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HOOPS, ROY  
MODERN MATURITY

THE WHITE HOUSE

Office of the Press Secretary

For Internal Use

October 6, 1993

INTERVIEW WITH THE FIRST LADY  
BY ROY HOOPES OF "MODERN MATURITY" MAGAZINE

Q -- the time of Pearl Harbor, Robert Montgomery (inaudible) was working in this room (inaudible) Colonel -- no, Lieutenant Commander (inaudible) literally in the Map Room in the White House.

MRS. CLINTON: That's right. This is it.

Q This is it, yes.

MRS. CLINTON: Yes. And I wanted to put up old maps on the walls.

Q Yes.

MRS. CLINTON: But at the end of the war, all the old maps were thrown away, and this is the only one we could find. A man who worked as a young, you know, young Lieutenant, I think, he picked it up and took it home with him, even though they were told to just throw them away and destroy them.

And lucky for me, we knew who -- you know, he knew people who knew us and so he donated that to the White House. But I would love to have the maps all around the walls.

Q Yes. I'm surprised that they got away, really.

MRS. CLINTON: I am, too.

Q You would think that somebody --

MRS. CLINTON: I'm going to keep trying, because I can't believe there are not more around (inaudible).

Q I assume everybody will try the Army Map Service, which would be the logical beginning.

MRS. CLINTON: Let's try that again, Lisa. Will you make a note of that, try the Army Map Service? That's an excellent idea.

Q On McArthur Boulevard?

MRS. CLINTON: Yes. Well, thanks for coming by.

Q Well, thank you for taking the time.

MRS. CLINTON: I'm glad to.

Q I guess we might as well get into it.

MRS. CLINTON: Okay.

Q People over 65 are already covered by Medicare. What do you tell seniors when they ask, "How will your health care plan help me?"

MRS. CLINTON: I tell them several things. I tell them first of all that we are going to be adding two benefits to Medicare that are not currently available: namely, prescription drugs and a good beginning on long-term care, particularly home-based care and community-based care. So that, for senior citizens, we're going to be giving them more benefits than they currently have.

Secondly, we're going to get the whole system on a firmer financial footing by getting everybody insured and by preventing the kind of downward pressures on Medicare that we have seen because what has been happening is that, as the private system has gotten more and more expensive and the budget deficit has gotten bigger and bigger, people have looked to reduce the rate of growth in Medicare without doing anything about trying to get the system better controlled to be able to sustain a firm financial footing for Medicare into the future.

Then the third thing I would say is that, through what we are doing, we are going to be providing care, we believe, at high quality but at less cost, which will benefit current Medicare recipients and those who come after, because we have this big bulge coming into the Medicare system. Many of the people who are 67 or 68 now, given how people are living, can live another 25 years.

When all of the baby boomers are in the Medicare system and with the huge increase in population in the Medicare system, if we don't try to deliver high-quality care at less cost, we're going to have to be making very tough decisions to eliminate services, to eliminate coverage, to further depress it, you will have more Medicare recipients being turned away or being told that doctors won't take Medicare.

So I think for those three big reasons, this is a major change that will be positive for Medicare.

Q Define a little more what you said, you're making a start on the long-term care.

MRS. CLINTON: Right.

Q What do you mean by that?

MRS. CLINTON: Well, right now, as all of us know, Medicare doesn't provide long-term care coverage. Medicaid, if you are Medicaid eligible and Medicare eligible, will pay for those individuals who spend themselves into poverty and have the option only of going into a nursing home.

Probably the single biggest concern that I heard out in the country from both older Americans and people in their middle years who are caring for parents and other older relatives, is why the system is biased in favor of nursing home care against other kinds of care, yet provides no help.

So what we want to do is begin to reimburse for home health care and community-based care and begin to provide nursing home care for sub-acute patients who don't need to be in hospitals but, if they are discharged from the hospitals, then the family picks up the whole financial burden instead of now being kept in the hospital so Medicare pays.

And yet, we can't go immediately from where we are to providing all the long-term care that everyone will need now and into the future. So the choice we've made is to begin to build in a very firm footing for long-term care.

We've got to do a couple of things. We not only have to pay for long-term care, we have to train more home health care workers. We have to convince more hospitals and community centers to provide adult day care during the day, which is a form of long-term care that keeps people in their

homes but gives them the kind of support they need during the working hours.

If we do that, and make some of the other changes we're making, like raise the spend-down limit for Medicaid, we will actually be able to take care of more people at less cost than we are currently providing.

I'll just give you one example. When I was in Philadelphia last spring, I visited St. Agnes hospital. It is a Catholic hospital that has served that neighborhood for many, many years and, like many hospitals, really pressed financially today. It has a very high Medicare population.

As one of its services, it offered to provide adult day care, which patients ranging from Alzheimer's patients to disabled patients to perfectly physically healthy older patients but who needed some supervision during the day, could be take care of. In order to make it pay, they tried to keep the cost as low as possible, so they charged, I think, \$35 a day. But many of the families in their neighborhood could not afford \$35 a day for a five-day work week.

So those patients who were in the adult day care either had to be left at home while their children or nieces or nephews worked, or they had to be put into nursing homes.

What the hospital staff said to me is: "If our people could get just a little bit of help -- they might be able to afford \$10 or \$15 a day -- if they could get just a little bit of help, they not only would feel better because their family members would be nearby and they would then go home with them at night and on weekends, but we would all save money. Because, as it is now, we don't pay for the \$35-a-day adult day care, but we pay for the much more expensive nursing home care."

So that's the kind of approach we want to begin to implement.

Q Yes. How do you feel that the inevitable bureaucracy that will emerge from a universal health care plan will be more efficient and less costly than the one that exists now among the health care providers?

MRS. CLINTON: Because I think that the bureaucracy that exists now, in both the private insurance system and in the public system, is based on a reimbursement method that

pays doctors for what they do on a test-by-test or procedure-by-procedure basis.

It is a huge job to keep track of all those individuals expenses, then to monitor them and to micro-manage the decision, so that you've got doctors now having to call some insurance companies and saying: "Can I provide this test? Will it be covered?" You've got doctors under Medicare fighting with Medicare because they didn't code their bills right when they did something for a patient.

What we want to do is to say, "Look. All of that expense that goes into this system doesn't translate into one bit better care for any patient. What we want instead to do is to say, 'How much will it cost to take care of patients in a high-quality, medically-appropriate way?'"

Then, instead of paying doctors on a test-by-test basis, if they organize themselves like, for example, the May Clinic is organized, where they are on salaries, where they then don't get paid more if they order more tests, but they have an incentive to try to get their patients well without that kind of test-driven financing, we think we can eliminate a lot of the bureaucracy.

The second big piece of the bureaucracy comes in eligibility. In the private sector, "Are you eligible?" is a question that is answered by underwriters and insurance agents and employers and layer upon layer of people who are trying to determine whether you're a good or bad risk and, if you're a bad risk, how much more they have to charge you.

In the public sector, in the Medicaid program, you have hundreds of forms that have to be filled out. You've got all these people filling out forms for people and then checking to make sure they told you the truth. By the time we add up how much money we're spending, about 10 cents out of every dollar we spend in health care in our country goes to administrative costs that are not directly related to providing good quality health care.

So we think our system will eliminate and simplify the system dramatically.

Q In both the case of long-term care and prescription drugs, we anticipate some opposition to the money it's going to cost. What do you feel about the complete funding of those programs and the problems you're going to run into there?

MRS. CLINTON: I think you're right. There will be opposition. I've been very gratified by the support that AARP and other organizations have given to the proposals for prescription drugs and long-term care because they will be funded by reducing the rate of growth in Medicare.

Actually, they will have a little more money than that, because the costs for doing that will be slightly more than bringing down the costs of increasing Medicare without providing additional benefits, and we think we've worked out how that can be funded.

But there will be those who say, "We shouldn't give any new benefits to anybody." And my answer to that really has got several parts.

First of all, prescription drugs are a benefit that we think will save money in the long run. It's not only a human issue where we know, unfortunately, there are too many people who go without prescriptions because they can't afford them, or they self-medicate.

You know, if the bottle says "Take four a day and then have a refill," too many people who can't afford that next prescription say, "Well, I'll just take one a day and it will last four times as long." And, of course, it doesn't work.

We know, from looking at medical reviews of patient records, that too many people, particularly older Americans, end up in the hospital because of inadequate or improper medication.

If we have a system in which prescription drugs are provided at a much lower and subsidized cost, we think we will actually be saving money because we won't have so many people going into the hospital. We think that we will be eliminating a lot of the problems that are caused through complications because people are not adequately medicated.

The same with long-term care. If we provide more options to nursing homes, which is very expensive, then we know we will be taking care of people the way they want to be taken care of at less cost.

So we know there will be opposition to both of these programs. But both in terms of human and economic costs, the President really believes they are worth fighting for.



one-half the cost of Boston?

There are many reasons for that, having to do with what doctors hospitalize people for, whether doctors prescribe more tests than they should on any kind of fair reading. If we begin to get doctors to change the way they practice without, in any way, decreasing quality, we can actually take care of more Medicare recipients better than we are now.

So we think -- and Dr. Everett Koop has told me that there are probably \$200 billion of unnecessary costs in the current system. So we know that we are going to be putting some new money in. We've got the "sin" taxes, we've got the employer-employee contribution. But we are absolutely intent upon not putting a whole lot of new money in this system until we get it to be more efficient.

If everybody got their health care delivered at the cost that it's delivered at Mayo Clinic or in Rochester, New York, we would save billions and billions in this country overnight. So we are going to try to bring the people who charge too much down to the level where high quality is delivered at a more cost-effective rate.

Q When you first came out with those figures, they were challenged quite a bit, in particular the savings on Medicare. Have you gone back and taken another look at those figures?

MRS. CLINTON: Sure. And we're going to keep looking at them. They were really challenged, not on the basis of their accuracy and whether or not they would support the drug benefit and the long-term care benefit, but whether it was politically realistic to expect us to lower the rate of increase in Medicare.

That's what this next couple of months is all going to be about. People who really care about Medicare and about what happens to older Americans have worked with us. AARP, its counsel, its advisors, have been working with us over the last months, and they have taken very hard, hard analysis of this.

It is not at all doubted that we could lower it and then provide these additional benefits. What is doubted is whether we can get the Congress to make the hard changes that are going to be required, not just in Medicare and Medicaid, but in the way we set up our whole health care system.

I'm banking that we can, because I think that the only thing worse than not trying to get this system to be better is to let it continue doing what it is. I don't think that's secure for anybody, and we want to make everybody secure in this system, and I think that's what we're going to try to achieve.

Q You obviously feel there is no lessening of quality in the Medicare program.

MRS. CLINTON: That is my number one priority. I mean, there isn't anything more important to me, that everybody have health security with a good set of benefits that is delivered in a high-quality manner. But I've just seen enough evidence. I'll use the Mayo Clinic again, because nobody in the world doubts its quality. Kings and queens come there from all over the world to be treated.

The Mayo Clinic is a multi-specialty clinic where the doctors are paid on salary. Last year, it's prices only went up 3.9 percent when the average in Medicaid was 16 percent, Medicare 11 percent, the private sector 9 percent.

Now why were they able to do that, when their quality remained absolutely top-notch? Because they weren't paying themselves on how many tests and procedures you ran, so that you didn't have surgeons and radiologists kind of fighting over the same amount of money.

Because, you know, if a surgeon says to a patient, "I don't know that I need to operate on you. Instead, why don't we send you over for the internist to see whether medicine would work," that's money out of the surgeon's pocket.

Unfortunately, in today's health care market, there is no incentive for the surgeon to do that because, if he thinks it's all right to do the operation even if something else might be more cost-effective, nobody is standing there saying, "Hey, you know, don't you think we ought to send him to the internist?" So that each doctor, in effect, kind of operates on his own and makes the decisions because that's will put, you know, reimbursement in his practice.

Whereas, at Mayo, when you're on a salary, you don't lose anything if you're a surgeon and you say, "I'm going to send you over to the internist. Maybe we don't need to do this operation after all."

Q How do the salaries compare there with what they make in the private sector and, do you think that some doctors work below cost, as it were, to get the reputation or credentials of having been at the Mayo Clinic?

MRS. CLINTON: I've been to the Mayo Clinic. They think they are very well paid. I don't know that they are as well paid as some doctors who just keep the system going and do as many procedures as they can -- you know, those people who advertise for cataracts and get people to come in and oftentimes perform cataracts even before they are necessary. There is a lot of money in doing those kinds of procedures.

I think we have to take a hard look at why would we, in the most important profession in our lives, pay people not on how good a job they did or on some set amount that we thought was a fair return for what their education and their training deserved, but on how many tests or operations they did? When you stop and think about it, it doesn't make a lot of sense. But that's the way we've grown up, and we're paying a big price for it.

One more example on that, took, that I thought was real important is, Pennsylvania, which has been collecting information about quality and cost, if you just take one operation, the coronary bypass operation, in one hospital in Pennsylvania, you can get it at \$21,000 and at another hospital, \$84,000 and just about every price imaginable in between.

The state went in and they looked at quality. The hospital that gives you a coronary bypass at \$21,000 actually scored higher on some quality indicators than those that were much more expensive.

My argument is, if more hospitals had high-quality coronary bypass operations available at \$21,000, we would actually care of more people. Right now, we've priced some people out of the market, or they wait too long because they can't afford it because they're either not insured or their insurance won't pay all of it or they don't have a Medigap policy to pick up the difference. Yet, if we could get the cost down, more people would be able to have high-quality care.

Q That gets into another area. To get the whole country running on the level of the Mayo Clinic, both with quality and efficiency, what kind of an organization do you envision will run the thing? Somebody

has to police everybody in the system to make it run like the Mayo Clinic.

MRS. CLINTON: What we think, instead of trying to police it, is to set some basic ground rules and then to try to have the market and competition create the environment so that, for example, the federal government would say, "Every American is entitled to this set of benefits."

How you deliver it should be up to the hospitals and the doctors and the insurance companies and the other professionals in each area so that you might have, as we do now, some people getting their care from HMOs, some getting it from networks of physicians and hospitals, some staying with the fee-for-service network that people have grown accustomed to.

For the first time, there would be incentives for everybody to try to learn what really works. If a hospital in Pennsylvania is going this operation at \$21,000, let's send somebody there and find out how they do it and how it makes a difference.

I've talked to lots of doctors and nurses who say it's very common that when you're in the operating room you might need one of something and you rip open a package of 12 and you throw the other 11 away. Well, that's a simple example. Or, you know, because of cost shifting in the hospital, what might be a \$5 bottle of aspirin out in the pharmacy costs \$5 an aspirin inside the hospital.

So we know that there are things we can do better, but there is no reason for most physicians to change their behaviors, just like there is no reason for most patients. Because, in the current system, most people who are insured get their insurance chosen by the employer.

We want the employee to make the choice so that an employee can say, "You know, I'm a health 28-year-old. I don't need the most expensive plan. I'm going to go with the plan that's the least cost and I've going to save me some money."

In maybe ten years, when that young person has children, they'll look and they'll say, "Well, I'm going to go to this plan because they emphasize care for children and I want that." That's the kind of choices we want, and we think then the marketplace and competition can move more people to be more efficient.

Q As you expand this program down in the future, have you ever looked into the costs in the future? Won't it inevitably reduce the quality of health care, just by the numbers of people that are to go in, both by the 37 million now plus the baby boomers coming aboard? Have you contemplated that rapid growth?

MRS. CLINTON: We have. We've looked at that, and we've looked at both other countries that cover everybody and the state of Hawaii, which covers nearly everybody -- about 97 percent.

In both kinds of models, actually people's health care across the board is better than what we have. Their life expectancy is longer; infant mortality is less; problem with different kinds of diseases caught earlier often because people go to primary care physicians more frequently.

In Hawaii, for example, they spend far less of their state income on health care. The patients in health care often see their doctor more frequently but, because they do, they catch problems sooner, so they don't have so many people ending up in the hospital needing care.

We think if we get everybody into the system and we increase the number of primary care physicians and we have everybody insured and we have a benefits package that stresses preventive care, we will actually be solving problems earlier. What happens now is too many people wait too long and then they get care at the most expensive place -- namely, the emergency room -- and that costs them and it costs the rest of us too much money.

So we really think that, by bringing everybody in, we will have a better chance at both containing costs and making sure quality doesn't decrease. Because what is happening right now is, in many parts of our country, because our medical system is broken in some places, people are being denied access.

Hospitals are closing that take care of Medicaid and Medicare patients. You have physicians not taking certain kinds of patients any more. And there are lots of pressures being put on the system which really result right now in people being denied care. We think in a system that emphasizes prevention and better access, we will actually take care of problem more cheaply than we do now and in the long run.

Q Your plan makes it possible for some people, at least, to still choose their own doctors. Would you explain how this works?

MRS. CLINTON: We are going to make it possible for everybody to choose their own health plan. Right now, often, too often, the government or private insurance companies or your employers tell you who you have to go to. What is happening now is so many people are being pushed into plans where they are told who the doctors are, and they have no choice.

We are going to put that power in the hands of the individual. Just like in the Federal Employee Health Benefits Plan now, every year you get a list of plans and you choose, you sign up for them. Every year, under this plan, people will choose and sign up for their own plan. If they have a doctor that they like, they can go to the plan where that doctor is. If they want a cheap plan because they think they're healthy and they don't want to pay much, they can go into the cheap plan. But they will get that choice.

Then doctors won't be discriminated against, as they are now. Doctors will be able to join more than one plan. Right now, many doctors are told, "If you practice in this plan, you can't take anybody else." We don't agree with that.

There will always be a fee-for-service network, where every doctor who wants to be is a member of that, so that if you want ten different doctors and they are in three or four different plans, you can find them all in the fee-for-service network and so that would be the plan you would choose.

Q Doesn't that inevitably mean, though, that the choice of the doctor is going to come out to more money, costing you more?

MRS. CLINTON: The more choice you have, like in the fee-for-service network, initially it will probably cost a little bit more, just like it does now. If you go into an HMO now, you pay less than if you go into a Blue Cross plan that has a fee-for-service network. That will not change. But, unlike now, doctors won't be told they can only be in one kind of plan. So if you prefer a plan over an other plan, you will most likely be able to find your doctor.

Q Your plan calls for some federal

and state controls but, at the same time, attempts to promoted competition, which thrives best when there are no government controls. Can you explain this rather complex concept?

MRS. CLINTON: We are trying to strike the right balance. And, you know, there are government controls in our system now. Medicare is a very tightly-controlled system. And, in every state, people who want to sell health insurance have to get state insurance commissioner or state approval. We we've got lots of regulation in our system right now.

What we believe is that if we have competition based on quality and price, we will have more people able to afford better health care because it will be delivered more efficiently.

So we're trying to strike the right balance between eliminating a lot of the controls and regulation that are in there now, where they basically almost get in between the patient and the doctor and tell them what to do, by setting out certain requirements that have to be met, but then getting out of the way and letting the marketplaces and individual communities decide how best to do it. Because we don't want to tell Vermont that they have to do exactly what California does but we want to tell both states, "We want everybody insured; we want everybody guaranteed a benefits package; we want to maintain quality; and we want to do it in a cost-effective way that preserves" --

(End Side 1.)

(Begin Side 2, in progress.)

Q -- influence your views on health care costs?

MRS. CLINTON: It influenced them very, very (inaudible), both as a member of the patient's family, seeing firsthand the very strong features of our health care system and some of the weaknesses.

Also, because I was there for so long, I had the opportunity to speak with many doctors and nurses and pharmacists, and people who keep the system running; and I had a real, firsthand look at some of the problems they face trying to take care of patients, because of government interference or private insurance company regulations and paperwork and red tape and how patients can be treated

depending upon what category they fall into and whether or not a family can get reimbursed for some kind of care that's given a family member, depending upon what the fine print in their insurance company policy says.

So it was a very difficult, but a very informative experience for me, because I was literally in the hospital for about 12 or 15 hours, sometimes 18 or 20 hours, every day.

Q What has been the most difficult and frustrating aspect of developing this program?

MRS. CLINTON: I think there have been so many good parts, because I feel so positive about the country's attitude now in trying to provide health security for everybody. I think that is such an important goal. I think what has been frustrating is that we are all -- our attitudes are all determined by our own experiences. We really have about 250 million experts in health care in America.

People who have never been sick don't understand what it's like to be chronically ill, and they don't put themselves in the other person's position. Young people who think they're immortal don't believe they will ever have an accident or, I guess, ever grow old like the rest of us. They don't know why they should have to pay for insurance.

If you go through all the different problems that I have encountered, I'm so frustrated that many people who haven't personally experienced what it's like to be uninsured, or to have a pre-existing condition, or to be laid off from a job and lose your insurance, or have to mortgage your home to put your mother in a nursing home or, you know, all the problems that I have learned about firsthand, that if people haven't personally experienced it, they may not understand why this whole health care proposal has so many pieces to it because we have so many different problems we're trying to address.

I guess what is ultimately rewarding to me is that I've seen, over the last nine months, people begin to say, "There, but for the grace of God, go I." Even those of us who are very well insured, who have never had to worry about getting good medical care, know that something could happen tomorrow and that might not be the case.

What I'm happy about is that people are beginning to act like a country again, a community. I have this old-

fashioned idea that young people ought to help pay for old people and healthy people ought to help pay for sick people because, at some point, we're all going to be sick and we're all going to be old. I'm beginning to see people begin to understand that they don't lose anything by trying to help somebody else; in fact, they gain more security.

If everybody is secure, then we are all better off. Instead of fighting over who gets this particular procedure because "I can afford it and you can't," if all of us can afford it, there will be more of it for everybody. So it's been frustrating but ultimately rewarding to watch the whole country really commit itself that everybody should have health care and that it should be high-quality health care that is never taken away from anyone.

Q Thank you. Your enthusiasm is contagious. Have you ever thought about running the program yourself?

MRS. CLINTON: Oh, no. No, no, no. There are many experts to do that. But I'm very excited about seeing this get passed into law. A friend of mine sent me some of the debates that were around Social Security back in the 1930s, and the opponents to this made the same arguments back then.

Q And for Medicare.

MRS. CLINTON: And for Medicare. You know, the country kind of goes in a cycle -- it's almost a 30-year cycle -- and I think we're ready, now, to take this next important step to make every American secure, and I'm just convinced it's going to happen.

Q Let's hope so.

MRS. CLINTON: Yes. Thank you so much.

Q Thank you very much.

MRS. CLINTON: Thank you for your time.

Q Thank you.

MRS. CLINTON: I really appreciate it. Thank you, Lisa.

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Q This is it, yes.

MRS. CLINTON: Yes. And I wanted to put up old maps on the walls.

Q Yes.

MRS. CLINTON: But at the end of the war, all the old maps were thrown away, and this is the only one we could find. A man who worked as a young, you know, young Lieutenant, I think, he picked it up and took it home with him, even though they were told to just throw them away and destroy them.

And lucky for me, we knew who -- you know, he knew people who knew us and so he donated that to the White House. But I would love to have the maps all around the walls.

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MRS. CLINTON: I am, too.

Q You would think that somebody --

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Q I assume everybody will try the Army Map Service, which would be the logical beginning.

MRS. CLINTON: Let's try that again, Lisa. Will you make a note of that, try the Army Map Service? That's an excellent idea.

Q On McArthur Boulevard?

MRS. CLINTON: Yes. Well, thanks for coming by.

Q Well, thank you for taking the time.

MRS. CLINTON: I'm glad to.

Q I guess we might as well get into it.

MRS. CLINTON: Okay.

Q People over 65 are already covered by Medicare. What do you tell seniors when they ask, "How will your health care plan help me?"

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Secondly, we're going to get the whole system on a firmer financial footing by getting everybody insured and by preventing the kind of downward pressures on Medicare that we have seen because what has been happening is that, as the private system has gotten more and more expensive and the budget deficit has gotten bigger and bigger, people have looked to reduce the rate of growth in Medicare without doing anything about trying to get the system better controlled to be able to sustain a firm financial footing for Medicare into the future.

Then the third thing I would say is that, through what we are doing, we are going to be providing care, we believe, at high quality but at less cost, which will benefit current Medicare recipients and those who come after, because we have this big bulge coming into the Medicare system. Many of the people who are 67 or 68 now, given how people are living, can live another 25 years.

When all of the baby boomers are in the Medicare system and with the huge increase in population in the Medicare system, if we don't try to deliver high-quality care at less cost, we're going to have to be making very tough decisions to eliminate services, to eliminate coverage, to further depress it, you will have more Medicare recipients being turned away or being told that doctors won't take Medicare.

So I think for those three big reasons, this is a major change that will be positive for Medicare.

Q Define a little more what you said, you're making a start on the long-term care.

MRS. CLINTON: Right.

Q What do you mean by that?

MRS. CLINTON: Well, right now, as all of us know, Medicare doesn't provide long-term care coverage. Medicaid, if you are Medicaid eligible and Medicare eligible, will pay for those individuals who spend themselves into poverty and have the option only of going into a nursing home.

Probably the single biggest concern that I heard out in the country from both older Americans and people in their middle years who are caring for parents and other older relatives, is why the system is biased in favor of nursing home care against other kinds of care, yet provides no help.

So what we want to do is begin to reimburse for home health care and community-based care and begin to provide nursing home care for sub-acute patients who don't need to be in hospitals but, if they are discharged from the hospitals, then the family picks up the whole financial burden instead of now being kept in the hospital so Medicare pays.

And yet, we can't go immediately from where we are to providing all the long-term care that everyone will need now and into the future. So the choice we've made is to begin to build in a very firm footing for long-term care.

We've got to do a couple of things. We not only have to pay for long-term care, we have to train more home health care workers. We have to convince more hospitals and community centers to provide adult day care during the day, which is a form of long-term care that keeps people in their

homes but gives them the kind of support they need during the working hours.

If we do that, and make some of the other changes we're making, like raise the spend-down limit for Medicaid, we will actually be able to take care of more people at less cost than we are currently providing.

I'll just give you one example. When I was in Philadelphia last spring, I visited St. Agnes hospital. It is a Catholic hospital that has served that neighborhood for many, many years and, like many hospitals, really pressed financially today. It has a very high Medicare population.

As one of its services, it offered to provide adult day care, which patients ranging from Alzheimer's patients to disabled patients to perfectly physically healthy older patients but who needed some supervision during the day, could be take care of. In order to make it pay, they tried to keep the cost as low as possible, so they charged, I think, \$35 a day. But many of the families in their neighborhood could not afford \$35 a day for a five-day work week.

So those patients who were in the adult day care either had to be left at home while their children or nieces or nephews worked, or they had to be put into nursing homes.

What the hospital staff said to me is: "If our people could get just a little bit of help -- they might be able to afford \$10 or \$15 a day -- if they could get just a little bit of help, they not only would feel better because their family members would be nearby and they would then go home with them at night and on weekends, but we would all save money. Because, as it is now, we don't pay for the \$35-a-day adult day care, but we pay for the much more expensive nursing home care."

So that's the kind of approach we want to begin to implement.

Q Yes. How do you feel that the inevitable bureaucracy that will emerge from a universal health care plan will be more efficient and less costly than the one that exists now among the health care providers?

MRS. CLINTON: Because I think that the bureaucracy that exists now, in both the private insurance system and in the public system, is based on a reimbursement method that

pays doctors for what they do on a test-by-test or procedure-by-procedure basis.

It is a huge job to keep track of all those individuals expenses, then to monitor them and to micro-manage the decision, so that you've got doctors now having to call some insurance companies and saying: "Can I provide this test? Will it be covered?" You've got doctors under Medicare fighting with Medicare because they didn't code their bills right when they did something for a patient.

What we want to do is to say, "Look. All of that expense that goes into this system doesn't translate into one bit better care for any patient. What we want instead to do is to say, 'How much will it cost to take care of patients in a high-quality, medically-appropriate way?'"

Then, instead of paying doctors on a test-by-test basis, if they organize themselves like, for example, the May Clinic is organized, where they are on salaries, where they then don't get paid more if they order more tests, but they have an incentive to try to get their patients well without that kind of test-driven financing, we think we can eliminate a lot of the bureaucracy.

The second big piece of the bureaucracy comes in eligibility. In the private sector, "Are you eligible?" is a question that is answered by underwriters and insurance agents and employers and layer upon layer of people who are trying to determine whether you're a good or bad risk and, if you're a bad risk, how much more they have to charge you.

In the public sector, in the Medicaid program, you have hundreds of forms that have to be filled out. You've got all these people filling out forms for people and then checking to make sure they told you the truth. By the time we add up how much money we're spending, about 10 cents out of every dollar we spend in health care in our country goes to administrative costs that are not directly related to providing good quality health care.

So we think our system will eliminate and simplify the system dramatically.

Q In both the case of long-term care and prescription drugs, we anticipate some opposition to the money it's going to cost. What do you feel about the complete funding of those programs and the problems you're going to run into there?

MRS. CLINTON: I think you're right. There will be opposition. I've been very gratified by the support that AARP and other organizations have given to the proposals for prescription drugs and long-term care because they will be funded by reducing the rate of growth in Medicare.

Actually, they will have a little more money than that, because the costs for doing that will be slightly more than bringing down the costs of increasing Medicare without providing additional benefits, and we think we've worked out how that can be funded.

But there will be those who say, "We shouldn't give any new benefits to anybody." And my answer to that really has got several parts.

First of all, prescription drugs are a benefit that we think will save money in the long run. It's not only a human issue where we know, unfortunately, there are too many people who go without prescriptions because they can't afford them, or they self-medicate.

You know, if the bottle says "Take four a day and then have a refill," too many people who can't afford that next prescription say, "Well, I'll just take one a day and it will last four times as long." And, of course, it doesn't work.

We know, from looking at medical reviews of patient records, that too many people, particularly older Americans, end up in the hospital because of inadequate or improper medication.

If we have a system in which prescription drugs are provided at a much lower and subsidized cost, we think we will actually be saving money because we won't have so many people going into the hospital. We think that we will be eliminating a lot of the problems that are caused through complications because people are not adequately medicated.

The same with long-term care. If we provide more options to nursing homes, which is very expensive, then we know we will be taking care of people the way they want to be taken care of at less cost.

So we know there will be opposition to both of these programs. But both in terms of human and economic costs, the President really believes they are worth fighting for.

Q Except for certain "sin" taxes, you do not envision new taxes to pay for the plan. Would you explain how you plan to pay for your plan?

MRS. CLINTON: Yes. Most of the new money will come from employers and employees who are not currently contributing to insurance. Most of the people who are privately insured are insured -- in fact, 90 percent of us -- through employment. But there are about 37 million uninsured people, most of whom are workers or the families of workers who are without insurance.

If everybody who is currently uninsured but working and everybody who is on Medicaid but working makes a contribution to the health care system, then we will, with the matching contributions from their employers, be providing most of the new funding that goes into the system.

Secondly, there are currently federal expenditures for health care -- Medicare and Medicaid are obviously the biggest, but there are others as well -- that we think can be used to support some of the programs that will enable everybody to be insured.

For example, there is a federal program now that supports hospitals that take care of a lot of uninsured people and, therefore, have a lot of unpaid-for care. As we get more people paying for themselves with their employer contribution, we won't need to put in so much money to take care of uncompensated care. That money can be used to help subsidize low-wage workers and small businesses so that they can afford to go into the insurance market.

If we reduce the rate of increase in Medicare -- and I want to be real clear about this, particularly for your readers. We are not talking about cutting Medicare. Medicare is supposed to grow 11 percent next year. Our people in this country aren't reaching the age of 65 at that fast a rate. Because we think that the costs in Medicare can be better contained than they are now, we would reduce the rate of increase to about 7 percent.

There are many examples around of cities like New Haven or Rochester, New York or Rochester, Minnesota that provide high-quality health care for Medicare recipients at one-half or one-third of the cost of cities like Miami or Philadelphia or Boston. If you look carefully at those different populations -- New Haven is only 100 hundred miles from Boston. Why can they take care of Medicare patients at

one-half the cost of Boston?

There are many reasons for that, having to do with what doctors hospitalize people for, whether doctors prescribe more tests than they should on any kind of fair reading. If we begin to get doctors to change the way they practice without, in any way, decreasing quality, we can actually take care of more Medicare recipients better than we are now.

So we think -- and Dr. Everett Koop has told me that there are probably \$200 billion of unnecessary costs in the current system. So we know that we are going to be putting some new money in. We've got the "sin" taxes, we've got the employer-employee contribution. But we are absolutely intent upon not putting a whole lot of new money in this system until we get it to be more efficient.

If everybody got their health care delivered at the cost that it's delivered at Mayo Clinic or in Rochester, New York, we would save billions and billions in this country overnight. So we are going to try to bring the people who charge too much down to the level where high quality is delivered at a more cost-effective rate.

Q When you first came out with those figures, they were challenged quite a bit, in particular the savings on Medicare. Have you gone back and taken another look at those figures?

MRS. CLINTON: Sure. And we're going to keep looking at them. They were really challenged, not on the basis of their accuracy and whether or not they would support the drug benefit and the long-term care benefit, but whether it was politically realistic to expect us to lower the rate of increase in Medicare.

That's what this next couple of months is all going to be about. People who really care about Medicare and about what happens to older Americans have worked with us. AARP, its counsel, its advisors, have been working with us over the last months, and they have taken very hard, hard analysis of this.

It is not at all doubted that we could lower it and then provide these additional benefits. What is doubted is whether we can get the Congress to make the hard changes that are going to be required, not just in Medicare and Medicaid, but in the way we set up our whole health care system.

I'm banking that we can, because I think that the only thing worse than not trying to get this system to be better is to let it continue doing what it is. I don't think that's secure for anybody, and we want to make everybody secure in this system, and I think that's what we're going to try to achieve.

Q You obviously feel there is no lessening of quality in the Medicare program.

MRS. CLINTON: That is my number one priority. I mean, there isn't anything more important to me, that everybody have health security with a good set of benefits that is delivered in a high-quality manner. But I've just seen enough evidence. I'll use the Mayo Clinic again, because nobody in the world doubts its quality. Kings and queens come there from all over the world to be treated.

The Mayo Clinic is a multi-specialty clinic where the doctors are paid on salary. Last year, it's prices only went up 3.9 percent when the average in Medicaid was 16 percent, Medicare 11 percent, the private sector 9 percent.

Now why were they able to do that, when their quality remained absolutely top-notch? Because they weren't paying themselves on how many tests and procedures you ran, so that you didn't have surgeons and radiologists kind of fighting over the same amount of money.

Because, you know, if a surgeon says to a patient, "I don't know that I need to operate on you. Instead, why don't we send you over for the internist to see whether medicine would work," that's money out of the surgeon's pocket.

Unfortunately, in today's health care market, there is no incentive for the surgeon to do that because, if he thinks it's all right to do the operation even if something else might be more cost-effective, nobody is standing there saying, "Hey, you know, don't you think we ought to send him to the internist?" So that each doctor, in effect, kind of operates on his own and makes the decisions because that's will put, you know, reimbursement in his practice.

Whereas, at Mayo, when you're on a salary, you don't lose anything if you're a surgeon and you say, "I'm going to send you over to the internist. Maybe we don't need to do this operation after all."

Q How do the salaries compare there with what they make in the private sector and, do you think that some doctors work below cost, as it were, to get the reputation or credentials of having been at the Mayo Clinic?

MRS. CLINTON: I've been to the Mayo Clinic. They think they are very well paid. I don't know that they are as well paid as some doctors who just keep the system going and do as many procedures as they can -- you know, those people who advertise for cataracts and get people to come in and oftentimes perform cataracts even before they are necessary. There is a lot of money in doing those kinds of procedures.

I think we have to take a hard look at why would we, in the most important profession in our lives, pay people not on how good a job they did or on some set amount that we thought was a fair return for what their education and their training deserved, but on how many tests or operations they did? When you stop and think about it, it doesn't make a lot of sense. But that's the way we've grown up, and we're paying a big price for it.

One more example on that, took, that I thought was real important is, Pennsylvania, which has been collecting information about quality and cost, if you just take one operation, the coronary bypass operation, in one hospital in Pennsylvania, you can get it at \$21,000 and at another hospital, \$84,000 and just about every price imaginable in between.

The state went in and they looked at quality. The hospital that gives you a coronary bypass at \$21,000 actually scored higher on some quality indicators than those that were much more expensive.

My argument is, if more hospitals had high-quality coronary bypass operations available at \$21,000, we would actually care of more people. Right now, we've priced some people out of the market, or they wait too long because they can't afford it because they're either not insured or their insurance won't pay all of it or they don't have a Medigap policy to pick up the difference. Yet, if we could get the cost down, more people would be able to have high-quality care.

Q That gets into another area. To get the whole country running on the level of the Mayo Clinic, both with quality and efficiency, what kind of an organization do you envision will run the thing? Somebody

has to police everybody in the system to make it run like the Mayo Clinic.

MRS. CLINTON: What we think, instead of trying to police it, is to set some basic ground rules and then to try to have the market and competition create the environment so that, for example, the federal government would say, "Every American is entitled to this set of benefits."

How you deliver it should be up to the hospitals and the doctors and the insurance companies and the other professionals in each area so that you might have, as we do now, some people getting their care from HMOs, some getting it from networks of physicians and hospitals, some staying with the fee-for-service network that people have grown accustomed to.

For the first time, there would be incentives for everybody to try to learn what really works. If a hospital in Pennsylvania is going this operation at \$21,000, let's send somebody there and find out how they do it and how it makes a difference.

I've talked to lots of doctors and nurses who say it's very common that when you're in the operating room you might need one of something and you rip open a package of 12 and you throw the other 11 away. Well, that's a simple example. Or, you know, because of cost shifting in the hospital, what might be a \$5 bottle of aspirin out in the pharmacy costs \$5 an aspirin inside the hospital.

So we know that there are things we can do better, but there is no reason for most physicians to change their behaviors, just like there is no reason for most patients. Because, in the current system, most people who are insured get their insurance chosen by the employer.

We want the employee to make the choice so that an employee can say, "You know, I'm a health 28-year-old. I don't need the most expensive plan. I'm going to go with the plan that's the least cost and I've going to save me some money."

In maybe ten years, when that young person has children, they'll look and they'll say, "Well, I'm going to go to this plan because they emphasize care for children and I want that." That's the kind of choices we want, and we think then the marketplace and competition can move more people to be more efficient.

Q As you expand this program down in the future, have you ever looked into the costs in the future? Won't it inevitably reduce the quality of health care, just by the numbers of people that are to go in, both by the 37 million now plus the baby boomers coming aboard? Have you contemplated that rapid growth?

MRS. CLINTON: We have. We've looked at that, and we've looked at both other countries that cover everybody and the state of Hawaii, which covers nearly everybody -- about 97 percent.

In both kinds of models, actually people's health care across the board is better than what we have. Their life expectancy is longer; infant mortality is less; problem with different kinds of diseases caught earlier often because people go to primary care physicians more frequently.

In Hawaii, for example, they spend far less of their state income on health care. The patients in health care often see their doctor more frequently but, because they do, they catch problems sooner, so they don't have so many people ending up in the hospital needing care.

We think if we get everybody into the system and we increase the number of primary care physicians and we have everybody insured and we have a benefits package that stresses preventive care, we will actually be solving problems earlier. What happens now is too many people wait too long and then they get care at the most expensive place -- namely, the emergency room -- and that costs them and it costs the rest of us too much money.

So we really think that, by bringing everybody in, we will have a better chance at both containing costs and making sure quality doesn't decrease. Because what is happening right now is, in many parts of our country, because our medical system is broken in some places, people are being denied access.

Hospitals are closing that take care of Medicaid and Medicare patients. You have physicians not taking certain kinds of patients any more. And there are lots of pressures being put on the system which really result right now in people being denied care. We think in a system that emphasizes prevention and better access, we will actually take care of problem more cheaply than we do now and in the long run.

Q Your plan makes it possible for some people, at least, to still choose their own doctors. Would you explain how this works?

MRS. CLINTON: We are going to make it possible for everybody to choose their own health plan. Right now, often, too often, the government or private insurance companies or your employers tell you who you have to go to. What is happening now is so many people are being pushed into plans where they are told who the doctors are, and they have no choice.

We are going to put that power in the hands of the individual. Just like in the Federal Employee Health Benefits Plan now, every year you get a list of plans and you choose, you sign up for them. Every year, under this plan, people will choose and sign up for their own plan. If they have a doctor that they like, they can go to the plan where that doctor is. If they want a cheap plan because they think they're healthy and they don't want to pay much, they can go into the cheap plan. But they will get that choice.

Then doctors won't be discriminated against, as they are now. Doctors will be able to join more than one plan. Right now, many doctors are told, "If you practice in this plan, you can't take anybody else." We don't agree with that.

There will always be a fee-for-service network, where every doctor who wants to be is a member of that, so that if you want ten different doctors and they are in three or four different plans, you can find them all in the fee-for-service network and so that would be the plan you would choose.

Q Doesn't that inevitably mean, though, that the choice of the doctor is going to come out to more money, costing you more?

MRS. CLINTON: The more choice you have, like in the fee-for-service network, initially it will probably cost a little bit more, just like it does now. If you go into an HMO now, you pay less than if you go into a Blue Cross plan that has a fee-for-service network. That will not change. But, unlike now, doctors won't be told they can only be in one kind of plan. So if you prefer a plan over an other plan, you will most likely be able to find your doctor.

Q Your plan calls for some federal

and state controls but, at the same time, attempts to promoted competition, which thrives best when there are no government controls. Can you explain this rather complex concept?

MRS. CLINTON: We are trying to strike the right balance. And, you know, there are government controls in our system now. Medicare is a very tightly-controlled system. And, in every state, people who want to sell health insurance have to get state insurance commissioner or state approval. We we've got lots of regulation in our system right now.

What we believe is that if we have competition based on quality and price, we will have more people able to afford better health care because it will be delivered more efficiently.

So we're trying to strike the right balance between eliminating a lot of the controls and regulation that are in there now, where they basically almost get in between the patient and the doctor and tell them what to do, by setting out certain requirements that have to be met, but then getting out of the way and letting the marketplaces and individual communities decide how best to do it. Because we don't want to tell Vermont that they have to do exactly what California does but we want to tell both states, "We want everybody insured; we want everybody guaranteed a benefits package; we want to maintain quality; and we want to do it in a cost-effective way that preserves" --

(End Side 1.)

(Begin Side 2, in progress.)

Q -- influence your views on health care costs?

MRS. CLINTON: It influenced them very, very (inaudible), both as a member of the patient's family, seeing firsthand the very strong features of our health care system and some of the weaknesses.

Also, because I was there for so long, I had the opportunity to speak with many doctors and nurses and pharmacists, and people who keep the system running; and I had a real, firsthand look at some of the problems they face trying to take care of patients, because of government interference or private insurance company regulations and paperwork and red tape and how patients can be treated

depending upon what category they fall into and whether or not a family can get reimbursed for some kind of care that's given a family member, depending upon what the fine print in their insurance company policy says.

So it was a very difficult, but a very informative experience for me, because I was literally in the hospital for about 12 or 15 hours, sometimes 18 or 20 hours, every day.

Q What has been the most difficult and frustrating aspect of developing this program?

MRS. CLINTON: I think there have been so many good parts, because I feel so positive about the country's attitude now in trying to provide health security for everybody. I think that is such an important goal. I think what has been frustrating is that we are all -- our attitudes are all determined by our own experiences. We really have about 250 million experts in health care in America.

People who have never been sick don't understand what it's like to be chronically ill, and they don't put themselves in the other person's position. Young people who think they're immortal don't believe they will ever have an accident or, I guess, ever grow old like the rest of us. They don't know why they should have to pay for insurance.

If you go through all the different problems that I have encountered, I'm so frustrated that many people who haven't personally experienced what it's like to be uninsured, or to have a pre-existing condition, or to be laid off from a job and lose your insurance, or have to mortgage your home to put your mother in a nursing home or, you know, all the problems that I have learned about firsthand, that if people haven't personally experienced it, they may not understand why this whole health care proposal has so many pieces to it because we have so many different problems we're trying to address.

I guess what is ultimately rewarding to me is that I've seen, over the last nine months, people begin to say, "There, but for the grace of God, go I." Even those of us who are very well insured, who have never had to worry about getting good medical care, know that something could happen tomorrow and that might not be the case.

What I'm happy about is that people are beginning to act like a country again, a community. I have this old-

fashioned idea that young people ought to help pay for old people and healthy people ought to help pay for sick people because, at some point, we're all going to be sick and we're all going to be old. I'm beginning to see people begin to understand that they don't lose anything by trying to help somebody else; in fact, they gain more security.

If everybody is secure, then we are all better off. Instead of fighting over who gets this particular procedure because "I can afford it and you can't," if all of us can afford it, there will be more of it for everybody. So it's been frustrating but ultimately rewarding to watch the whole country really commit itself that everybody should have health care and that it should be high-quality health care that is never taken away from anyone.

Q Thank you. Your enthusiasm is contagious. Have you ever thought about running the program yourself?

MRS. CLINTON: Oh, no. No, no, no. There are many experts to do that. But I'm very excited about seeing this get passed into law. A friend of mine sent me some of the debates that were around Social Security back in the 1930s, and the opponents to this made the same arguments back then.

Q And for Medicare.

MRS. CLINTON: And for Medicare. You know, the country kind of goes in a cycle -- it's almost a 30-year cycle -- and I think we're ready, now, to take this next important step to make every American secure, and I'm just convinced it's going to happen.

Q Let's hope so.

MRS. CLINTON: Yes. Thank you so much.

Q Thank you very much.

MRS. CLINTON: Thank you for your time.

Q Thank you.

MRS. CLINTON: I really appreciate it. Thank you, Lisa.

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