people in the working groups have been working night and day to begin shaping a health care agenda that will pass the Congress and serve all the American people.

The challenge is to create a plan, and to put a system in place that recognizes and serves the diverse needs of all Americans. This will be tough but I believe it must be done if we are to give the American people a sense of security about health care protection . . . security for themselves and security for their children.

A nation that does not make it a priority to care for the health of its children cares little about its future. It is just plain old fashioned common sense -- healthy children yield healthy adults. Healthy adults are productive workers. To ensure the success of our country we need productive workers. This is the investment argument that we've all become so adept at using. It's a good argument and an important one.

But the best argument for keeping our children healthy is simply that they are our children -- America's children. And we as adults must be held responsible for taking care of this nations children. It is our job, and it should be our privilege.

In the final report of the of the National Commission on Children, we quote Lynn Clothier, the Executive Director of the Indiana Health Centers in Madison Indiana. Whenever there is a

discussion about doing what is right for children I remember Clothier's words.

> I can't believe we can care so little about these children that we simply look the other way.

Most of the people in this room do not look the other way. You see your work as a privilege. I know you do because I have visited many children's hospitals and talked to many of you. Your voices are the voices we need in our efforts to reform health care.

While representing only one percent of the nation's hospitals, children's hospitals serve about 12 percent of all hospitalized children.

Children's hospitals, on average, devote nearly 50% of their patient days to of inpatient care to the poorest children. Children's hospitals intervene each day to help children with chronic or congenital health conditions.

For many of America's children you are their best hope. We will need NAACRHI's help and leadership as we seek to reform a healthcare system that just doesn't work.

Dr. Norman Fost, one of the pediatrician's serving on a health care working group relayed this story to Mrs. Clinton, not too long ago. I would like to share this story with you this morning.

Recently Dr. Fost treated a 10-day old baby at UW Children's Hospital in Madison Wisconsin. When the child was three days old he came down with a fever. Most parents would have brought this child to a doctor. These parents didn't. They weren't bad parents. They work good , hardworking parents who couldn't afford health care. They loved their child but they were afraid.

Afraid that they didn't have insurance. Afraid that they couldn't afford the cost of a hospital visit. Afraid that a stiff hospital payment could make them choose between rent and food. So they hoped it was just a bad cold and they prayed that their infant soon would get better. But he didn't get better and a few dyas later he still had the fever. Now there really was no choice left. Whether they could afford it or not they had to get help for their child. They took thier infant son to a hospital emergency room.

This story does not end happily, in fact it ends tragically. The child wound up brain damaged. Dr. Fost says that if this family had brought their child to the hospital earlier, he could

have been easily and inexpensively treated. The child's parents have been bankrupted. Health costs for the child have amounted to thousands of dollars.

It is time to protect our children and give families freedom from fear. It is time for health care reform.

The goals for healthcare reform are straightforward and simple:

We have got to get health care costs under control. Health care costs are rising at four times the rate of inflation. We cannot sustain these costs.

We have got to cut waste and increase competition. those in the insurance and pharmaceutical industries should not be able to profit excessively. It's just not fair. Not when so many Americans are forced to pay so much for so little care.

We have got to give the American people a guaranteed comprehensive benefits package. Pediatric health care experts should have input in helping to define the special health needs of children. And those needs should be reflected in a comprehensive benefits package. This makes sense to me and it makes sense to those who are working on the Administration's plan.

I also want to note here that children not only have different health needs, they have different health care service delivery needs which any plan must take into consideration. Health care reform must be accountable to specialized populations.

Talk about getting costs under control sometimes raises a red flag. There is a concern that greater attention to budgeting may result in hospital payment systems which are biased against more high-cost, intensive care patients. Many of the patients I just described are children.

We will not develop a plan that turns its back on children but we will develop a plan which places an emphasis on prevention so that fewer and fewer children reach your hospital doors when their illnesses are critical.

We have also got to build this system simple. I know that one of your greates frustrations intoday's healthcare system is the burden of paperwork. Every day the paper work in hospitals steals time and money from those who give and those who receive care.

The Administration's health care reform proposal will drastically reduce the bureaucracy, and will turn attention away from the file cabinet and back to the bedside.

The country should not go another day and certainly not another year without reforming health care.

The Clinton Health Reform Plan
Security for Every American

Security for you and your family. That's what the President's health reform plan is all about.

Even if you're one of those people who's satisfied with your health care today, I'll bet you know someone who's not.

Somebody who lost their insurance when they switched jobs. Someone who can't afford health insurance. Someone who got terribly sick, and suddenly discovered hidden limits buried in the fine print of his policy. Someone who's paying a whole lot more this year for a whole lot less health care. And someone who can't even find a doctor for her kids.

If so, you're not alone. One of every four of you in this room risks losing the health insurance you have now in the next two years. You might lose it for a month, or two or three, or even six months or a year. And that's a terribly dangerous thing. Because if you or your child should -- God forbid -- get seriously ill when you're not protected -- all of your financial security could be wiped out. Perhaps forever.

[insert personal story]

That's what this health care debate is about. Can your family find peace of mind? Can you -- or your child or your mother -- get the highest quality care when you need it most? And get it without bankrupting you? No matter whether you've got a great job or are between jobs. No matter what disease hits or when it hits or who it hits.

To help you get the security you need, here's what the President and I are going to change.

Today, if you're sick or your child is sick or you lose your job or move to a different state, you lose your insurance. If you've got what insurance companies call a "preexisting condition," you're out of luck. You probably can't get insurance and, if you can, it costs three or four times what other people pay.

Under the President's plan, you'll get health security. Lose your job -- and you'll still be covered. Get sick -- you'll still be covered. Move to a new place -- and you'll be covered. That's what insurance is supposed to be all about.

Today, right now, there are people who are literally locked into jobs -- people who won't take better jobs because they're scared of losing their health care. That's because some companies offer great benefits -- while others give only bare bones coverage.

Under the President's plan, that won't happen. Everyone will be guaranteed a comprehensive package of benefits, no matter where you live or what you do.

Today, you're at the mercy of your boss. He can tell you what health plan you've got to use -- and even force you to give up your doctor.

Under the President's plan, you're in the driver's seat. You'll get to choose among health plans -- and if you want to stay with the doctor you see now, fine, no problem.

But that's not all we're going to do. We're going to make sure that what you're charged for health care is brought under control.

Every day, every hour, exploding health care costs are picking all our pockets and handbags. Right now, as you sit here, you're paying for someone who's been forced to go

into an emergency room because he or she doesn't have insurance. And the next time you hear about a hospital charging $20 for a Tylenol, you'll know that you're paying for the 20 patients in the emergency room who will never see a bill -- and couldn't pay it if they did.

Right now you're being charged twice as much for health care as someone in Germany or Japan -- but when it comes to the survival rate for heart attacks, the United States doesn't even make the top twenty. Right now, what you're being charged for the drugs you need is rising three or four times faster than in other places -- and yet children in the Third World stand a better chance of getting immunized than they do here.

So we're going to change the way things work. We're going to crack down on those insurance companies and drug companies that are making high profits -- but not investing in better care. We're going to bring health care costs under control and within a budget -- because we think that if your family has to live within a budget, that's good enough for the health care system, too. Only then can we get this deficit under control, and help our nation compete and win again.

Then we'll be able to give you the security you deserve. The peace of mind that your family will get affordable high quality health care -- no matter when illness stikes. No ifs. No ands. No buts.

And when the new health care plan is up and running, you're going to get a health security card. You carry that card with you. It guarantees you access to a comprehensive package of benefits, no matter where you live or where you work.

And that package won't just take care of you if you wind up in the hospital or have terrible trouble or need a fancy test. It will turn around this crazy system and give you the kind of care that keeps you and your children from getting sick in the first place. In the nation that invented the polio vaccine, that's the very least we can do.

You'll be able to choose from a variety of health plans. Stick with the doctor you see now if you like. Or join a network of doctors and hospitals and pay a little less. Or pay a flat fee to a plan that covers all your services for the year.

And then every plan will be graded on what its customers think -- in simple, understandable ways. So if you're unhappy with your health care, you'll be able to vote with your feet.

And you'll be able to wave good-bye to the endless, complex forms and all the hassles. Because we're going to scrap a system that produces so much paper that even if you've got the patience to wade through it, you probably don't understand it.

That will be gone. We'll take 1500 forms and make them into one or two.

Today, families that face the worst illnesses have to spend their time poring over insurance forms to figure out which insurance company is going to cover what -- rather than spending time with their loved ones.

That will be gone.

Today, nurses and doctors are forced to fill out form after form, each one more complex than the last. Some nurses have to fill out 19 forms for each patient -- and then those are checked and checked again.

All of that will be gone. We're going to let medical professionals practice medicine again.

Today, companies play games with each other, trying to shift employees onto the other's plan. And if you do get injured on the job, the crazy and costly workers comp system comes into play -- and fraud is never far behind.

That will be gone. We're going to tie everything together and make our health care system whole.

Today, the government has gotten so deep into the business of micromanaging health care that it can't find its way out. The books that tell you whether Medicare or Medicaid will cover something are so big and thick that nobody can understand them. They've got checkers checking checkers. You get the feeling that there are more people writing regulations than doctors delivering care.

And that, too, will be gone. Because we're going to crack down on the waste and simplify the system and make this big mess make sense.

Now let me say to the small business owners in this room that, if you're covering your employeees right now, we're going to bring your costs under control. We're going to protect you. We're going to stop the insurance schemes that discriminate against you and drive your premiums through the roof. We're going to let you team up with other small businesses and negotiate for the same rates that insurance companies give the big guys.

And if you're not covering your employees, we're going to help make insurance affordable for you and your family. We're going to ask everybody -- workers and

employers alike -- to chip in for health care. We're going to give you the assistance you need but we're going to stop asking the folks who are now paying for insurance to pay for those who don't. Because it's not fair when the dry cleaner who covers his workers has to pay a whole lot more because the owner of the car wash down the street can't pay the price.

The bottom line is simple: everybody benefits if everybody takes responsibility.

[small business story]

Today, if you live in rural America or in a small town, you probably can't even find a doctor. Maybe it was the ridiculous malpractice fees that forced the town obstetrician to close down shop. Or the fact that this nation is producing thousands of plastic surgeons -- but not enough pediatricians.

Under the President's plan, all that will change. We're going to bring real health care to rural America -- both in person and through technology. And we're going to produce the family doctors and pediatricians that your family needs.

Now there are a lot of people out there who are going to tell you that we don't need to change. They're going to try to scare you by making up all sorts of stories about terrible things. Then they'll tell you that they agree we need some reform -- but only on their terms.

What they won't tell you is that they're the ones who have been lining their pockets while the rest of us have had our pockets emptied. The ones who have caused the gridlock that let this messy system get even more messed up. The ones who have

spent their huge profits not on helping people get better -- -- but on lobbying and figuring out new ways to put health care out of the reach of the people who need it most.

Well, the fact is they can outspend you. But they can't outnumber you. You can win this fight for your family's security.

And when we join together and pass the President's plan, you'll have the peace of mind you deserve. A guarantee that you'll never lose your health insurance. Never. That no insurance company's fine print will steal your benefits. That you'll get comprehensive, high-quality care through a doctor or plan that you choose -- without ending up in the poorhouse.

Let's get one thing straight: health care is a right. Your right. And when it comes to health care, and when it comes to human needs and human suffering, there are no Republicans or Democrats. There are just Americans.

And every day more American families lose their health insurance -- and even if you're one of the lucky ones who likes you've got, the odds that you'll have it next year aren't great, and they're getting worse. Every day, what you're charged for health care keeps rising and rising -- and eating up your income and the future of your kids. And every day the special interests back in Washington keep blocking us from helping you.

You deserve the freedom from fear. Our nation deserves the freedom to grow. We all need the change. And we need it now.

HEALTH CARE REFORM:
QUESTION AND ANSWERS

Q: Will I still be able to choose my doctor?

A: Yes. You will always be able to choose your doctor. [I've got a doctor back in xxxx and I love him, and I would never support anything that would change our relationship.] Every American will have the choice of a variety of health plans -- you can go to an HMO, join a network of doctors and hospitals, or continue to get care on a fee-for-service basis the way most people do now. It's your choice.

Today, some businesses have limited people's choice of doctor in an effort to control costs. That won't happen under the Clinton plan. No boss will be able to tell you what doctor to go to or what health plan to join.

Q: If I have a good plan through my employer now, will the new plan be as good?

A: Yes. Your benefits package will cover at least as much as -- and probably more than -- the one you have now. It's modeled on the packages offered by Fortune 500 companies. And it's guaranteed, so your boss or insurance company can't take away your benefits or tell you to go read the fine print in your policy when you get sick.

Nobody will dictate to you what kind of plan you're on or where you have to go to get care. You choose <u>where</u> you get your care and <u>how</u> you get your care -- your boss or insurance company doesn't choose it for you.

Q: I like my health insurance. Why should I pay to insure others?

A: You won't. Like now, you'll be paying to insure yourself and you'll also be getting the peace of mind that, if you lose your job or get sick, you won't lose your insurance.

And remember: right now, you and your company are paying for the people who don't pay for their own health care. That's why you get charged $19 for a Tylenol when you go to the hospital. Because for every person like you who pays the bill, there are five others who don't.

The Clinton plan asks everyone who can to contribute to their own insurance. What <u>you</u> pay will go directly to <u>your</u> health coverage and <u>your</u> health security -- so that you will never be in danger of losing your insurance.

Q: Will the new health system mean that I have to pay higher taxes?

A: No. Some people advised us to impose a new, broad-based tax -- such as a national sales tax -- to pay for health care reform. But the President rejected that advice because he believes the middle class is already paying its fair share.

Here's how the plan provides health security to American families: First, it cracks down on the health profiteers who make a killing off the current system. Next, it asks smokers to pay to make up for the high health costs they add to the system.

And finally, it asks every employer and worker to contribute to the cost of their health care. But the money will go directly to their health plan to provide comprehensive benefits and health security -- the guarantee that you will never lose your insurance. The government never touches the money.

Q: How are you going to control costs?

A: Right now, what you're charged for health care is spiraling out of control. Insurance companies make outrageous profits by raising your premiums; drug companies charge high prices for basic prescription drugs; and unnecessary paperwork and fraud sends the costs of the whole system through the roof.

The Clinton plan will stop all that. It says to those who profit from the status quo: you've got to hold down your prices -- or we're gonna hold them down for you. It cracks down on fraud and eliminates excess paperwork.

Only if we take these strong actions to control costs can we provide true peace of mind and security to all Americans.

Q: Won't quality be sacrificed for the sake of cost savings in the new system?

A: Absolutely not. That's just an old scare tactic from the special interests that profit from the status quo.

The Clinton plan will improve the quality of American health care. Under the Clinton plan, the best technologies in the world will be put to work for you. There will be more primary care doctors and nurses to give care. And there will be a simple consumer report card -- so that doctors and hospitals are held accountable based on results, not on how many forms they fill out.

Most important, the Clinton plan will give American families the security that they will never lose their insurance.

Q: Won't this plan kill small business?

A: No, health care reform will help and protect small business. Today, insurance companies either won't cover small businesses and their employees or charge them high premiums that put insurance out of reach. Many small business owners can't afford to cover their families or employees -- because they had the initiative and courage to start a small business. That's not right.

The Clinton plan helps small business in three ways: First, it will aggressively control costs and prevent insurance companies from discriminating against small businesses. Second, it will eliminate the paperwork that each small business now has to deal with. And third, it will pool small businesses and individuals to give them the same bargaining power in buying insurance that big companies have.

The plan will be gradually phased-in with government assistance to ensure that small businesses that don't currently provide insurance can afford to cover their employees.

Q: What will happen to businesses that provide insurance, will their costs go up?

A: For many businesses, costs will actually go down. And over time, by getting health costs under control, we'll stop the chilling effect that exploding costs have on businesses.

Right now, businesses that cover their employees are paying for those that don't. That's not fair. The Clinton plan is based on fairness and responsibility. Every employer has to take responsibility for covering their employees -- giving them the security that they will never lose their insurance.

Q: Will insurance companies be able to deny me coverage if I have a pre-existing condition?

No. Right now, insurance companies can refuse to cover you if your daughter has asthma or if you're diagnosed with a heart condition -- and they do it all the time. Under the Clinton plan, that can't happen. Insurance companies will have to accept you -- whether you're healthy or sick. And you'll have the security of knowing that no one can ever take that insurance away from you.

Q: Will I still have my health insurance if I switch jobs?

A: Absolutely. Right now, some workers are locked into their job because they fear losing their benefits. If they do switch jobs or lose their job, they place their family's financial and health security at risk. That's not right. It's got to change -- and it will.

The Clinton plan gives you the security that you will never lose your insurance. If you switch jobs, you keep your insurance. If you lose your job, you're still covered. Complete security -- no ifs, ands or buts.

Q: Won't these "health alliances" create more bureaucracy and paperwork?

A: Absolutely not. Right now, if you own the corner grocer store, you've got to spend half your time doing paperwork and negotiating with insurance companies. The health alliances will replace all that hassle.

The Clinton plan allows businesses and individuals to team up in health alliances and negotiate for high-quality care at an affordable price -- so that you and your family can have a full range of health care choices -- without every person and every business going through the hassle of all that paperwork.

Q: Won't government involvement in health care just mean more paperwork for everybody?

A: No. Right now, doctors, nurses and patients are buried under a blizzard of paperwork. If you go to the doctor, you've got to fill out a bunch of different forms; and the doctor's got to fill out a bunch more. It's a waste of everybody's time and money.

The Clinton plan will take all the forms offered by the 1500 different insurance companies and turn them into one. We'll cut costs and eliminate all the hassle. There will be less paperwork -- and better health care.

Q: I don't believe you. The government's going to be <u>more</u> involved in health care but there will be less micromanagement of doctors and hospitals?

A: That's right. In the current system, doctors and hospitals have to pass a lot of different inspections and fill out a lot of different forms. But none of it does very much to improve the quality of care.

Under the Clinton plan, the government will set standards -- high quality, choice of health plans and doctor, security that you'll never lose your insurance, controlled costs, universal coverage and reduced bureaucracy. And then the government gets out of the way.

Q: Why are we changing so much about health care?

A: Right now the system is designed for the protection of the powerful health profiteers. That's wrong. Health care reform must protect American families -- not the special interests.

Right now the insurance companies have all the power. They pick and choose among consumers -- only covering healthy people and making a healthy profit. The Clinton plan will put consumers in the drivers' seat so that consumers get to pick and choose -- not insurance companies.

The Clinton plan will improve the quality of care and maintain your right to choose a doctor. If you like your health care now, it may be that you don't see much change after reform.

We've had too many studies, reports and commissions. We know the system's broke -- it's time to fix it. Only comprehensive reform can fix the problems of the current system and guarantee Americans the security they deserve.

Q: Isn't it true that managed competition is untested?

A: The Clinton plan is not managed competition. It draws on elements of many different ideas that have been put forward to reform our health care system. And it draws on the best models that work today in communities and states because what works in North Dakota won't work in New York. It is a uniquely American solution to an American problem.

It's based on the following principles: providing security for American families; controlling skyrocketing costs; improving the quality of care; increasing choice of doctors and health plans; and simplifying the system.

Q: What are we going to do to get doctors into rural areas? How can "managed competition" work when there is no competition?

A: Right now, two-thirds of rural counties do not have enough doctors. It's no wonder. Rural doctors provide more charity care than any doctors in the country, and they often get paid late. In many cases, rural doctors can't even take a day off because there isn't another doctor for miles around.

The plan will include incentives for doctors to practice in rural areas, and it will help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors.

Q: How will this reform help people that live in cities get high-quality care?

A: First, by providing a comprehensive benefits package to all Americans that emphasizes primary and preventive care. In today's system, too many Americans end up in the emergency room because they didn't get the primary care they needed. That's not right, it costs the system too much money, and we're going to change it.

And second, it will increase the number of doctors in urban areas by providing incentives for doctors to practice in cities and expanding the National Health Service Corps to reach more people in cities.

Q: Will physicians be able to practice as they do now -- or will Big Brother look over their shoulder?

A: Let's get one thing straight. Under the current system, doctors have too many people looking over their shoulders, second-guessing their professional judgement. And over the past twelve years, increased regulation by the government has meant more time filling out forms and less time caring for patients.

The Clinton plan will change that. It will create a single insurance form -- so doctors don't have to figure out the thousands of different forms used by over 1,500 different insurance companies today. It will simplify peer review and coordinate inspections.

And it will stop Washington from micromanaging doctors. So that doctors will be freed up to do what they do best -- deliver the highest quality care in the world.

Q: Will this plan do anything about all those crazy lawsuits?

A: Yes, it will. In the current system, doctors are forced to spend too much time practicing "defensive medicine" -- performing extra tests because they're looking over their shoulder for lawyers. It's not helping improve care -- but it is helping to drive doctors out of the profession and make costs go sky-high.

The Clinton plan will include serious malpractice reform that protects doctors and reduces frivolous lawsuits. It will find ways to avoid going to court all the time. And it will let doctors return to what they were trained to do -- delivering the highest quality of care in the world.

Q: Will the new system reduce doctors' independence and force them into a group practice or HMO?

A: No. Doctors will be able to continue their private practice, enter a group practice, join a network of doctors and hospitals or enter into several different arrangements. It's up to each doctor.

Q: Will I be able to stay on Medicare?

A: Yes. Older Americans will still be able to receive their Medicare benefits as they do today.

In fact, Medicare beneficiaries are likely to have more choices after reform -- they can continue to get care the way they do today or they may be able to get their Medicare benefits through different health plans offered under the new system.

Q: Medicare has the most bureaucracy and red tape in our current health system. If the President's plan retains Medicare, how is the new system going to reduce my paperwork and hassles?

A: The current system is riddled with unnecessary paperwork and burdensome hassles. Forms breed more forms. Checkers check checkers who check checkers. Doctors and nurses spend more time with paper than patients; and the quality of care suffers as a result.

The Clinton plan will introduce a single insurance form to replace the thousands of different forms used by over 1,500 different insurance companies today. To reduce some of the difficulties posed by the Medicare program, peer review will be simplified and inspections coordinated. And the Clinton proposal reduces micromanagement of doctors.

Q: How can you have a comprehensive health reform package that doesn't comprehensively cover long-term care?

A: This plan makes a serious start in addressing the need for long-term care. Today, you have to worry that you're not going to be able to take care of your parents when they get older.

The Clinton plan takes vast strides toward covering home- and community-based care with a special emphasis on creating ways for older Americans to continue to live in their own home and communities with dignity and independence. And it gives you the security that your parents or relatives with disabilities will get the care they need as they grow older.

Q: Won't your plan lead to job losses in the insurance industry?

A: Efficient insurance companies are likely to do well and are likely to go into the business of running health plans. But health insurance remains a small piece of the insurance industry, and some insurance companies will adapt to the new conditions and are likely to put a greater emphasis on other kinds of insurance.

Looking at the health care industry as a whole, there will be a shift in jobs. More people will be directly giving care, and fewer people will be filling out forms.

Q: Will the plan cover undocumented immigrants?

A: No. Only American citizens and other legal residents will be able to get the comprehensive benefits package. Undocumented residents that currently receive coverage under community-based programs and Medicaid will continue to do so.

Q: When is the President going to release his plan?

A: The American people demanded action on health care in the 1992 election, and the President is committed to passing health care reform this year. He is still consulting with members of Congress about the best time to introduce the proposal.

Q: I heard this plan was cooked up by a bunch of government bureaucrats. Why weren't there doctors involved?

A: More than 100 doctors, nurses and other health professionals were involved with the President's Task Force on Health Care. But the professional lobbyists did not write the legislation. That's why you heard complaints from some of the special interests in Washington.

The Task Force effort was the most open and inclusive policy-making process in American history. The process directly involved more than 500 people from all over the country. And Mrs. Clinton, the Task Force, and other members of the Administration reached out to over 500 groups for advice and input.

FOR IMMEDIATE RELEASE
February 12, 1993

Contact: Lisa M. Caputo
Neel Lattimore
Karen Finney
(202) 456-2960

REMARKS BY HILLARY RODHAM CLINTON
AT HEALTH CARE CONFERENCE
February 11, 1993

Pennsylvania State University
Harrisburg, Pennsylvania

MRS CLINTON: Thank you very much, Harris. (Applause.) I am delighted to be here with Senator and Mrs. Wofford and Governor Casey and all the rest of you who are gathered on this campus of Pennsylvania State University.

When Senator Wofford called and asked me to come and participate in this conference, I immediately thought that it would be a good idea, because as Governor Casey has just said, in many respects the march toward facing reality and reforming our health care system in this country started right here in Pennsylvania with the election of Senator Wofford, and it has continued through the efforts of Governor Casey and the work he's doing at the state level.

But I also would have been terribly remiss not to have accepted, since I'm sure my father, who is a Penn State alum, and my brother, who is a Penn State alum, would have thought that any call by the Nittany Lion, whether about health care or anything else, had to be responded to. (Laughter.) So for both policy and familial reasons, I am delighted to be here at Penn State, Harrisburg. (Applause.)

I had a wonderful visit in South Philadelphia earlier. I visited the St. Agnes Medical Center, talked with members of the staff and patients there, and heard what I am hearing from people all over the country and what I heard again at lunch. And that is that in this richest of all countries, there is a growing sense of personal vulnerability and personal insecurity because of the way our health care system has failed us. And that no matter how we look at the problem of providing quality health care to every American, no matter what point of view we might bring to this conference about what the best way to do that might be, we know two things.

MORE

First of all, we cannot go on the way we have been going. We do not have a system of health care in America. We have a patchwork, broken-down system. As a gentleman said to me this morning at St. Agnes -- a medical doctor -- he said, "You know, there's that old saying: If it ain't broke, don't fix it." He said, "This system is broken and desperately needs to be fixed." He said, "If I were talking about it as a patient, I would say that it is in intensive care and we're not seeing the kind of vital signs that would lead us to believe it will recover." And I think that that is a fair assessment from those who are on the front lines, either as patients or as providers.

And the second thing we know is that we are already spending more money than any nation on earth in both absolute and relative terms, but we are not doing a good job in providing the kind of health care that that money should provide. We have to face up to the costs in this system, and we have to have the courage to talk about that openly, as all of you are prepared to do this afternoon. And we have to recognize that there will need to be changes in our health care delivery and financing systems if we are going to control costs. And that controlling costs is a necessary first step in not only providing universal access to health care for all Americans, but in beginning to eliminate that sense of vulnerability and personal insecurity that affects all Americans, even those currently with insurance.

So I want to salute those of you who have put this conference together, to thank Senator Wofford and Governor Casey. And to pledge, on behalf of the President and the Vice President and all those in the Clinton-Gore administration, their absolute commitment to doing what is necessary, despite how tough it will be, to present legislation in May that will hold out the promise of a new health care system for all Americans, and then get about the business of trying to implement it so that we can see it in action sometime by the end of this year.

Thank you very much. (Applause.)

###

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release May 1, 1993

REMARKS BY THE FIRST LADY
IN COMMENCEMENT ADDRESS TO
THE UNIVERSITY OF MICHIGAN

MRS. CLINTON: Thank you, President Duderstadt and thank you, regents, other honorary degree recipients, faculty, alumni, family members and citizens who are gathered here. But most of all, thank you to the graduates of the class of 1993 for letting me be part of this celebration. (Applause.)

It is a real pleasure for me to be here on a glorious Saturday afternoon that does remind us of football Saturdays, in which the celebration is not in terms of downs or yardage, but in terms of accomplishments and achievements of each of you. This is a university steeped in tradition, whose reputation for excellence goes far beyond the borders of this state.

Having grown up in the Midwest myself, I have always thought of Michigan as one of those institutions whose commitment to academic excellence and to public service certainly made it stand out above so many others. And of course, also being from the Midwest, I always thought of Harvard as the Michigan of the East. (Applause.)

Excellence is not just a word, it is a benchmark. And it represents what you have achieved. Because for those of you who are graduating, you are still in a minority of young Americans, most of whom do not go on to college or, even if they do, do not graduate from a four-year institution. So your excellence is not only about you, but it is about your generation and your country.

And when I talk about excellence, let me just expand for a moment about what I mean. To me, excellence is not found in any single moment in our lives. It is not about those who shine always in the sun, or those who fail to succeed in the darkness of human error or mistake. It is not about who is up or down today or this week. It is about who we are, what we believe in, what we do with every day of our lives. And for me, it is always telling when I think about excellence as to how someone deals with adversity and challenge. And I really believe, standing here in this great university, that the Fabulous Five are excellent and Chris Weber

MORE

deserves the kind of thanks that we can give him for going on and going forward. (Applause.)

When life, as a friend of mine has often said, hits you in the jaw and knocks you down, the real challenge is whether you get up and how you feel about yourself from that time forward. That's not only true in the lives of individuals, it's true also of institutions and even of countries.

I graduated from college 24 years ago, before MTV or rap or CDs or cellular phones. Back then if you had said 10,000 Maniacs, you probably would have been talking about Haight-Ashbury in San Francisco.

The '60s were a time of momentous change in our country, but also a time of dislocation; a time of activism and optimism flowing from the civil rights movement, the Peace Corps, the space program. But our ambitions for a better world were also scarred by deep societal wounds, President Kennedy's assassination, the murders of Martin Luther King and Robert Kennedy, the divisions of the Vietnam era, and the combustible mix of racism and poverty that exploded in so many of our cities.

When I graduated in 1969, I, like many of you, had dreams for my own life, but also for the world into which I was going. In a commencement speech, I talked about that. And going back and reading it now, I see the idealism, I see the excitement, and I know that at 21, I was perhaps unable to appreciate the political and social restraints that one faces in the world. But I am glad I felt like that when I was 21, and I have always tried to keep those feelings with me. I want to be idealistic. I want to care about the world. I want to be connected to other people. And I hope that you will as well. (Applause.)

The world has changed a lot in the intervening years. As one of the student speakers has already said, the Cold War is over. We are grateful for the opportunity to reach across in friendship to a former enemy like Russia. We have achieved greater rights for minorities and women. We remain the most powerful nation on Earth.

And yet we, too, have our challenges. We, too, must face the new problems that afflict our country. We see still too much inequality. We see too many people working too hard, but not getting ahead any longer. We see too few of our people being able to take advantage of the changes that this new world represents, because they are not prepared. They don't have the educational background, they are not given the kind of stability and structure within their families that enables them to understand how to deal in this new

world. We see, too, a society that is often coming apart instead of coming together. But that is the world as it is. And we can bemoan it, or we can be challenged by it to change.

Certainly we face obstacles. Even though we do celebrate the end of the Cold War, we have new problems. Places with names like Bosnia and Somalia that I never heard of when I graduated from college are now on the front pages of our newspapers. We worry about nuclear proliferation, ethnic hatred, starvation, political instability, and terrorism. And at home, we watch our cities crumbling under the dual assault of drugs and guns that create a level of violence that is unacceptable. It is not any longer possible for us to postpone confronting what we are doing to our children in these cities where they cannot even leave their homes in safety to walk to school. (Applause.)

We need to take a collective, deep breath and decide how we will proceed in this moment of history to deal with the challenges we face. And you each will have a role in that. You each, either by effort and planning, will shape a life and make a contribution, or by an abdication of responsibility for your life, you will have your life shaped for you. Like generations of Americans before you, you will look for the right balance in your lives -- a balance of work, family, and service; a balance between your rights as individuals and your responsibilities to your families, your communities, and your country.

Perhaps your experience here at Michigan will help serve as a guide, because here you have met people from diverse backgrounds; you've had your ideas and beliefs tested; you've had to learn what you are willing to stand for and stand against.

Universities are incubators of ideas and havens for free speech and free thought. And I hope that each of you has taken advantage of that because we will need your best thinking as we struggle to find that proper balance between rights and responsibilities. Regrettably that balance has been thrown out of kilter over the last years. Throughout the 1980s we heard too much about individual gain, about the ethos of selfishness and greed. We did not hear enough about what it meant to be a member of a community; to define the common good; to repair the social contract.

An exaggerated emphasis on "me" as opposed to "we" has accentuated the gaps between us and has resulted in the problems that I have referred to. And so what we now have an opportunity to do is work to right that balance again, to develop shared goals and to be part of reaching them. It does not mean sacrificing individual rights. It does not mean stifling the spirit of any of us. But it does mean that promoting the common good in our democratic system

requires us to work together to provide each other with certain rights and opportunities. And in return it requires each individual to be responsible to themselves for themselves and on behalf of their families.

This is what we now must work to define. During the 1960s we argued endlessly over that as we worried about the proper position to take with respect to the major issues of that decade. What was the individual's responsibility to speak out and act out against conditions that he or she thought were wrong.

And the most eloquent explanation I have heard about the individual's responsibility to society comes from Vaclav Havel, the playwright who is now the President of the Czech Republic. He went to prison during the Communist regime in Czechoslovakia because he could neither be free as an individual nor responsible as a member of a community. And he wrote from prison to his wife Olga, "Everything meaningful in life is distinguished by a certain transcendence of human experience beyond the limits of mere self-care toward other people, toward society, toward the world. Only by looking outward, by caring for things that in terms of pure survival, you needn't bother with at all, and by throwing yourself over and over again into the tumult of the world with the intensity of making your voice count -- only thus will you really become a person."

And there are two great issues now on the horizon of our country where all of us have a chance to feel that intensity and make that contribution. The first is national service. And in many ways, the roots of the idea of national service were planted in this university in 1960 at a rally on this campus at the student union by President John F. Kennedy. (Applause.) When President Kennedy, at 2:00 a.m. in the morning, asked how many students were willing to contribute to their country, to use their skills and their intelligence to help people around the world, he was challenging that generation to seek a greater purpose in life. And he knew that a free society's ability to compete in the world depends upon the willingness of citizens to help others to help themselves. Don't just, as the old saying goes, give a fish to a hungry person; do that, but then help that person to learn how to fish. Reach out and give that person the tools needed to become self-sufficient and responsible. (Applause.)

And today, the need for that call to responsibility is as great as ever. During the last presidential campaign, President Clinton stood on the steps of Rackham and talked about service programs, and called, in his inauguration for a season of service, a call which more than 4,500 students on this campus have already answered with community service this year.

And then yesterday, my husband offered his own national service plan, a domestic Peace Corps that will help young people pay for college or job training by performing community service, helping children learn to read and write, working in hospitals, helping the homeless, cleaning up the environment. Helping yourself by helping others -- the classic way that we try to reconcile right and responsibilities, and which really fuels the meaning of citizenship in this country.

And for many of you who are not yet sure about your own futures -- what kind of job you will get, where you will live, what kind of life you will lead -- this opportunity to contribute is still available, because there are always ways for you to look around and help. The small ways, added one to the other, make big differences.

And the second great issue is health care. Because if we do not deal with the health care crisis that is affecting all of us, we will not be able to put our country on a firm and stable footing for the future. We have to be determined to deal with all of the other problems -- to reduce the deficit, to create jobs, to provide better opportunities for people.

But at the root of our economic and human challenge lies the fact that, although we are the richest country in the world, we spend more money and take care of fewer people than many countries that are not as rich as we when it comes to health care.

What I have heard as I've traveled around this country, from state to state, are stories of people who are employed with insurance, not sure whether they will have it next year, worried about the layoffs; worried about the plant picking up and moving; worried about the end of what they thought they didn't have to worry about at all before. And so many others who work every day for a living have no insurance at all.

Most people in this country who are uninsured get up every day and go to work. They would be a lot better off when it comes to health care if they went on welfare. What kind of signal is that to our citizens, if we provide opportunities for people who do not work and turn our backs on the people who are in this stadium today who have sacrificed to enable you to attend this university, but themselves can't count on health care if they need it when they leave here this afternoon? (Applause.)

And then yesterday, my husband offered his own national service plan, a domestic Peace Corps that will help young people pay for college or job training by performing community service, helping children learn to read and write, working in hospitals, helping the homeless, cleaning up the environment. Helping yourself by helping others -- the classic way that we try to reconcile right and responsibilities, and which really fuels the meaning of citizenship in this country.

And for many of you who are not yet sure about your own futures -- what kind of job you will get, where you will live, what kind of life you will lead -- this opportunity to contribute is still available, because there are always ways for you to look around and help. The small ways, added one to the other, make big differences.

And the second great issue is health care. Because if we do not deal with the health care crisis that is affecting all of us, we will not be able to put our country on a firm and stable footing for the future. We have to be determined to deal with all of the other problems -- to reduce the deficit, to create jobs, to provide better opportunities for people.

But at the root of our economic and human challenge lies the fact that, although we are the richest country in the world, we spend more money and take care of fewer people than many countries that are not as rich as we when it comes to health care.

What I have heard as I've traveled around this country, from state to state, are stories of people who are employed with insurance, not sure whether they will have it next year, worried about the layoffs; worried about the plant picking up and moving; worried about the end of what they thought they didn't have to worry about at all before. And so many others who work every day for a living have no insurance at all.

Most people in this country who are uninsured get up every day and go to work. They would be a lot better off when it comes to health care if they went on welfare. What kind of signal is that to our citizens, if we provide opportunities for people who do not work and turn our backs on the people who are in this stadium today who have sacrificed to enable you to attend this university, but themselves can't count on health care if they need it when they leave here this afternoon? (Applause.)

And it is not just an economic issue, and not just an individual human issue. If we look at a state like Michigan we can see how competitively we have given away advantage after advantage over the past years, because our auto companies, for example, pay more in health care benefits because they cannot control costs in a

system that has gone crazy, and the expense of those health care costs make the automobiles produced in this state much more expensive than those with which we compete from around the world. We have essentially said to our manufacturers, tie both arms behind your back; be at a disadvantage; have to lay off workers because we, your government, will not control the health costs that you face every day.

If we do nothing, the current money we now spend, which is 14 percent of all goods and services produced in America, will rise by the year 2000 to over 18 percent. That means that unless we change now, by the year 2000 almost $1 out of every $5 that you and every American earn will be spent on health care. And we will not have insured one more American, provided better health care in our rural areas or inner cities. This is a problem we can no longer ignore.

We need to give peace of mind and security to every American, and we need to have the courage to change. The plan that the President will come forward with will do just that. You will have the right to choose your own doctor. You will have the right always to have health care no matter who you work with. If you change jobs, if you lose your job, you will not lose your health care. (Applause.)

If you have a preexisting condition, you will be insured. (Applause.) And if you are an older American, you will get some help on prescription drug costs and a beginning of a long-term health care system to give you the dignity and respect you deserve to have. (Applause.)

And if you are a physician or a nurse or a pharmacist or a dentist from one of the schools here on this campus, you will no longer be spending 20 to 40 percent of your time and income on filling out countless, meaningless forms that have to be sent to the checkers who check the checkers in the current system. (Applause.)

And if you are an employer, you will see these extraordinary premiums that you have been paying and struggling with stabilize and begin to decrease. And what we will find is a society where, once again, all of us have a right to be taken care of, have a right to have access to the finest health care in the world, but have to be responsible by taking care of ourselves, by seeking out primary and preventive health care so that we don't permit our health to deteriorate.

There will be something in this proposal for everyone to do. And there will be ways for all of us to change. But this is one of these moments in history when we talk about national service and

health care that give us the opportunity to feel fully alive and engaged, and to know that we will not only be helping ourselves but we will truly be building the kind of community that we will be proud and grateful to live in.

These are very exciting and difficult times. But each of you can make a contribution. And I expect that in your various ways you each will be looking for ways to do that. Be involved. Make your voice heard. Embrace the challenges and don't lose heart when the buzzer sounds, because there will always be ways for you to demonstrate your excellence if you don't give up.

And it is the same for our country. We really are at a fork in the road. Will we end the denial of the last years in which everything was fine and those on the top prospered, while those in the middle and the poor saw their opportunities diminish? Will we continue to live in a sense of unreality that we don't have to get our deficit down, we don't have to balance our budget, we don't have to provide jobs for people who, through no fault of their own, are being replaced by machines and automation and robots? Will we take on the challenges of our disintegrating family structure and our violent communities? I think we will. And I think the class of 1993 will be there to make sure that we do.

Thank you. And Godspeed. (Applause.)

END

THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript May 6, 1993

REMARKS OF THE FIRST LADY
TO SENATE SELECT COMMITTEE ON AGING

Capitol Hill

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

Q Open heart hearing --

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

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

Q -- (laughter) --

Q We believe in amnesty -- conversion --

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

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

MORE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SENATOR: (Inaudible.)

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

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

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

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

Would you give us a little of your --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SENATOR:That's no excuse.

MRS. CLINTON: Thank you, Senator.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MRS. CLINTON: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. CHAIRMAN: One more question.

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

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

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

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

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

END