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PHILADELPHIA INQUIRY
DR. KOOP

THE WHITE HOUSE
Office of the Press Secretary

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INTERVIEW OF THE FIRST LADY
PHILADELPHIA INQUIRER -- DR. KOOP

Q -- how you plan to re-position or regain momentum or perhaps recondition the plan (inaudible).

MRS. CLINTON: Well, I don't think I am the general, but as a foot soldier I will tell you how I see it. I don't know if I am going to find a hill or not. But we will get everybody in position.

I think we are just going to try and give and take, but I would not read too much into that. There is a lot of jockeying going on, which is understandable, and will continue for a while because you kind of move the action into the congressional caucus. And there is a natural concern on the part of all these interest groups about how to get their strongest negotiated position going into that congressional caucus.

So, you know, you look at something like the BRT thing you referred to. You talk to every one of those guys and say to them, "You really support a health plan that removes your tax deductibility and forces your workers into the lowest cost plan?" They say, "Of course not. But we want to be in a negotiating position, and we think we will have more leverage, both on the administration and the Congress if we do this." That's their choice. But that doesn't particularly concern me. That's kind of their decision about how they are going to position themselves.

From my perspective I think that, based on everything I see out there, and all the polls and focus groups and everything I am looking at, there has been a steady support in the mid to high fifties for the plan, without any real description. And there is overwhelming support for the key features of the plan. Anytime you ask people whether they feature getting rid of lifetime limits or whether they approve the feature of having a shared responsibility between employers and employees, the range of support is from 60 on up. So this battle is just beginning.

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And the one thing I guess I have learned, watching legislative processes, is not to over-react; and wait until the situation gels, and continue to martial support for the basic parts of what we are trying to achieve. And that's what we are doing. I am not at all concerned about where we are. We are about where I thought we would be at this point.

Q One of the things that I hear a lot from either doctors or people (inaudible), is a real concern on the part of those (inaudible) that a new kind of health care system that (inaudible) is going to really affect (inaudible). Health care providers are going to (inaudible).

How do you respond to those kinds of concerns?

MRS. CLINTON: That's exactly what's happening right now. I mean, the status quo is forcing more and more physicians into managed care systems. More employers are choosing such systems and eliminating choices for their employees. And if we do nothing the outcome would be more and more close-panel HMOs, fewer choices for either the patient or the physician, and less time; with no increase in reimbursement for the clinical time spent with somebody in your office, but a continuing downward pressure on the price paid for the procedure or the test. That is the way we pay physicians, on the piece-work basis.

So I say to physicians, if you are really unhappy with what you see happening in medicine right now, if you are tired of patients calling you up and saying, "Doctor, I am sorry, but my employer has changed policies and I can't come to you anymore," then you have a lot to gain in changing the status quo where the choices of your patients will be theirs, not their employers; where we will increase the reimbursement of primary care physicians because we know that they are under-reimbursed compared to specialists; and where you will have incentives in managed care to provide preventive care as part of the basic benefits package which will increase doctor-patient contact, not decrease it.

So I would just ask them where they heard that it was going to do all these things. They probably heard it from advertisements by the insurance companies which don't want you any change.

Q Do you think the administration (inaudible) Mr.

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Smith Goes To Washington co-op and energize the people to counteract the lobbying groups that are trying to (inaudible)? I haven't seen the appeal from you or the White House for the man in the street to come out and demand that their interest be served (inaudible).

MRS. CLINTON: I think that will happen. But, you see, until the -- here is the position we are in now, which is why I answered the first question the way I did. We don't have a bill yet because -- when we set that up we knew that it was going to be changed in the committee process. We have got five different committees that are the major committees, and I guess probably about ten more that are minor in both houses, that are in the process now of marking up the bill. And there are going to be variations in how they put together the pieces which is why we have created kind of a bottom-line mentality, which is what's overwhelmingly supported by the American public.

They want guaranteed private insurance without the kind of limitations and cost that are associated with insurance now; and a comprehensive benefits package.

But, you know, Ways and Means may have a different approach than Ed and Labor, which will have a different approach than Senate Finance Committee, and so forth. Very hard to enlist people in the abstract. This is the way we see what's happening, the sort of leadership of both houses, including the committee chairs, want us to continue doing what I am doing; coming to Philadelphia, talking about what we think the plan is about, positioning us in a way that is supportive of the best health care system in the world against the stupidest financing system in the world, is what I said earlier, and to continue to build public support for a change in the status quo in a certain direction.

Once there is a bill, once we know what we can actually expect to get out of these committees, there will be tremendous public support. But right now even the groups that represent large segments of the public are still jockeying. And you know the seniors group want to know the best deal they can get on prescription drugs. They think we have got the best deal, but they are still shopping. That's all part of this legislative effort that is going on. But I think that you can count on intense public pressure being generated once we can say, you know, write your member and tell him to support Bill XYZ. We can't do that right now.

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If we were trying to engender that kind of support around the President's plan, wouldn't we know there will be changes in it? And we welcome those changes because we want there to be strong congressional ownership on it. We have to go through it all over again. It's not the timing --Q So you ultimately plan to do that?

MRS. CLINTON: Yes. absolutely.

DR. KOOP: The situation now is that the people who have the most to gain by health care reform are the sick and the poor. No money, no organization. Those who have the most to lose by it, well organized and well funded. Now, that's got to be shifted. It's going to take something to enlighten the public to get a hold of their congressmen and senators talk to them..

But I think the kind of things that happen today with the First Lady presenting the issues and showing up at states (inaudible).

Q What is your response to the Spector chart that threatens or suggests that your preliminary proposals would create this monster bureaucracy that would be impenetrable and create all kinds of, presumably, patronage hires and take it away from the private enterprise? What do you say to that?

MRS. CLINTON: Well, we have got a couple of alternative charts. We are going to get into a duel of charts. I have one big chart which says Republican Health Plan, with a blank on it. And I have another chart which tries to show the existing system, which is mind-boggling. Then I have an accurate chart which starts with real people and how they would navigate the new system, which is much simpler than the existing system.

I thought it was a very clever ploy. That's what they all are experts in, at clever ploys and diversionary tactics, so they don't have to meet the real issues. The real message of that, there is no health care crisis, which is patently absurd and is not a tenable political position. But if they want to have a duel over charts, we can come up with charts, too. That's then, from my perspective --

One of their more effective arguments is to scare people that the government will take over the system, and

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that the government will tell you who you can go to, and will take away your choice. And we know we've got to counter that. That has been something we have been working on.

Q What are your counter-points today? (Inaudible) very strongly today that one of the two major government-run programs, Medicaid, as its proposal, ends government-run medicine. Now, it puts Medicaid constituents (inaudible) private sector insurance which is a huge step away from government-run medicine.

MRS. CLINTON: I think that -- I went back and I looked at all the campaigns that were drawn against health care reform efforts, starting with Roosevelt, Truman; against Medicare and against Medicaid, until it kind of fell of its own weight against Nixon's proposal. And it's always the same argument, the specter of socialism is the specter of the government is the specter of people getting in there and taking over the system.

And this is not a government system. We are keeping private insurance. Some would argue we shouldn't. Then it would be certainly more efficient in many ways to eliminate. But we are keeping private insurance and we are building up a system that works, the employer system.

Anytime your opposition has a lot of money -- there was one estimate that the opposition against Truman, which was primarily organized medicine. And the commercial insurers spent \$60 million. And that was real money back in '47 and '48. Anytime they do that, you've got to counter it.

But I think we will have more than enough ammunition to counter it. Lots of groups are organizing, raising money to run counter-ads. It's just going to take a while.

But most Americans -- the press engages so fast. And they watch the deals, and they watch the nuance, and they try to figure out who is on first. Most Americans are still digesting the state of the union. This other stuff hasn't made any impression on them. And the support for health care reform has remained steady. So most Americans are just kind of waiting for the Congress and the President to get it done. And when it's appropriate they are going to be called on to stand up and express their support.

Q When do you think it will get done?

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MRS. CLINTON: When do I think health care will get done? Well, I think we are going to try to have a bill by the August recess.

Q (Inaudible).

MRS. CLINTON: Well, by the August recess. They hope to have a bill by the August recess. That's what our hope is.

Q Moynihan said he expected the Senate would have it on the floor by the middle of the year, which will be June.

MRS. CLINTON: That's what we are aiming for. It's a very ambitious schedule.

Q That's what I was thinking.

MRS. CLINTON: And part of what we are struggling with is, there has never been piece of legislation like that. As hard as the budget battle was, as hard as NAFTA was, there was only one committee in the House responsible. You could go ahead and get it out of that one committee.

Now we've got a much more complicated situation and it is unprecedented. The last huge piece of legislation they tried was the Energy Bill in the seventies, and they created a super committee for it. They wouldn't do that this time. Everybody wanted their piece of it because they see it as their legacy. So every committee wants to have their mark on it.

I am not in any way underestimating difficulties as this. But I think we will win either way. We either get a bill by the August recess, which guarantees private insurance and deals with the problems that people have in their heads about health care or we have a mid-term election about health care. I mean, either way is good for the country in my opinion. And the latter is good for Democrats. Because, I mean, if they filibuster, if they won't come with the votes to get this done in the right way, there is nothing like a campaign to focus public attention, much more so than any other way of doing it. So I think it's a win-win situation here.

Q One of the (inaudible), if I remember correctly,

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of health care reform, when it was initiated, a fact that I don't hear in the current debate, is the cost, the overall cost, and the impact on the deficit. I was wondering, is it too early to re-focus on that? I haven't heard very much conversation about that, what impact it would have on the deficit. I understand you don't know what version is going to come out, but what is your hope?

MRS. CLINTON: Well, you know, we are doing a lot better with the deficit than we even predicted. The latest figures from the OMB are considerably higher even than we thought would be. We have made a lot of progress thanks to the budget and the economic package that was signed. But there is no doubt that even though -- I wish I had all these charts. They are all in color and (inaudible). But even with the charts, would show discretionary spending going down for the first time, and where the deficit would have been, and all that stuff.

We run into a brick wall in about '98/'99 because of health care costs. If you do not control health care costs, if you do not control the continuing reduction of the deficit -- and the President has said that ever since last year -- what you've got is an interesting set of choices from the Congress.

Our bill does reduce the deficit. There is no doubt about that. Even an independent study by Lorne (phonetic) and Associates, who is a health care analysis firm, concluded it does reduce the deficit even though we are putting more money into the system.

The other plans that are out there either do not reduce the deficit or try to reduce the deficit by decreasing expenditures in Medicare and Medicaid without making comparable changes in the private sector. They reduce the deficit on paper in the short run. They have increased it in the long run because if you just reduce Medicare and Medicaid, then what you are doing is throwing more uninsured into the system, which increases the costs to the private sector because of the cost shifting, which leads more employers to drop more employees, which puts them into the pool where they are government assisted.

I mean, all of this is part of the same unified system. So the President's plan would reduce the deficit, and it would reduce it considerably by 2,002. But more

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important than that -- because people can argue, well, will it reduce it 50 million, will it reduce it 35 million -- there is no argument that the comprehensive approach that is proposed would avoid having the deficit balloon back up. Coopersville, the deficit goes up. The Republicans, the deficit goes up. So there isn't any other bill out there that can it will control federal expenditures.

And one of the great challenges for the Congress, as they deal with this, is to be honest about these other approaches. That's why I view this kind of boomlet around some of these other approaches as a negotiating position. We need to be supported by people whose positions are mutually contradictory and will be shown to be so as we move forward in the faith.

Q (Inaudible) and we can argue the merits. The bottom line is that we aren't really talking about the critical decisions that need to be made, (inaudible) in terms of better tradeoffs and that type of thing. Basically saying that we have the research, we have all of the new technologies, all of the new medical procedures, and the cost to go along with that, and not have to trim something over here.

I wonder if you could respond to that as sort of a general (inaudible) against the plan.

MRS. CLINTON: We are not standing on street corners saying that Decision X is going to be impossible to make in ten years (inaudible) Decision Y. Because the way we try to structure this is to push a lot of those decisions down to the local and regional and state level so that. I have had this conversation with some of those people. From our perspective it is very difficult to engage the American public in a discussion about rationing services, for example, in the absence of universal coverage.

I mean, Oregon is always talked about as this great courageous state that went forward on rationing, and they did it for the Medicaid population. They weren't trying to ration for the non-Medicaid population. So people that come together very seriously in their community say, well, what should those people on Medicaid get or not get? They weren't saying, what should I get or not get.

Until there is universal coverage, so that

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everybody has a sense of security, you are not going to get that kind of discussion going in this country. But the way we have tried to set this up is get universal coverage and you provide services at the local level within some kind of budget discipline which forces people to make hard decisions: Do they need an MRI or don't they need an MRI. They should decide. Not somebody sitting in Washington.

So I see this all as an evolution in order to get to the point where those conversations can be had. Because right now when Dr. Koop and I go to the medical groups, and I always say, or he says later, I always say right now we ration. The uninsured are three times more likely to die from the same ailment as the insured. And invariably whenever I say that, I am attacked by doctors. They tell me it's not true, that's not the way the system works, and I must be mistaken. Or they say, well, that's true until they get to the hospital. But then survival is the same --

A PARTICIPANT: It's worse in the hospital.

MRS. CLINTON: It's worse in the hospital. So we can't have that conversation now about the facts that are existing. So I think we need to get to universal coverage before we expect to have sensible conversation.

Q How about the other aspect of what Hill was saying about the fact that it would have a chilling effect on bringing about new drugs, a cure for AIDS, and all that kind of thing, on the biotech issue?

MRS. CLINTON: Oh, did you imply that? Because I didn't get that.

Q (Inaudible). If indeed we have a tough budget (inaudible) force us to make decisions, so that means zero type of financing.

MRS. CLINTON: Well, there is so much money in the system right now that is misspent, poorly spent, that I don't think anyone who has really studied -- and I know Rheinhardt doesn't (inaudible) -- would argue that we are going to undermine research or pharmaceutical development in this country if we try to have some kind of budgetary discipline.

I said earlier today at the Civic Center that all last year I was just hammered day in and day out by the

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biotech groups. They had everybody in the world calling me, saying, you know, you are going to destroy biotechnology; major capitalists won't invest in us anymore; Wall Street is turning their back on us; we are going to have to go offshore for our money. I mean, you know, it was just the sky is falling and all these people are rushing around.

End of '93 I went and got the statistics. Investments in biotech groups were up 23 percent. Major capitalists were pouring money into biotech groups.

So from my perspective, that fear -- which in some cases I think is legitimate, and in other cases mask other interests -- is rebutted by the following: Number one, we are pumping more money into the health care system. We are going from 14 and a half percent of GDP to 17 and a half percent of GDP by the year 2000. And we are going to be spending the money on more direct medical services like research and prescription drugs and the like, and far less of it on paperwork bureaucracy, insurance companies and the like. So the net increase and reallocation is huge for medical care.

Secondly, we are going to be putting at least \$15 billion dollars a year into prescription drugs which will go right into the pockets of these drug companies.

Thirdly, drug companies have a very hard time justifying, except by scare tactics, the price that they charge. And they keep saying the same thing, if you try to do anything to us, we will go out of business and it will be terrible for America. Well, Americans fund most drug research directly or indirectly. We fund it through the NIH, we fund it through academic health centers, we fund it in all different kinds of ways. And some may be independent and totally freestanding, but that is the minority. And yet Americans pay anywhere from two to 15 times for the same drugs, that are sold overseas, to people who have made no contribution to the research or the development because the prices are controlled.

We are not proposing price control although I have these arguments with the heads of all these drug companies all the time. We are proposing that we get information about their costs which we then can make available to the market place. They will not open their books, they will not tell

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you what things cost. And they are of the sky-is-falling school, so that no matter what you ask them, they say if you make us do that, we will just have to leave.

What we are trying to do is to strike a balance. We are putting more money into these guys, huge amounts of money. But we would like not to control their prices, but we would like some better information so consumers and providers can make better decisions. Because if we get that prescription drug benefit in, Medicare will become the largest drug purchaser in the world. And we think we ought to get things like discounts, we ought to get some other breaks that we should get for that kind of trade-off.

DR. KOOP: They are indeed pushing the pharmaceutical houses. I talked to a group of eleven pharmaceutical houses that are very altruistically (inaudible), and they are concerned about health care in the Third World. Those eleven companies have (inaudible). So what could happen to (inaudible).

Q I heard some strong points on the national budget issue coming up (inaudible).

DR. KOOP: (Inaudible) the facts of the matter, because it's personalities. John Kitzauber (phonetic), who is the president of the Senate, who put this thing through in the beginning, is a (inaudible). So am I. We have people up there who were very much interested in the demographics of this. And he invited us out. And when we looked at it we found that if Oregon had reallocated its present resources, they could have given everything to the Medicaid people without taking from the poor to give to the poor.

I tried to make this point today at the Forum: The medical profession and the states have to reallocate resources because the Federal government can't force them to do that, But the Federal government eventually will force them to stop doing things. We would get back to having necessary permits for planning and so forth, which you don't have to have, for the people will take charge of their own responsibility.

MRS. CLINTON: I just want to follow up because this is one of the key arguments we are going to have in Congress. Our plan calls for premium caps. We adopted that approach as opposed to either a totally free market approach,

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which we believe will bust the deficit and lead to escalating costs, or to a heavily price control approach where you set the price for every treatment that anybody gives. Because we wanted to do what Dr. Koop was saying. We wanted to be able to say to a state or a region, here are the budget parameters, and they will be a very comfortable cushion in which you will make these decisions. You go make the decisions.

Philadelphia may decide, through its medical community and whatever local decision-makers are at the table, that they want to limit the number of MRIs and CAT scans in Philadelphia because they have more than they need.

Pittsburgh may decide they are short, and so they want that within their budget.

Q Why wouldn't the caps (inaudible)?

MRS. CLINTON: Well, I think because we got the competition under the caps. Part of what we think makes this workable is that you've got competing health plans. Each of them are going to try to get our business, each of whom is going to have to offer compensation based on both price and quality for the first time. But each of whom is going to have to price its services within some kind of budget discipline.

And what we are finding in what we consider to be analogous situations, is that, just as Dr. Koop pointed out about Oregon, there is so much fat in the system that once health plans really have to compete, and have to make some hard decisions, they are coming in below what the projected budgets are in places like Florida which have set up purchasing (inaudible). We have no reason to believe that won't happen in the entire country.

But as a backstop, these premium caps will be there in the event that a health plan exceeds what should be a reasonable amount. They are not going to be put out of business, but they are going to be told that they have got to go through and take a hard look again about how to reallocate their resources.

Q One problem that I have come across is the whole issue of cost effectiveness (inaudible) hardship. And under the whole issue the question of what is cost effective.

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Most of the experts agree that the studies are (inaudible) whereas in this plan they are relying heavily on someone determining the cost effectiveness. And generally that tends to be -- the company will have the financial incentive to try to show (inaudible) of their own product.

How are you going to deal with that? You have one small agency now that is trying to learn something about cost effect. How do we trust this study? What will (inaudible)?

MRS. CLINTON: That's where we agree with those who want to give a role to the marketplace. I mean, we want this to be kind of worked out through the marketplace.

Let me just give you a couple of examples about where we see this going. If you look at the way we reimburse physicians today, it is largely done on a piece-work basis. We stopped paying people, who made clothes, that way, 50 years ago in many instances. But that's what we still do with doctors. There is therefore no incentive to be cost effective because you have to keep gaining and building up your services to be able to get paid.

Now, that is just a financing cost effectiveness, that we think if properly changed through other incentives, could make a huge difference. It has nothing to do, necessarily, directly with quality --

(End tape 1, side 1.)

MRS. CLINTON: -- physicians in that position every day through more integrated delivery networks, through a model like Mayo, which is a multi-specialty clinic, which, when it started, was called socialism by the American Medical Association; where physicians are on salary, very good salaries, but they are not paid by the procedure. You actually can be more cost effective and quality driven. That's one of the outgrowths that we think will come from reorganizing the way we finance health care so that cost effectiveness, then, through competing health plan, to people making some hard decisions, will be joined with quality to give us a better outcome.

Q Yes. But aren't you somewhat concerned? At least from my research, I think that there is a great gap in our ability to distinguish (inaudible) deemed to be cost effective. You can (inaudible) appear cost effective in one

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study, and the company will go ahead and count it that way (inaudible).

There are perfect examples in the debate over (inaudible) arena. I think that there is great room there for a lot of (inaudible).

MRS. CLINTON: Let me go back to what I said about the drug companies and what we want from them, which is information. You said it exactly right. Where do doctors get their information about drugs? Initially from the drug companies. And often unrelated to cost effect or quality. But who put on the best seminar and gave the best brunch at the Medical Society meeting, all of which is sponsored by the drug companies.

We want more and better information. And that can come through clinical trials and through other kinds of research. But a lot of that is done before the drug goes to market. But it's not readily available except in the way the drug company wants to present it initially. And then you've got to go through kind of real-world, practical, clinical trials to acquire a new base.

If drug companies were required, as we are asking them to be, in the health care plan, to come to a health board, not to get their price set, but to give information that can then be made available, we would be further along toward determining cost effectiveness than we are now where we start basically from zero with competing propoganda from drug companies.

None of this is going to happen overnight. We have to change imbedded attitudes and practice styles and behaviors of people. But right now we need to change the incentives initially that will move us in that direction, and then watch it carefully to make sure that it holds correctly.

DR. KOOP: One of the problems with cost effectiveness is it shouldn't even be considered until you know what works and doesn't work in the theory and practice of medicine. We don't know that yet. Now, if you knew that, then you could say here are two things that both work. Which is cost effective?

And one of the little discussed things in the President's plan is the provision for professional

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foundations which are totally professionally operated, the purpose of which is to study utilization, informed decision-making on the part of patients and outcome research. And I would think ten years from now, if there is no transaction a doctor will do in his office, it doesn't automatically become a unit of evidence in outcome research. So that what he can pull up on his computer in January is quite different than it is in March, but he has contributed to it all during that time. That takes it completely out of commercial hands.

A PARTICIPANT: We need to wrap up.

MRS. CLINTON: I just want to make one last point, which is that Dr. Koop, who has been extremely helpful during this process, given us lots of good advice, and actually read early drafts of the plan, has said over and over again that many features of this plan have been getting no attention whatsoever, like the use of technology, like the professional foundations -- I am never asked about them, people are not paying attention to them -- have in the long run the possibility of huge payoffs for the entire system.

And what I worry about is that we will narrow the debate and we will make marginal changes that are in the absence of this kind of systemic reform, and we will therefore lose a lot of what's in this plan, the kind of a leading edge like the technology and some of these quality outcome things that, in the absence of it, we will not be able to do effectively under the budget, as we currently have in the Federal government, and we will lost an opportunity to have both the price and the quality term. That's why we went with comprehensive plan. People say it's long and it's complex, but everything is in there. Some of the competing plans are four or five or 800 pages long and they don't have anything except the financing and a few other features.

We have tried to look at every issue and put it out there. And what we hope is that we can keep the focus on comprehensive reform and not have it narrowed too soon.

But I wanted to say, before I am dragged out of here, that you all have done a great job covering this. I think that both the reporting and the editorials and the cautions and the encouragements, all that you have done in your coverage, has been among the best in the entire country. So I am grateful for what you have already done. I feel like I am preaching at the choir in terms of what you all know,

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and what you have already communicated. But I can stress how important that's going to be from now going forward. I wish I could get other papers to go at it in the kind of depth and understanding that you have brought to it because it is going to be hard enough to do. And not having accurate information will make our job even harder.

Q Just among the best? (Laughter)

MRS. CLINTON: The best.

(The interview was concluded.)

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