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Divider Title: Penn State 2-11

FOR IMMEDIATE RELEASE
February 12, 1993

Contact: Lisa M. Caputo
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REMARKS BY HILLARY RODHAM CLINTON
AT HEALTH CARE CONFERENCE
February 11, 1993

Pennsylvania State University
Harrisburg, Pennsylvania

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

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

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

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

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

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

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

Thank you very much. (Applause.)

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Divider Title: New York 2-21

FOR IMMEDIATE RELEASE
Sunday, February 2[illegible], 1993

Contact: Lisa Caputo
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Remarks of First Lady Hillary Rodham Clinton
"First Ladies of Song: A Musical Tribute to Eleanor Roosvelt"
Alice Tully Hall
New York, N.Y.
February 21, 1993

It is a privilege and a pleasure to be here in New York tonight to honor the memory of one of the truly great First Ladies of this city, this state, and this nation -- Eleanor Roosevelt.

New York, of course, has long been the gateway to America. Our international symbol is the great lady who stands proudly in your harbor as a beacon of liberty to all the citizens of the world who yearn for freedom. For more than a century, she has proudly lifted her lamp to "the tired and the poor" --"the homeless and the tempest tossed" -- to all who have dreamed of America as a land of opportunity and promise.

The statue of Eleanor Roosevelt that we gather to support tonight will, therefore, be another historic monument raised to a woman here. How fitting that she should stand just a few miles up the shore of the Hudson River from the stately lady of the harbor. For Eleanor Roosevelt's lifetime of service and her passionate commitment to justice have been a beacon of

inspiration not only to her contemporaries but to my generation as well.

There is no prouder name in American history than Roosevelt, because the men and the woman who carried it to prominence -- Theodore, Franklin, and Eleanor -- reached out from the world to which they had been born to feel and heal other people's pain.

Each, in their own way, was strengthened by misfortune. And each in their own way, came to understand the sufferings, the struggles, and the strengths, of men and women far less fortunate than themselves.

Eleanor Roosevelt grew up privileged but unloved, with an instinctive sympathy for everyone who refused to be held back by circumstance.

My friend and mentor Marian Wright Edelman loves to repeat Eleanor Roosevelt's words of wisdom: No one can make you feel inferior without your consent.

Hesitantly at first, but, later, with a quiet determination, Eleanor Roosevelt reached beyond the confines of her background and pushed against the limits placed on the women of her time.

When she followed her husband to Washington in 1933, she lent her voice of compassion and concern to a nation at the depths of the Great Depression.

Since Franklin Roosevelt was restricted not only by the demands of his office but by his own physical condition, she became his "eyes and legs" -- and often his ears, as well.

From the coalfields of West Virginia to the slums of the great cities, Eleanor Roosevelt visited with, and listened to, Americans who had lost their jobs, their homes, and their hope. She saw their plight and spoke up for policies that would ease their pain: from housing programs, to the Civilian Conservation Corps, to fair labor laws, and the first hesitant measures against racial discrimination.

And, often, she'd return to the White House, not only with new ideas but with new friends. Her guests included not only heads of state but southern sharecroppers and northern garment workers. At a time when Americans needed to believe that somebody in Washington cared about their lives, Eleanor Roosevelt helped make the White House the people's house.

Quietly, and without moral vanity, Eleanor Roosevelt answered injustice with the force of her own personal example. Attending a meeting in Alabama, she saw to her dismay that the

crowd was completely segregated by race. So she moved her own chair to the middle of the aisle that separated the whites from the blacks.

Learning that the Daughters of the American Revolution had barred Marian Anderson from singing in their auditorium in Washington, Eleanor Roosevelt resigned from the D.A.R. and helped organize an outdoor concert for Anderson on the steps of the Lincoln Memorial.

Three decades after Eleanor Roosevelt's death, her life and legacy are timeless because she gave unselfishly and unstintingly of herself to meet the challenges of her times.

For all of us who admire her, our challenge is not to do exactly as she did, but to live in the same spirit as she did.

Growing up at mid-century, in a midwestern suburb, in a middle class family that loved and teased and challenged me, I cannot begin to understand the burdens that were her birthright.

Eleanor Roosevelt became "a voice for the voiceless," an advocate for those who could not speak for themselves because of poverty or prejudice.

Today, there are still those who suffer but cannot speak for themselves. I think particularly of those of our children who grow up in rural or urban poverty, deprived of a decent chance to become the men and women God intended them to be. Decades ago, Eleanor Roosevelt declared that "A minimum standard of security must be at least possible for every child." Her vision still challenges us today; and I believe that, if she were with us now, she would be leading the fight to make sure every child gets a healthy start and a Head Start.

Thanks to the movements that Eleanor Roosevelt helped inspire, fewer Americans are without a voice.

But people still fear that they will be shouted down by those with privilege -- or they won't be heard by those with power. Our challenge is to make sure that the voices of ordinary Americans are not drowned out -- and that our leaders listen to those who must live with the consequences of their decisions or their indecision.

Last week, at a hearing in Harrisburg, I heard working men and women warn that a sudden illness or injury could bankrupt their families. And, yes, I will do what I can to see that their stories are heard, and something is done about their plight.

Eleanor Roosevelt's life was a lesson in integrity: a word that means not only honesty but wholeness. A loving wife, a caring mother, a concerned citizen, she met the challenges and balanced the needs that women have always experienced in our lives, from the White House to every one of our homes.

And even before that statue is completed, she stands tall in the memories of all of us who share her dedication not only to public service but to a life that truly balances the public and the private self.

"Action creates its own courage," she said. And courage can be "as contagious as fear."

How beautiful. How true. And how timeless.

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Divider Title: Little Rock 3-4-93

THE WHITE HOUSE

Office of the Press Secretary

REMARKS BY HILLARY RODHAM CLINTON
AT MARCH OF DIMES MEETING

March 4, 1993

Little Rock, Arkansas

MRS. CLINTON: (in progress) -- all of the logistics being examined for days and days until finally he had to accept the fact that he wouldn't be able to be either in *Barnhill last night or here this evening.

And I want on his behalf to thank the March of Dimes, to thank the Steve Stevens and all who are part of this organization here in our state, to thank Dr. Hauss and Beverly Sills and Alan Rosenthal and all who are part of the March of Dimes on a national level; for recognizing his commitment to making it possible for all of our children to be as beautiful and energetic as Allison is, whom I had a chance to meet tonight and will be the Arkansas Ambassador for the March of Dimes.

Because in my husband's personal and political experience over the past years, he has seen what I have also seen, and that is the tragic waste of human life and potential that comes because of the problems that occur due to birth defects and also the problems that occur due to inadequate prenatal care and the problems which occur to children after they're born because of a failure of immunization or of well-child care or of some other preventable childhood disease or problem.

It is very difficult not to be committed to what the March of Dimes stands for once you have had a personal experience. But I hope that all of us who have not had a personal experience will feel similarly committed.

I started my day today by flying to New Orleans. And both of the senators and the congressmen from New Orleans and I went to a small business where the people who are working there could buy into their company insurance plan, but because of the escalating costs of insurance, the business owners couldn't afford to make it as available as they wished and the workers, by and large, could not

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*phonetic

afford to buy it. And I sat and talked with men and women who get up every day and go to work, people who feel very strongly that they don't want anybody's help or any kind of charity, what they want is to be able to pay their own way. And yet for many of them, since 1985, they have not been able to afford health insurance. And so they pray a lot and hope a lot that nothing happens to them or their families.

But, you know, things do happen. So I listened to the stories that have become much too commonplace. These men and women were representative of the 37 to 40 million Americans who do not have health insurance at all and who, because they work, are not eligible for government-assisted health care. They are joined by millions of other Americans who still have insurance but who are watching the costs of that insurance sometimes double or triple over the space of a year or two.

And the system that we currently have is inadequate to meet the needs of any of us because it is not meeting the needs of all of us. Because what eventually happens to the men and women I spoke with, as they told me, is that having to forego regular primary and preventive health care, eventually they are forced to make decisions.

One kind of decision was represented by the woman who told me that she did try to get an annual exam because she wanted to keep healthy -- paid for it out of her own pocket -- and last year was told that after taking a mammogram, it was clear that she had a mass in her chest, and she was referred to a surgeon. And the surgeon after looking at the mammogram said to her, you know, I should do a biopsy, but because you don't have insurance, I'm just going to watch this for awhile.

And I took that very personally because as many of you know, Bill's mother is a breast cancer survivor, and I would hate to have thought that when she went to her surgeon, her surgeon had said, let's watch it for awhile; instead of saying, as he did, let's check you into the hospital. Or as the result of being in this situation might be, as another gentleman told me, when he finally got very sick and couldn't self-medicate himself anymore, he went to the emergency room because he didn't have a doctor. And in the emergency room he stayed for four hours and came out with a bill of $1,000, which is one-seventeenth of his annual income and possible for him to pay except maybe with small payments over many years. And he doesn't know what he's going to do, but you and I will pay for that in our health insurance and in the costs that will be shifted to us because he's unable to pay for it himself. Or perhaps we will once again see the result that a doctor from the charity hospital, where Virginia

Kelly trained years ago told me, where 50 percent of the women who give birth there now have had no prenatal care.

All of these stories are not just statistics in some dry report, they are the stuff of which people are living and coping with on a daily basis. If my husband does anything in this first year of his presidency, he hopes it will be to take the very human problems posed by our inadequate health care system and combining them with the very difficult problems caused by our economic situation, come up with a comprehensive solution because they are inextricably linked to each other. (Applause.) We will never solve our budget problems; we'll never deal adequately with the deficit until we deal with the health care crisis and the escalating costs that are in danger of breaking the system that we have left.

And so when Bill made his decision to pursue both of these, he was acting out of a deep conviction that as a country we had to face up to our problems. And maybe it's because he's from Arkansas, and maybe because he'd been a governor, he couldn't understand why that had not been done before. But it finally is being done now.

And what I want to say to all of you tonight is that when Franklin Roosevelt started the March of Dimes, he may have done so out of a personal experience, but he also did it because he understood what it meant to invest in people for the future. He understood that it was not just the right and human thing to do, but that finding a cure for polio would save our country money as well as lives.

And what the March of Dimes has done is very clearly challenge all of us to keep investing in our children, investing in our future, solving the problems that are there to be solved by putting our heads together, facing reality, and getting on with the work of making a better future for all of us.

And I am so grateful to so many of you in this room for all that you have done over the years to make it possible for all of us together to make progress. And I am so hopeful that we will take the lessons that have been learned from our state and apply them in our country, and that with all of us working together in the next few years, we will be able to say we have made a difference and we have made life better for America; and we've made Americans' future more secure.

Thank you all very much. (Applause.)

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Divider Title: Nat'l Comsn. on Children
4-2-93

THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript April 2, 1993

REMARKS BY THE FIRST LADY
IN TELEPHONE CALL TO THE NATIONAL COMMISSION ON CHILDREN

MRS. CLINTON: Hello everyone. I'm so sorry I cannot be there with you as I had long planned. I want to thank you for continuing the commitment that the National Commission has shown and led the way in demonstrating our support for families and children.

I especially want to thank Senator Rockefeller, who has personally led this crusade for a number of years, as well as Senator Dodd, from whom you just heard, and my old friend Governor Romer and Mayor Frazier, and all the public officials and representatives of business in the public sector who are there. It is so important at this point that we continue to stress the relationship between strong families, healthy children, good jobs, and a solid future for all Americans.

And I'm very pleased that the President's policies on the economy and health care reflect the hard work that went into the recommendations of the National Commission. It is not going to be easy to reinstill the kind of commitment to children and families that we need at all levels of our society, starting with, as Carol Rasco said this morning, the family itself and parental responsibility and moving through the kind of public-private partnership that the Commission has championed to the kind of public policies that will make a difference.

During the campaign I often spoke about how it's a false choice to choose between either helping families with government policies or trying to instill strong values so that families can help themselves. We need to do both. And we need to understand that children are the products both of the values of their parents and of our society.

So I am so grateful that you are standing firm on behalf of not only the values that are reflected in families around this country, but also in the values that should be reflected in our society at every level.

Thank you all very much for what you're doing. I'm sorry I cannot be there with you. But in my case, as in the cases of many of you in this audience, families really are the most important part of our lives and we all need to show that commitment in every way we can.

Thank you all very much. (Applause.)

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Divider Title: Austin Q + A 4-6-93

THE WHITE HOUSE

Office of the Press Secretary

For Internal Use April 6, 1993

REMARKS OF THE FIRST LADY
IN QUESTION AND ANSWER SESSION
AT LIZ CARPENTER LECTURESHIP SERIES

University of Texas
Austin, Texas

Q Now, I've heard that Barbara Jordan is willing to consider an appointment to the Supreme Court. (Applause.) But I've also heard she said it's on the condition you move the Court to Manchek. (Laughter.) If that were not possible, do you have any clues for us as to the person or type of person we might look to replace Justice White on the U.S. Supreme Court? (Laughter.)

MRS. CLINTON: The only clues that I have are that the President has said over and over again that he wants somebody who will be a symbol of excellence and have some understanding of what life is really like beyond the halls of academia or the previous administration's. And I think that he is hopeful that the person he selects will have the kind of universal appeal that everyone will say, there was a good choice.

We have returned to choosing people who are uniformly acknowledged as being excellent choices without the kind of problems and strive that we've had in the past. (Applause.)

* * *

Q I think when we start questioning our motives and thinking on an individual level, we can start feeling on a societal level. And I think that raises the question, what can we do in our own daily and individual lives to change our perspective on society and start looking for success?

MRS. CLINTON: Well, I think there are a lot of ways of answering that. I would hope that particularly here on this campus which provides so many people maybe the last or only opportunity to take a little time to think about the meaning of life and to think about who you are -- that those will not seem to be trivial or irrelevant pursuits. That really trying to think through your particular gifts is a very important part of defining who you are and

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what kind of contribution you can make. Developing a sense of confidence in your capacity to influence events around you and to help other people.

And I would also hope, spending some time to develop your own spiritual life, because part of what we are confronting is such a -- (applause) -- such a challenge to how we get through the days, the years ahead of us. That how everyone defines it, it is very hard to imagine that we will remold society or to heal it, in Ronnie's terms, without some spiritual awakening and without some understanding that eternal truths are eternal for a reason -- they have stood the test of human experience and they need to be reinvigorated in our individual lives.

Because how one defines success can be either very fulfilling or very empty. And that I think is what each of us has to challenge ourselves about on a daily basis. And there are few venues better for doing that than a university campus, and few greater opportunities than students have to try to come to grips with those sorts of issues. (Applause.)

* * *

Q People do have hope and I think they want to believe that government can be a partner with them in doing what they want to do rather than an obstacle. What do you think from your vantage point in Washington, what can the federal government do to help local communities and help these institutions rebuild themselves?

MRS. CLINTON: Well, I think you've put it the right way; government needs to be -- the federal government anyway needs to be a partner, government needs to be a partner on all levels. But government cannot and should not try to replace individual initiative or community efforts or empowerment -- the kinds of things that Ernie Cortez and others have fought for and stood for. But what we're trying to figure out how to do at all levels of government, here in the state of Texas with Governor Richards, or in Washington with the President, is to use government to reempower people who have lost hope, who have felt alienated not just from government but from themselves, their neighbors; to give them some tools so that they can become independent and to end the cycle of dependency that has for too long fueled government programs.

I mean, government began to exist more for those who were beneficiaries than for the common good. And particularly we see that in the examples that Ann gave earlier about how programs go on whether or not they have any legitimate purpose that is being served; but we also see it in the kind of perpetuation of dependency on

government that is not healthy for either government or the individuals.

So by pursuing welfare reform, by trying to create entrepreneurial activities, by trying to give, for example, housing projects back to tenants so that they are responsible for themselves, by trying to give the kind of incentive that will enable individuals to take personal responsibility and to bring communities together around that, the government can become a true partner in creating individual responsibility. And I think that will lead to better citizens and will lead to a better government. (Applause.)

* * *

Q Let me take that point to a different level for a question to Mrs. Clinton. You talk about we all belong to communities. We also all belong to interest groups, which say -- Robert Reich, the Secretary of Labor said that interest groups have replaced communities in the tradition sense of the dominant organized force in American life. Mrs. Clinton, can you create a comprehensive health care reform that the most powerful interest groups in Washington cannot frustrate? (Applause.)

MRS. CLINTON: Very well put. Well, I don't mind if they frustrate as long as they don't beat it. (Applause.) You know, they're going to be obviously directly interested in all of this.

I want say just a word, though, Bill, when you said the difference between communities and interest groups, there is a difference. I mean, one of things that I have found is that interest groups by definition employ people whose livelihood depends upon keeping the interest group agitated so that they will have to continue employing them to try to solve problems that the employees of the interest groups have made up. (Applause.) So I find all the time, not just with health care, but on other issues, that the paid representatives of the interest group often don't speak for the community of interests that they are paid to represent. (Applause.)

Now, is it going to be difficult to bring about change in a system as complicated as our health care system, which represents one-seventh of our economy? It will be absolutely very difficult. But if we approach the changes that are going to be proposed with good faith on the part of all of us, no matter who we are or who we represent, I believe there will be a consensus that reflects the national consensus that we have to change the way our health care system operates. And that in order to achieve that change, every single interest represented in the health care system will have to give up something. We will all have to change for the better good of the entire system. And that, I hope, will be a

compelling enough argument to overcome the strong objections of some of those who will be asked to change the way they've been doing things.

Q Do you wish that you had not imposed a deadline for finishing the program? Would you like to have more time?

MRS. CLINTON: Well, I think that what the President did was to impose a deadline in part to make sure it got finished. You know, there's a way in Washington of never finishing anything that you start. (Applause.) I think that as long as it is finished in May -- we may not be as early in May because of some delays that we've experienced -- but certainly, as long as it's finished in May, I think the President will be satisfied, because he wants to move it. Because if we do not deal with health care while we are trying to deal with the deficit, we have not dealt with the deficit. (Applause.)

The majority of Americans understand that, because even though the President's budget has received extraordinary support in the country and in the Congress, even cutting the deficit by the approximate $500 billion that is now projected over the next four to five years will not be sufficient unless we gain control over the exploding health care costs that will perpetuate and eventually increase the deficit to the level that it would have been had we not taken the steps the President has outlined, and even greater deficits will result.

So dealing with health care is not just a human imperative, it is a budgetary necessity -- not just for the federal government, but as the Governor can tell you, for every state government, for most country governments, and equally important, for most businesses and households in this country. So I hope that the speed with which the President is trying to move on this, which reflects his sense of urgency about it, will be recognized and acted upon by the Congress. But, of course, the only way to make sure that happens is if the people in this arena bring some pressure and urgency to bear once the plan is unveiled and the President moves forward with it. (Applause.)

* * *

Q I would like to ask Mrs. Clinton her thoughts about the concepts that are floating and many -- they vary around managed competition from a more purist form to those which encompass global budgeting. And I would like to ask if you believe the move towards a managed competition kind of plan would allow us to have the kind of reform which we so desperately need, including benefits for mental health and long-term care. (Applause.)

MRS. CLINTON: The kind of plan that the President talked about during the campaign and that he believes would most likely work in our country is a form of delivery that would use as

its base a standard comprehensive package of benefits for all Americans. Depending on how much we are willing to pay, those benefits can include some mental health benefits, substance abuse benefits and can begin toward moving us to a system of long-term care.

Part of the challenge that we face in putting this package of benefits together is to strike the right balance that is fair to all Americans, those who are currently insured but not adequately ensured; those who are uninsured; those who are paid for by Medicaid and government programs; so that we have a benefit package that all of us will feel will meet our hospitalization, our primary and preventive health care needs, our catastrophic needs and hopefully mental health, substance abuse, and some beginning efforts on long-term care.

Now, in order to be able to do that, you have to face some really tough questions about how it's going to be paid for and who's going to pay for it. And I think that what the President believes is that maintaining choice, maintaining quality control, maintaining some competitive public-private system is more likely to produce the kind of long-term gains that we hope to see in this system through controlling costs than any other system that we could try at this time.

Now, what he also believes is that we need to have some flexibility at the state level so that states are able to -- if they are already moving in a certain direction that is compatible with controlling costs, providing universal access and ensuring quality, they can have some flexibility to do that; where they are not, then they will be mandated to achieve certain objectives that the federal government would set.

* * *

Q It seems to me there are two real issues. One, how do we get a whole lot more people involved in leadership? And we're trying to encourage our students here to do that. How do we tell them why they should do it? And, second, when you were doing your last phrasing about, if you get to a certain point, you need spiritual healing -- and I thought about how do we keep our energy up? How do we have that healing of the soul that allows us to go? And I would love for you to comment on either of those for my students and others who are in this audience.

MRS. CLINTON: Those are two large questions that we could spend the next hour on. I think you're right about leadership. And when Liz introduced Governor Richards, she said that 20 years ago when the National Women's Political Caucus started, it started with

faith that women would be recognized as leaders. And I don't know that anybody would have predicted that in just 20 years, one of the largest states in the country would have one of the most popular governors in the country, and she would be a woman. (Applause.)

But I think that what is out there for anyone is a chance to be a leader at all kinds of levels. And you're so right there to say that we need lots of leaders. If you look at any of our institutions, they need leadership. And they need leadership that is willing to take risks and to say things as they see them at the risk of being unpopular; to be willing to change direction when necessary; to be willing to admit mistakes. Those are not easy things to do, but the rewards are great, even in something as personal as just your own personal growth and, hopefully, beyond that in the kinds of contributions you can make to whatever institution you're committed to and to the larger society.

So leadership doesn't have to be with a capital L at the gubernatorial or the presidential level to make a difference. It can be in a family; it can be in a church; it can be in a workplace; it can be in a voluntary organization. There are so many opportunities, and those can lead somewhere else. So I think that any way we can encourage people to have enough confidence in themselves to believe they can be leaders, we will all be better off for it.

Q In the last 10 minutes, we're going to give Paul and Ronnie the chance to ask some of the very specific questions that you've collected from students in our last 10 minutes. But let me just ask a final personal question of you. There's a wonderful story about the medieval knight who comes riding back into the castle; his armor is all tattered, his horse is dragging and drooping, his spear is lanced, is bent. He's clearly been -- he's disheveled. He's clearly been in some major event. And the king says to him, "Sir knight, what in the world has happened to you?" He said, "Where have you been?" And the knight says, "Oh sire, I've been out ravaging and plundering and pillaging your enemies to the west." And the king says, "I have no enemies in the west." And the knight says, "Now you do, sire. Now you do." (Laughter.) I'm wondering, have you been surprised by the enemies you've made? (Laughter.)

MRS. CLINTON: Well, sure, I'm surprised I've made any. (Laughter and applause.) I've been more surprised -- I don't know that I've earned any enemies, although I do think having some enemies, depending upon who they are, is probably a compliment in lots of quarters. (Applause.)

I guess I've been more personally surprised at how much interest there is in me and, since I have read a lot of history in the last couple of months, how it's really deja vu all over again.

So many of the same things that are being said about me were said about Abigail Adams or Dolly Madison or Eleanor Roosevelt, or a lot of the women who have been in this position. It just makes good copy, so it kind of keeps getting redone over and over again. So I'm more surprised by that.

And I suppose that both the President and the Vice President and everybody associated with this administration will be make enemies because they're trying to change the status quo; and the status quo, just like the knight on the horse, is a very strong and noble enemy to have, but it's one that needs to be taken on. And so we'll probably have some enemies because of that. (Applause.)

* * *

Q I very much would like to raise some questions that have been put to me by my fellow students. Having spoken to many students who, like myself, intend to be physicians, there is a great deal of insecurity about the field that we are headed into, especially nowadays. One of the most common problems that physicians indicate they have is dealing with a public that often holds unrealistic expectations of what modern medicine can achieve for them. When these often unattainable results are not produced, lawsuits are often the results. Physicians today spend about half their time thinking about how to cure their patient, and the other half of the time figuring how they can defend themselves from future lawsuits. This concern with excessive liability is one of the greatest obstacles that physicians cite as bogging down the medical system. (Applause.) How can the upcoming health care reform provide physicians with relief from this binge on litigation and all the destructive effects that that litigation has?

MRS. CLINTON: You're right to express the feelings of physicians who do believe that both the cost of malpractice insurance and lawsuits arising out of allegations of malpractice, along with the kind of defensive medicine that they believe they have to practice are major problems for physicians today. And there will be some steps taken to address the extraordinary burdens that malpractice premiums place on physicians to try to remove that financial disincentive toward the responsible practice of medicine. And there will also be steps taken to provide some alternative approaches to trying to resolve disputes that arise in the context of the doctor-patient relationship, while maintaining access to the courts for those individuals and cases that need to be there.

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Divider Title: Austin, TX 4-7-93

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release April 7, 1993

REMARKS OF THE FIRST LADY
AT LIZ CARPENTER'S LECTURESHIP SERIES

University of Texas
Austin, Texas

3:00 P.M. CDT

MRS. CLINTON: Thank you so much. I am reminded, in following Anne Richards, of that old story of the fellow who died in one of the early Arkansas floods and makes his way to heaven and is met at the gates. And St. Peter says, "Well, you're just in time for our monthly seminar. What do you want to talk about?" The man said, "I want to talk about the most important experience that I have ever encountered. I want to talk about what it is like to be in a flood. I feel like I can make a real contribution to that dialogue." St. Peter says, "Fine. You'll go on after Noah." (Laughter.) So, here we are after Noah. (Applause.)

You know, it is not a common experience for me to be in any Texas athletic facility and feel good about it -- (applause) -- but I must say that now that we're no longer in the same conferences, my state and yours, that I am honored to be -- (laughter) -- in the arena where the Lady Longhorns play. (Applause.) And I also have to say -- and I hope that you feel the same way I did -- I was mighty proud of Texas Tech, too. I thought that was a great victory. (Applause.)

You know, when Liz Carpenter asked me to come speak at her little seminar -- (laughter) -- it was one of those conversations that you have with Liz -- those of us who are lucky enough to know her and call her a friend -- where her enthusiasm just kind of takes over. She said, I'm going to have some of my friends in, we're going to do this lecture. You know, it will be fun. I'll get Anne to come over and Mrs. Johnson will come over, and we'll just have a good old time.

And I had this sort of mental image of being over in one of the small rooms at the LBJ School and sitting with a bunch of my friends, maybe with some students around a table. And then I just

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put it out of my mind. And over the last two weeks, as Liz knows, it's been kind of touch-and-go for me whether I thought I could be here, and I told Liz that I would certainly try. And when it became clearer that I could, I renewed contact with the people who were helping her put this on and was then told that there were going to be thousands, maybe 14,000 people at this event.

And my first response was no, no, no, you must have read it wrong, there's an extra zero in there somewhere. But my second was why would I doubt Liz Carpenter on anything? If she's going to put on a lectureship that's like Anne says, it's going to be a big one and besides it's in Texas. So what do we expect? And I'm just pleased to be part of it. (Applause.)

I also want to say a special word of appreciation to Mrs. Johnson. You know, there is that wonderful old saying about how you never quite know what it's like until you've walked in another person's moccasins. Well, I don't know if you've ever worn moccasins, Mrs. Johnson, but I'm getting a sense of what it is like to try to walk in the footsteps of you and the other women who have been in the position that I now find myself in. And every day that goes by, I am more impressed by the kind of qualities that you and other women in this position have brought to taking care of your personal business on behalf of your family and your husband, and also trying to make your contribution to the country. And all of us in this arena are grateful for the grace and beauty by which you carried out both of those functions and as a wonderful example, not just for me, but for all of us. And I very much wanted to say that to you publicly. (Applause.)

You know, after you hear what I have to say, you'll think that Governor Richards and I not only coordinated outfits but coordinated comments. And I suppose the only thing left for me is to get a hair-do like that. (Laughter.) You know, I'm actually due for a new one and I figure that if we ever want to get Bosnia off the front page, all I have to do is either put on a headband or change my hair and we'll be occupied with something else. (Laughter and applause.)

But what Anne Richards talked about is what I want to expand on in my remarks leading into the panel discussion with all of these distinguished panelists and with questions from many of you that I understand were submitted. Because the problems that she alluded to are not just American problems, they are not just governmental problems. We are at a stage in history, I would suggest, in which remolding society certainly in the West is one of the great challenges facing all of us as individuals and as citizens.

And we have to begin realistically to take stock of where we are, stripping perhaps away the romanticism that Governor Richards referred to, to be able to understand where we are in history at this point and what our real challenges happen to be.

And I say that it is not just an American problem because if one looks around the Western world, if one looks at Europe, if one looks at the emerging democracies, at Asia, if one looks certainly here in North America, you can see the rumblings of discontent, almost regardless of political systems, as we come face to face with the problems that the modern age has dealt us.

And if we take a step back and ask ourselves, why is it in a country as economically wealthy as we are despite our economic problems, in a country that is the longest surviving democracy, there is this undercurrent of discontent -- this sense that somehow economic growth and prosperity, political democracy and freedom are not enough -- that we lack at some core level meaning in our individual lives and meaning collectively -- that sense that our lives are part of some greater effort, that we are connected to one another, that community means that we have a place where we belong no matter who we are. And it isn't very far below the surface because we can see popping through the surface the signs of alienation and despair and hopelessness that are all too common and cannot be ignored. They're in our living rooms at night on the news. They're on the front pages; they are in all of our neighborhoods.

On the plane coming down I read a phrase in an article in the newspaper this morning talking about how desperate conditions are in so many of our cities that are filled with hopeless girls with babies and angry boys with guns. And yet, it is not just the most violent and the most alienated that we can look to. The discontent of which I speak is broader than that, deeper than that. We are, I think, in a crisis of meaning. What do our governmental institutions mean? What do our lives in today's world mean? What does this economic global event that Governor Richards spoke of mean? What do all of our institutions mean? What does it mean to be educated? What does it mean to be a journalist? What does it mean in today's world to pursue not only vocations, to be part of institutions, but to be human?

And, certainly, coming off the last year when the ethos of selfishness and greed were given places of honor never before accorded, it is certainly timely to ask ourselves these questions. (Applause.)

One of the clearest and most poignant posings of this question that I have run across was the one provided by Lee Atwater as he lay dying. For those of you who may not know, Lee Atwater was

credited with being the architect of the Republican victories of the '70s and the '80s. The vaunted campaign manager of Reagan and Bush. The man who knew how to fight bare-knuckled in the political arena, who was willing to engage in any tactics so long as it worked and he wasn't caught at it.

And yet, when Lee Atwater was struck down with cancer, he said something which we reprinted in Life Magazine, which I cut out and carry with me in a little book I have of sayings and Scriptures that I find important and that replenish me from time to time that I want to share with you.

He said the following: "Long before I was struck with cancer, I felt something stirring in American society. It was a sense among the people of the country, Republicans and Democrats alike, that something was missing from their lives, something crucial. I was trying to position the Republican Party to take advantage of it. But I wasn't exactly sure what it was. My illness helped me to see that what was missing in society is what was missing in me. A little heart, a lot of brotherhood.

The '80s were about acquiring -- acquiring wealth, power prestige. I know. I acquired more wealth, power, and prestige than most. But you can acquire all you want and still feel empty. What power wouldn't I trade for a little more time with my family? What price wouldn't I pay for an evening with friends? It took a deadly illness to put me eye-to-eye with that true, but it is a truth that the country, caught up in its ruthless ambitions and moral decay, can learn on my dime.

I don't know who will lead us through the '90s, but they must be made to speak to this spiritual vacuum at the heart of American society, this tumor of the soul."

That to me will be Lee Atwater's real lasting legacy, not the elections that he helped to win. (Applause.)

But I think the answer to his question -- "who will lead us out of this spiritual vacuum" -- the answer is all of us. Because remolding society does not depend on just changing government, on just reinventing our institutions to be more in tune with present realities. It requires each of us to play our part in redefining what our lives are and what they should be.

We are caught between two great political forces. On the one hand we have our economy -- the market economy -- which knows the price of everything, but the value of nothing. That is not its job. And then the state or government which attempts to use its means of acquiring tax money, of making decisions to assist us in

becoming a better, more equitable society as it defines it. That is what all societies are currently caught between -- forces that are more complex and bigger than any of us can understand. And missing in that equation, as we have political and ideological struggles between those who think market economics are the answer to everything, those who think government programs are the answer to everything, is the recognition among all of us that neither of those is an adequate explanation for the challenges confronting us.

And what we each must do is to break through the old thinking that has for too long captured us politically and institutionally, so that we can begin to devise new ways of thinking about not only what it means to have governments that work again, not only what it means to have economies that don't discard people like they were excess baggage that we no longer need, but to define our institutional and personal responsibilities in ways that answer this lack of meaning.

We need a new politics of meaning. We need a new ethos of individual responsibility and caring. We need a new definition of civil society which answers the unanswerable questions posed by both the market forces and the governmental ones, as to how we can have a society that fills us up again and makes us feel that we are part of something bigger than ourselves.

Now, will it be easy to do that? Of course not. Because we are breaking new ground. This is a trend that has been developing over hundreds of years. It is not something that just happened to us in the last decade or two. And so it is not going to be easy to redefine who we are as human beings in this post-modern age. Nor will it be easy to figure out how to make our institutions more responsive to the kind of human beings we wish to be.

But part of the great challenge of living is defining yourself in your moment, of seizing the opportunities that you are given, and of making the very best choices you can. That is what this administration, this President, and those of us who are hoping for these changes are attempting to do.

I used to wonder during the election when my husband would attempt to explain how so many of the problems that we were confronting were not easy Democratic-Republican-liberal-conservative problems. They were problems that shared different characteristics, that we had to not only define clearly, but search for new ways of confronting.

Then someone would say, well, you know, he can't make up his mind, or he doesn't know what he wants to say about that. When instead what I was hearing and what we had been struggling with for

years is how does one define these new issues. How do we begin to inject some meaning? How do we take old values and apply them to these new -- for many of us -- undreamed of problems that we now confront? And that is what all of us must be engaged in in our own lives, at every level, in every institution with which we interact.

Let me just give you some examples. If we believe that the reconstruction of civil society with its institutions of family, friendship networks, communities, voluntary organizations, are really the glue of what holds us together; if we go back and read de Toqueville and notice how he talked over and over again about the unique characteristics that he found among Americans and rooted so many of those in that kind of intermediary institution of civil society that I just mentioned, then we know we have to better understand what we can do to strengthen those institutions, to understand how they have changed over time, and to try to find meaning in them as they currently are.

That's why the debate over family values over the last year, which was devised for political purposes, seemed so off-point. There is no -- or should be no debates that our family structure is in trouble. There should be no debate that children need the stability, the predictability of a family. But there should be debate over how we best make sure that children and families flourish. And once that debate is carried out on honest terms, then we have to recognize that either the old idea that only parental influence and parental values matters, or the nearly as old idea that only state programmatic intervention matters are both equally fallacious.

Instead we ought to recognize what should be a common-sense truth -- that children are the result of both the values of their parents and the values of the society in which they live. And that you can have an important -- (applause) --
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(in progress) -- how best to make sure parental values are the ones that will help children grow and be strengthened, and how social values equally must be recognized for the role they play in how children feel about themselves and act in the world. And then we can begin to have what should be a sensible conversation about how to strengthen both. That's the kind of approach that has to get beyond the dogma of right or left, conservative or liberal. Those views are inadequate to the problems we see.

Any of you who have ever been in an inner city, working with young people as I have over the years, will know as I do the heroic stories of parents and grandparents who, against overwhelming odds, fight to keep their children safe -- just physically safe; and

who hold high expectations for those children; whose values I would put up against any other person in the country, but who has no control over the day-to-day violence and influence that comes flooding in the doors of that housing project apartment; and who need a society that is more supportive of their value than the one they currently have. (Applause.)

Equally, all of us know the contrary story of families with enough economic means, affluent enough to live in neighborhoods that are as safe as they can be in our country today, so they have the social value structure of what we would hope that each child in America could have in terms of just basic kinds of fundamental safety and physical well-being, but whose parental values are not ones to promote a childhood that is a positive one, giving children the chance to grow up to achieve their own God-given potential. So that the presence of values of society are not enough, either.

There are so many examples of how we have to think differently and how we have to go beyond not only the traditions of the past, but unfortunately for many of us, well-held and cherished views of the past; and how we have to break out of the kind of gridlock mentality which exists not just in the Congress from time to time, but exists as well in all of us as we struggle to see the world differently and cope with the challenges it has given us.

Yet I am very hopeful about where we stand in this last decade of the 20th century, because for all of the problems that we see around us, both abroad and at home, there is a growing body of people who want to deal with them, who want to be part of this conversation about how we break through old views and deal with new problems. And we will need millions more of those conversations.

Those conversations need to take place in every family, every workplace, every political institution in our country. They need to take place in our schools, where we have to be honest about what we are and are not able to convey to our children; where we have to be honest about the conditions with which are confronting so many of our teachers and our students day in and day out; where we have to be honest that we do have to set high expectations for all children and we should not discard any because of who they are or where they come from. (Laughter.)

And where we need to hold accountable every member of the educational enterprise -- parents, teachers and students. Each should be held accountable for the opportunity they have been given to participate in one of the greatest efforts of humankind, passing on knowledge to children. And we have to expect more than we are currently getting. (Applause.)

We also need to take a hard look at other institutions. As Governor Richards said we are in the midst of an intensive effort of trying to determine how we can provide decent, affordable health care to every American. (Applause.) And in that process we have had to ask hard questions about every aspect of our health care system. Why do doctors do what they do? Why are nurses not permitted to do more than they do? Why are patients put in the position they're in? (Applause.)

And we have with us today Bill Moyers, who has helped to enlighten all of us about how what we currently have is a system for taking care of sickness. We do not have a system for enhancing and promoting health. (Applause.) And what we need to do is recognize how each of us, whether we are a care giver or a care receiver -- and that role may change from time to time as we go through life -- will have to think differently about health care. And we will have to come up with a system that promotes wellness, promotes health and provides care for us when we are sick that we can afford.

But to give you just one example about how this ties in with what I have said before about how these problems we are confronting now in many ways are the result of our progress as we have moved toward being modern men and women: Our ancestors did not have to think about many of the issues we are now confronted with. When does life start; when does life end? Who makes those decisions? How do we dare to impinge upon these areas of such delicate, difficult questions? And, yet, every day in hospitals and homes and hospices all over this country, people are struggling with those very profound issues.

These are not issues that we have guidebooks about. They are issues that we have to summon up what we believe is morally and ethically and spiritually correct and do the best we can with God's guidance. How do we create a system that gets rid of the micromanagement, the regulation and the bureaucracy, and substitutes instead human caring, concern and love? And that is our real challenge in redesigning a health care system. (Applause.)

I want to say a word about another institution and that is the media, because it is the filter through which we see ourselves and one another. And in many ways the challenge confronting it is just as difficult as those confronting any other institution we can imagine. How does one keep up with the extraordinary pace of information now available? How do we make sense of that information? How do we make values about it even if we think we have made sense? How do we rid ourselves of the lowest common denominator that is the easiest way of conveying information? How do we have a media that understands how difficult these issues are and looks at itself

honestly because the role it must play is so critical to our success in making decisions about how we will proceed as a society?

I remember in the beginning of the campaign being asked a question at an editorial meeting in South Carolina that my husband was at to meet a lot of the editors and reporters from a lot of the small-town papers. These were not folks who you'll see on a TV station anywhere; these are people who got up every day and did the best they could to put out the paper that covered their community or their region. And one of the men, after hearing my husband speak, said, "Now, you've talked about how we have to change. How we have to change government, how we have to change society. But as a journalist, how do I change to be able to understand and report on those changes?" My husband said, "You know, I can't answer that. That's something you have to answer. But I'm really glad you asked the question, because every institution in our life has to ask those hard questions about who we are, what contribution we make to dealing with our problems and to injecting meaning again in the lives of us all."

So every one of our institutions is under the same kind of mandate. Change will come whether we want it or not, and what we have to do is to try to make change our friend, not our enemy. But probably most profoundly and importantly, the changes that will count the most are the millions and millions of changes that take place on the individual level as people reject cynicism, as they are willing to be hopeful again, as they are willing to take risks to meet the challenges they see around them, as they truly begin to try to see other people as they wish to be seen and to treat them as they wish to be treated, to overcome all of the obstacles we have erected around ourselves that keep us apart from one another, fearful and afraid, not willing to build the bridges necessary, to fill that spiritual vacuum that Lee Atwater talked about.

You know, one of my other favorite quotes is from Albert Schweitzer. And he talks about how you know the disease in Central Africa called sleeping sickness; there also exists a sleeping sickness of the soul. The most dangerous aspect is that one is unaware of it's coming. That is why we have to be careful. As soon as you notice the slightest sign of indifference, the moment you become aware of a loss of character or a serious longing of enthusiasm, it is best, take it as a warning. You should realize that your soul suffers if you can't live superficially. Not just your soul, but your society. Being here on this great campus, with so many thousands of people who care about learning and are committed to making a difference. Let us be willing to remold society by redefining what it means to be a human being in the 20th century, moving into a new millennium. Let us be willing to help our institutions to change, to deal with the new challenges that confront

them. Let us try to restore the importance of civil society by committing ourselves to our children, our families, our friends; and to reaching out beyond the circle of those of whom we know, to the many others on whom we are dependent in this complex society; and understanding a little more about what their lives are like and doing what we can to help ease their burdens.

Our greatest opportunities lie ahead, because so many of the struggles of the Depression and the World War and the other challenges posed by the Cold War and communism are behind us. The new ones are equally threatening. But we should have learned a lot in the last few years that will prepare us to play our part in remolding a society that we are proud to be a part of.

Thank you all very much. (Applause.)

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Divider Title: Easter Egg Roll 4-12-93

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release April 12, 1993

REMARKS BY THE PRESIDENT AND FIRST LADY AT EASTER EGG ROLL

The South Lawn

10:48 A.M. EDT

THE PRESIDENT: Good morning everybody. I want to welcome all of you here to the White House for the Easter Egg Roll and the Easter Egg Hunt. I want to say a special word of thanks to the sponsors who made this possible and say how wonderful it is for all of us here to see the children, especially for me and for Hillary.

And I want now to introduce the First Lady, who is the hostess for this event, to say a few more words about it. But let me again say how very, very grateful we are to see all of you here. This is a children's day for America at the White House, and I'm glad you're here to make it so special. Please welcome the First Lady. (Applause.)

MRS. CLINTON: Well, I'm so glad to see all of you here. And this year we've done a few things a little differently to try to make it even better for all of you.

You know, the very first Easter Egg Roll took place in 1809. Now, how many of you were here for that one? (Laughter.) Good. That was Dolly Madison who started it in 1809, and it used to be at the Capitol. And then it was moved here to the White House.

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Divider Title: Montana 4-17-93

THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript April 17, 1993

REMARKS BY THE FIRST LADY
AT HEALTH CARE BRIEFING

Great Falls, Montana

MRS. CLINTON: Thank you very much. I am so pleased to be here. I had other opportunities to come to Montana and visit. My husband and daughter and I had a wonderful night a few years ago in your Governor's residence, with then-Governor Schwendon*. And I am just so pleased to be back. And I've told anyone who will listen, I will take just about any excuse to return. So I hope you will give me that opportunity.

I am very grateful also for the invitation that I received from Senator Baucus to come to Montana. And yesterday Senator Baucus and Senator Burns and I were, at the invitation of Congressman Williams, in Billings. And I had an opportunity there to meet with citizens of Montana to talk about health care and came away impressed at the commitment and thoughtfulness that people are bringing to this very difficult issue.

And I'm particularly looking forward to hearing from those who will be making formal presentations and those who will be asking questions here this morning, because what I have found in my travels around the country is exactly what you have already heard from both of your senators and your congressmen, from your governor and your state senator and the chairman of Health Montana -- there is a great, deep yearning on the part of Americans to come together to reach a consensus to try to solve this particular set of problems that affects every individual, every household, every business, and every level of government. The whole dilemma that we are confronted with now with respect to health care is one that affects every single American.

I did not know until Congressman Williams told us this morning that people in Montana actually pay more for health insurance than people in any other country anywhere in the world. That is a fact that I wrote down and I will take with me. It is emblematic of the extraordinary problem that we are facing. The dimensions of that problem are one you in this state (gap in tape)

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(gap in tape) -- figures approximately $940 billion. That is all of us -- individuals, households, businesses, all levels of government. That $940 billion is a lousy investment, because we don't even cover every American. When we compare ourselves with other countries that have tackled these problems ahead of us, they not only cover all of their citizens, but they do it at less of a cost. What we want is to come up with an American solution that leaves room for a Montana solution so that all Americans will feel they are part of solving this health care crisis. (Applause.)

We also want to being to re-instill individual responsibility into the system. We want people to be more responsible for themselves, for their families, for their own health care. (Applause.)

The President is looking at a system that will be a national framework with certain national guarantees that all Americans will be able to rely on, but with the kind of state flexibility that states like Montana need to have.

And I want to say a special word about rural health care. In Billings yesterday when we were listening to some of the people there talking about the difficult they face with the distances and the other problems of access here in this state, I said that we needed to coin a new phrase, that rural is something I'm familiar with in Arkansas, but we're talking hyper-rural or mega-rural here in Montana. (Laughter.) So we probably need to come up with yet another way of discussing the problems that you particularly confront.

But one thing I can guarantee you is that my husband believes very strongly in making sure that rural America is adequately cared for, that its need are taken into account. That's what he has grown up with in believing; the kind of problem that he has lived with, he's understands and he feels. And we are going to do all that we can to put in to place a system that rural America will not only be able to take advantage of, but be participants in helping to shape.

Because no matter what the proposals that the President sends to Congress are, we know we have no magic bullet. There is not an easy answer to this problem, which has grown up over decades. We will need the continuing consultation and help from citizens all over America through their local governments, through their state governments, to be able to make sure that what we see as a vision of quality, affordable health care for every American becomes a reality.

So I view this as the first of many conversations I would like to take part in on behalf of my husband and others who are

working to make sure that we achieve these goals. Because once we come with a plan we will all have a lot of hard work ahead of us to make sure that plan works.

And I'm really counting on a new spirit of cooperation and commitment in our country. I want again to feel that I'm living in the country that I took for granted and was raised in. I know that for some people, that sounds nostalgic and maybe unrealistic. But I remember very well, even though I grew up in a suburb and not a rural community, that everybody looked out for each other, that neighbors really cared about each other, doctors made house calls -- those kinds of things that seem like part of distance past. But you know, there was a connection among us then that I would like to see re-instilled in America.

Health care touches us at our most basic human experience level. There's nothing like the birth of a baby, or the death of a loved one. There's nothing like walking those long hospital corridors or going out and seeing the joy on a person's face when you tell them that everything is going to be all right.

That's how we really, at the very most basic level, understand what it means to be a human being; understand what it is about life that connects us from generation to generation; makes us reliant in a most fundamental way upon each other. We've gotten away from that. We've watched bureaucracies and paperwork and red tape and distance between people replace that human caring that needs to be at the root of any health care system. And we can't wave a magic wand and reverse time.

But we can try -- as you work here on Health Montana and as we work on trying to take this system and make it human again -- to remember what is really important in our lives and those moments when we are so dependant upon each other. That's what I hope: that in a few years we will not only have a streamlined system; will not only have a better distribution of health care professionals, and have more primary and preventative health care physicians, and nurse practitioners, and physician assistants; will not only have better access, but we'll feel better about ourselves. Not just because we're healthier, but because we're part of a community of caring again. And health care can be the start of that if we do it right.

Thank you very much. (Applause.)

END

THE WHITE HOUSE

WASHINGTON

TO: AIRIS ANAGNOS

FROM: LISA CAPUTO

RE: TEXT FOR AWARDS DINNER

DATE: APRIL 17, 1993

THE FOLLOWING STATEMENT, AS REQUESTED, IS FOR YOUR ADA ELEANOR ROOSEVELT AWARDS DINNER. PLEASE LET ME KNOW IF YOU HAVE ANY QUESTIONS.

WHAT A SPECIAL OPPORTUNITY FOR ME TO PAY TRIBUTE TO MY DEAR FRIEND LINDA BLOODWORTH-THOMASON. I CAN THINK OF NO OTHER MORE WORTHY RECIPIENT OF THE AMERICANS FOR DEMOCRATIC ACTION "ELEANOR ROOSEVELT FREEDOM OF SPEECH AWARD." LINDA WOULD HAVE MADE MRS. ROOSEVELT SO PROUD, AND I'M CERTAIN THEY WOULD HAVE BEEN FRIENDS. ELEANOR ROOSEVELT SPOKE TO THE AMERICAN PEOPLE THROUGH HER NEWSPAPER COLUMNS AND LINDA SPEAKS TO US WEEKLY THROUGH THE TELEVISION CHARACTERS SHE HAS CREATED. LINDA'S WEEKLY MESSAGES ARE DELIVERED WITH WIT AND CHARM, MAKING US LAUGH AND ALWAYS MAKING US THINK.

WE LOVE YOU LINDA

HILLARY RODHAM CLINTON

Southern California

AMERICANS FOR DEMOCRATIC ACTION

1993 ELEANOR ROOSEVELT AWARDS DINNER

April 7, 1993

Melanne Verveer
The White House
Washington DC 20515

Dear Melanne:

On April 25, the Southern California chapter of Americans for Democratic Action will be awarding Linda Bloodworth-Thomason our Freedom of Speech Award at our Eleanor Roosevelt Awards Dinner. We are already aware that the President and First Lady will not be able to attend this event, however, we would be very enthusiastic about printing a congratulatory statement from the Clintons in our commemorative dinner journal.

I am enclosing a copy of the invitation and the response sheet for tickets and ads. We will waive the usual charge for a full page ad.

I appreciate your prompt attention to this matter, as our deadline for camera-ready ads is April 19.

Thank you for your consideration.

Sincerely,

Aris Anagnos
President

8124 W. Third Street / Los Angeles, CA 90048 / (213) 651-4440 / FAX (213) 658-6306

Southern California Americans for Democratic Action

Americans for Democratic Action is the nation's oldest liberal interest group. Founded in 1947 by Eleanor Roosevelt, John Kenneth Galbraith, Walter Reuther, Joe Rauh and other progressives of the day, ADA has been a leader in every important struggle for human rights, world peace, and social and economic equity.

The Southern California chapter (SCADA) is presently the largest in the nation. It includes among its members some of California's best-known and hardest working activists. We interview and endorse candidates at all levels, send our endorsement slates to voters, lobby elected officials, develop progressive policies and conduct voter education through grassroots organizing, public forums, action alerts, and news conferences.

Over the past year, we have been more active than ever before, registering thousands of new voters and turning them out to break the Reagan-Bush stranglehold on America. Now that we have put Democrats back in office, our mission is to ensure that they live up to their campaign promises to provide universal single payer health care; rebuild our cities and our economy; protect the environment, the rights of reproductive choice, and our civil rights.

Membership in SCADA automatically includes membership in the national ADA. Everyone who supports progressive principles is welcome to join. Our members do not always agree on specific issues, but we agree on basic liberal values and we intend to keep fighting for them.

HONORARY COMMITTEE

Southern California Americans for Democratic Action

Eleanor Roosevelt Awards Dinner

BRINGING AMERICA TOGETHER

Sunday, April 25, 1993

Southern California

AMERICANS FOR DEMOCRATIC ACTION

1993 ELEANOR ROOSEVELT AWARDS DINNER

ELEANOR ROOSEVELT AWARDS DINNER 1993 PRICE LIST

APRIL 25, 1993
at the Airport Hyatt
6225 W. Century Boulevard

I/we would like to support the ADA 1993 Eleanor Roosevelt awards dinner by purchasing the following:

JOURNAL ADS:

___Full page	$1,000	___Eighth page	$175
___Half page	$ 550	___Sixteenth page	$100
___Quarter page	$ 300	___Listing	$ 25

(Please print your ad copy on the reverse of this sheet or send camera ready art work.)

TICKETS:

___Sponsor	$ 150	___Regular	$ 75
___Sponsor's Table	$1,500	___Regular Table	$ 750

_____
Name of individual or organization

_____
Address

_____
City, State Zip

_____
Phone Number

Representative Jim McDermott
has been a consistent leader in the struggle for peace and justice. From his opposition to the Gulf war and military aid to El Salvador, to his support for reproductive rights and universal health care, he can be counted on to promote the values represented by Eleanor Roosevelt. We are honored to present him with the Eleanor Roosevelt Award.

Linda Bloodworth-Thomason
is an Emmy Award winning TV producer, political activist and West Coast host for the Clintons. She is the creator, writer, and executive producer of TV's outspoken "Designing Women," "Evening Shade," and "Hearts Afire." SCADA is proud to bestow upon her our first Freedom of Speech Award.

Reverend Cecil L. "Chip" Murray
is an influential community leader and the pastor of First A.M.E. Church in Los Angeles. He was the key figure in bringing the community together during the recent civil unrest. We are pleased to honor this man of peace with our Peace Award.

cordially invite you to attend

The Eleanor Roosevelt Awards Dinner

Sunday, April, 25, 1993
at the Airport Hyatt Hotel
6225 West Century Boulevard
Los Angeles

HONORING

Member of Congress
Jim McDermott

Television Producer
Linda Bloodworth-Thomason

Member of Congress
Maxine Waters

Actor & Community Activist
Edward James Olmos

Reverend Cecil L. "Chip" Murray
First A.M.E. Church

SPECIAL MESSAGE FROM
United States Senator
Barbara Boxer

MASTER OF CEREMONIES
Bill Press
TV commentator and author

5:00 p.m.
Sponsors' Reception - Rooftop Lounge
Guests Reception - Main Ballroom
Dinner will be served at 6:00 p.m.

RSVP

Edward James Olmos
is a highly esteemed actor, and a recipient of a Tony Award, an Emmy Award, and an Oscar nomination. He has been an inspiration to the disoriented community in rebuilding after the civil disturbance. We recognize his contributions with our Community Service Award.

Representative Maxine Waters
has emerged as one of the most significant African-American figures at the national level. As a second term member of Congress, she is an irrepressible voice for peace and freedom and a strong advocate of economic conversion and civil rights. She was the national co-chair of the Clinton presidential campaign. For her courage and leadership we are delighted to present her with our Rosa Parks Award.

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Divider Title: Lincoln, Neb 4-19

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release April 19, 1993

REMARKS BY THE FIRST LADY
AT HEALTH CARE BRIEFING

Lincoln, Nebraska

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you very much. (Applause.)

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Clinton Presidential Records
Digital Records Marker

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Divider Title: Youth Services 4-20-93

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release April 20, 1993

REMARKS BY THE FIRST LADY
AT NATIONAL YOUTH SERVICES CEREMONY

The South Lawn

2:35 P.M. EDT

MRS. CLINTON: Thank you very much. (Applause.) I want to thank Eli Segal for all of the work that he is doing in leading the charge to translate into reality the belief that national service is something that young people and not-so-young people -- all of us -- want to be a part of. And I want to thank all of you who have gathered here at the White House for this celebration.

Now, this is how campaign promises -- (laughter) -- sort of take on a new life. (Laughter.) A year ago, I have to confess, I never had any doubt that my husband would be President because I believed it was the right thing and I thought that the country was ready for the kind of change that he was advocating. So when, in a moment of careless aside -- (laughter) -- I told Vanessa, this is such a great program and we believe in it so much; why don't we do it in the Rose Garden next year -- (laughter and applause) -- I assumed that she was busy, she had a lot on her mind. (Laughter.) It didn't rank way up there with recruiting more people to be part of Public Allies. And I, frankly, didn't remember it either. (Laughter.)

So when our collective memory kicked in and we all remembered that I had invited all of you to come, I was very excited. But then, as often happens with campaign promises, you get to the small print. The small print is that I think specifically, Vanessa, I said, next year we'll do this in the Rose Garden. But then there were too many of you to fit in the Rose Garden, and so we fulfilled the campaign promise, but not exactly. So you're here at the White House and we're delighted you're here. And we're excited by what your being here represents.

We've already heard three of the most eloquent testimonies to service that anyone could hear when we heard from Carl and Sarah and Maria, because each in his and her ways talked about how service is not a one-way street. Service is not doing something for somebody else and that's the end. Service is being committed and

There's a young man named Matthew whose life has been changed because of Carl, just as Matthew has changed Carl's life. (Applause.) There are 20 children in a classroom whom I wish you had brought with you whose lives are being changed on a daily basis because someone named Sarah decided that teaching and using her education to help other people was something that would not only be good for her to do, but something she would be educated because she had done.

And then there are a lot of people like Maria who now feel part of our country because they have voted and because they have convinced other people to vote and because they now see that they have a stake in helping to change what goes on around them. (Applause.)

When I talk about service, I often quote my friend, Marian Edelman, with that wonderful line from her in which she said that service is the rent we pay for living. And service is a very fundamental way we connect with one another while we live. It is the way that we find meaning in our lives, both individually and collectively, because we see what we are capable of and we watch it being reflected in the faces of others.

We see it in the houses we build. We see it in the neighborhoods we help reclaim. We see it in the lives we touch. And then we come home and look in the mirror and know that we've been reclaimed, we've been touched, we've been served. And that is why this whole concept of national service that my husband believes in so passionately is at the root of what he sees as the need to rebuild and reclaim America.

And it is founded on very simple core values. And I'd like to talk about those core values, because community, opportunity, responsibility and education are really at the core. And the more we can expand the idea that we are interconnected and interdependent, that we need one another in order to be fully whoever we were intended by God to be, the more we understand the role that service has to play in an individual's life, in a community's life, in a nation's life.

So arrayed behind me are young people who are being honored for what they have done and what they represent. But also arrayed behind me are lives that have been changed because of service.

I am very hopeful that the decade of the '80s in which individuality and selfishness and greed were viewed as virtues is over. (Applause.) And I am particularly hopeful that the promise of

the '90s will be fulfilled. Now, will it be easy? Of course, it won't. As Eli said, I've been doing service in some way or another for many, many years. And has it always been a success? No, it hasn't. Have I always felt that maybe I helped to change something? Not always. But on balance in my life it has enriched my life and it has given me an opportunity to give back what I've been blessed with.

But it is not going to be easy on a national level to translate those very personal values into widely spread concepts and programs that will take root and grow, no matter who is President, no matter what Vanessa does next year, no matter who is the esteemed Senator from Pennsylvania or Illinois. Translating that kind of value into action and then making sure that action lives beyond the actors is what is behind our commitment to national service. (Applause.) Because we believe the American social contract, the American Dream, America itself, as we love it and understand it and believe in it, is at stake.

As we move forward from this day and this occasion, where we take a few minutes out to not only say thank you, but to celebrate the accomplishments of these young people, let's use the energy and the feeling that is gathered here to fuel us for the struggles that lie ahead, which are not really over a program called national service, but over the future of a country -- over what kind of people we are and will be, what kind of opportunities our children will have, what responsibilities all of us will feel for one another.

Service goes far beyond what we can even put into words. But those of us who have done it and believe in it know that it is part of what makes life meaningful and makes it possible for us to look each other in the eye, as Carl has done in his own face, and say I can be somebody, I can do something, I can make a contribution. And that's about the best definition of an American I've ever heard. (Applause.)

Thank you all very much. (Applause.)

END 2:45 P.M. EDT

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Divider Title: Michigan 5-1-93

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release May 1, 1993

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

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

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

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

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

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

MORE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you. And Godspeed. (Applause.)

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Divider Title: Senate Labor Com 5-4-93

THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript May 4, 1993

REMARKS BY MRS. CLINTON
TO THE SENATE LABOR COMMITTEE

Capitol Hill

SENATOR: -- (inaudible) --

MRS. CLINTON: Senator, I think you've very well described what we think the advantages or some of the advantages of this kind of approach will be. It does build on the present system which for a lot of reasons -- (inaudible) -- as a better point to start then trying to -- (inaudible) -- what people have become accustomed to, move a lot of the players immediately from the system to try to impose something new and different, untried in America on our people. And I think that there is a real -- (inaudible) -- of building on the present system which is very important.

Paying into a central purchasing entity is the sort of basic concept of managed competition because in so doing you're not only maximizing bargaining power but you are also, we believe, minimizing administrative costs and waste. Because, in effect, what we have done in the last year is permit -- (inaudible) -- insurance companies to move from being insurers to being administrators, as many of them are. They administer the large plans, the self-employed companies or self-insured companies, they administer the small group and non-group insurance at a tremendous cost to the entire system. More importantly, at a particular burden to small businesses and individuals.

We believe nationalizing bargaining power and diminishing the administrative costs will save money within the entire universe of the health care system in both the public and the private sector. And there are lots of complex -- (inaudible) -- issues that we have been struggling with to be sure that the way that the concept is designed is, number one, workable; number two, understandable and produces the kinds of results we think will flow from it. I believe that we are at the point where we think that the savings that will be realized from moving toward this system will permit us to phase in the burden on small business over a reasonable period of time. We will also be saving small business money as we

phase in and -- (inaudible) -- workers compensation and -- (inaudible) -- of health care particularly workers comp -- (inaudible) -- single biggest burden on many small businesses which we hear a lot about from small businesses.

We will be making insurance affordable for the smallest of businesses which now very often are priced out of the market because of their situation. We will be solving some of the problems that you and I heard about when we were together in Hyde Park in Boston of small businesses who couldn't even any longer afford to insure the families -- (inaudible) -- because of -- (inaudible) --

So, for all of those reasons we think that this is a system that will -- (inaudible) -- to -- (inaudible) -- the least costly way if you compare tax burdens, if you compare changes in the system, if you compare administrative costs on small business which I know is a major concern of everybody around the table.

SENATOR: -- (Inaudible.) --

MRS. CLINTON: That's a very good point, Senator. We have looked at -- (inaudible) -- exclusive contract have also been anticompetitive in another sense in addition to the -- (inaudible) -- they have kept other professional in addition to physicians out of the market. I mean they destroyed the -- (inaudible) -- They have basically prevented the use of a lot of -- (inaudible) -- without being overseen by a physician so that the whole thing has been a stark example of how out of control this system is because there's no budgetary discipline on it that people have to live -- (inaudible) -- and it is, unfortunately, the case that if one is a, say, a surgeon or an internist working in a hospital you don't pay much attention to what the radiologist or pathologist charges; that just goes on the bill. You don't even know what -- (inaudible) --

In managed competition with a budget, it's going to be the business of those internists and those surgeons to make sure their getting the best possible delivery of care from qualified professionals at a fair price, which is not now the case.

So, we think that the system itself will drive a lot of those contractual arrangements out of business. We are also of the belief that removing a lot of the anticompetitive state laws that currently help -- (inaudible) -- those monopolistic positions will help a great deal and -- (inaudible) -- additional ideas from the committee or from your staff, Senator, we would -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: Let me back up, Senator, to try to explain what we are attempting to do.

We're attempting to get good figures on both the cost side and the savings side. And that has been the most difficult task that we have confronted because, as I have learned, even getting good figures -- (inaudible) -- is difficult within the federal government itself. Different agencies use different economic models -- (inaudible) -- and you know the rest. That they come up with very, very -- (inaudible) -- to what costs are.

We have been working very hard and I think will be able to show you figures that we think accurately describe what the costs will be for universal coverage, that means insuring the uninsured. It means giving drugs and long-term care to older citizens under Medicare. It means bringing up some benefits for the under-insured. It means increasing the public health facilities that we've got so we truly have access once we expand to universal care whether it is rural Kansas or inner-city -- (inaudible) --

And we believe that there will be some way of balancing that among the public and the private sector. What our best estimate is that on the cost side accomplishing all of that is somewhere in the area of $100 billion. And I don't want to be held to it and I hope nobody goes and holds a press conference about it because we want to give you the exact figures.

We are also working hard to do the savings side of it because the savings side really will kick in, in the first year. And, so, the net cost will be considerably less than $100 billion and will grow over time so that it is a $100 billion up front cost that will be quickly paid for, in a sense, by the savings that we think both the public and the private sector will realize.

I have been reluctant to say well I will tell you exactly because -- we've got Treasury, OMB, HHS and CRS -- (inaudible) -- all these people running these -- (inaudible) -- and when I tell exactly how much it is and how much real savings we think we can get and how much of that real savings we think is -- (inaudible) -- I want to be able to -- (inaudible) --

But we believe we are looking at a wash. We think there will be $100 billion up front but with savings kicking in immediately.

SENATOR: -- (inaudible) --

MRS. CLINTON: Senator, I regret very much because I want to be as honest with both Republicans and Democrats as people

who have different points of view as I can. So when somebody asks me a direct question I want to be honest and I hope this can be done in the spirit in which I offer it which is we continue to -- (inaudible) -- around the truth is. And, so, I agree with you because I do not want there to be a lot of loose speculation because I don't think that's fair to the American people. But on the other hand I don't want to look a senator in the eye who asks me a question and say I don't know, I don't have any idea. I want to be as honest as I can. But then I don't want to have to read about it in the paper the next day. That's my dilemma.

SENATOR: -- (inaudible) --

MRS. CLINTON: That's definitely true. You know, one of the things we are working toward being able to do, which I think helps answer your question, Senator, is we want when we get all of this down and we're ready to have everybody look at it, pick over it, we're going to lay all this out. And the Chairman's point is a very good one. What is the cost of doing nothing. We are going up $100 billion a year now and there's no end in sight. And we know that's a result of our inaction.

So, that laying it out on a matrix so you can make those hard decisions and you can answer those questions in town meetings is something we're going to try to -- (inaudible) --

SENATOR: -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: Senator, we believe that we can phase everyone in. And we're looking at trying to have as early a -- (inaudible) -- as possible. The administrative issues having to do with whether we deal only with children in uninsured families or children in the custody of a parent who is insured but another parent isn't. Those are just as complicated as trying to set up an administrative -- (inaudible) -- give a health card to everybody by day 30.

That is our present intention. I think that if we were -- (inaudible) -- population group I would share your belief that we have to start with children. I 'm hoping that we will be able, though, to phase in at least adequate coverage for everyone within -- (inaudible) -- assuming we get legislation within a relatively expedited period of two to three years after that.

And, you know, that's why we need to get these numbers right -- (inaudible) -- very specifically when we think different levels of care can be promised to different people in different parts

of the country and all that -- (inaudible) -- make -- (inaudible) -- decisions.

I'm certainly open to suggesting to the President that in the event that those numbers don't work out that we start with the children.

Also, in the benefit package, we are stressing primary preventive health care because we think it will save us money. And we are enumerating the kind of diagnostic tests which we think are very important to people to have and we are enumerating by age the kind of -- (inaudible) -- clinical visits that we think children should be entitled to in addition to such things as immunizations.

With regards to special needs children, we think that phasing in the Medicaid -- (inaudible) -- will be a benefit to Medicaid disabled -- (inaudible) -- short -- (inaudible) -- because managed care -- (inaudible) -- been well done, has worked effectively for the Medicaid disabled adding much less cost than we currently have in the private -- (inaudible) -- or in the non-managed Medicaid system. So, we think that we will actually be able to cover more of our special needs children when we better manage the resources we are currently using, which is one of the very important reasons to try to get Medicaid into this system -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: In other countries, Senator, in countries with more -- (inaudible) -- they have a series of -- (inaudible) -- that children are expected to make and immunizations are part of those. And there is a level of primary care that is acceptable. For many of the people in the housing projects -- (inaudible) -- they don't have a primary physician. The emergency room is their primary physician which costs all of us money when they show up there.

We need -- I had -- (inaudible) -- meeting with representatives from the Catholic Hospitals Association the other day who were explaining to me one of their new models, which is to take people from emergency rooms to clinics which they run even if they show up at the emergency room. You've got to get them used to going somewhere where they begin to think primary preventive health care. -- (inaudible) -- immunizations then you've linked to ongoing care for the whole family instead of this -- (inaudible) -- event that may or may not happen to them.

And I think that's a very important part of this change in psychology.

SENATOR: -- (inaudible) --

MRS. CLINTON: Senator, this may be a -- (inaudible) -- you've got a lot of expertise -- (inaudible) -- but I think we have to look at ways of offering treatment with physicians in certain populations because we have a large number of mentally ill homeless. We now have the TB epidemic. All too often, the people, once they are treated, do not continue their treatment get very sick again and show back up at the emergency room where they then cost us a million dollars or whatever.

We have got to think through how we can have treatment with condition so that when people refuse to follow what our basic public health guidelines, we have some recourse. And I don't -- you know I think we have to think very dramatically about this. I mean we cannot let a TB epidemic spread in our big cities and we are on the brink of that in a number of cities. I mean I don't know if we have to look at sanitariums -- I'm not suggesting exactly what we do but we're going to have to take very strong public health medicine or we will never get ahead of the curve on the most difficult population that we're currently paying for and not really being able adequately to handle.

SENATOR: -- (inaudible) --

MRS. CLINTON: Senator, that is not something we have looked at directly. I know that Secretary Espy has been looking very closely at the feeding programs. What we have looked at is what role nutritional and dietitianal kinds of -- (inaudible) -- and systems -- (inaudible) -- with our home-bound elderly and others who are in need of -- (inaudible) -- Let me follow up on that -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: And you're right, the payoff is tremendous. One thing we have looked at -- (inaudible) -- linking -- (inaudible) -- with some of the guidelines or requirements for what we want people to do when they are getting public assistance. -- (inaudible) -- -- (inaudible) -- but I haven't looked at -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: Senator, we are looking at the long-term care with particular emphasis on home health care, health -- (inaudible) -- care, intermediary care. And we believe that we need to pursue those as alternatives -- (inaudible) -- not because, as you point out, at least 30 percent do not need to go to nursing homes. But we need an infrastructure of home-based intermediary care because or our exploding population. I mean it's 30 percent now the absolute

numbers that that will represent in 10 or 15 years is growing by leaps and bounds.

So, that here again is one of those problems if we don't get ahead of it we are going to be paying dearly for it. And a number of states have done some very creative work in this. They've gotten some waivers. They've put some state money in; took long-term care. And they're beginning to have the very results you're talking about. They are keeping people out of nursing homes which, of course, saves them money which permits them then to cover -- (inaudible) -- people.

So, we are going to recommend that we take a good beginning on long-term care. We're not going to solve the long-term care problem by any means but that we begin to invest in some of the programs that have been proven at state levels in a number of states. That we free up some of the regulations that currently exist in the Medicaid system so that states can use that money more effectively. And, I believe we'll begin then to build an infrastructure for long-term care that will enable us to make additional decisions -- (inaudible) --

SENATOR: -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: -- (inaudible) -- They run an adult day care center and most of their patients are family members kept at home whose children or other caring relatives go out to work during the day. So, they bring their older relatives and they stay at the hospital, which when you think about it is a great location because you have on-site help should anything happen. You have a lot of trained personnel. But it costs $35 a day and for a lot of working families that is too much. So, there needs to be some kind of sliding scale with some reimbursable opportunity there. But look at what we do. We say to these families, well, you want to keep your adult parent home, it's going to cost $35 a day, we're not going to give you any help; go ahead and put them in a nursing home -- (inaudible) -- carry the whole -- (inaudible) --

SENATOR: -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: -- (inaudible) -- careful with what I say so I don't raise any speculation unnecessarily. We're going to have to see -- (inaudible) -- look at what we give you -- (inaudible) --

We are looking very hard at medical malpractice and are trying to construct a system that will do what medical malpractice was originally intended to do, which is to serve as a deterrent against negligent medical practice. I mean, that's the whole point behind it. And we are looking at a variety of approaches. We're engaged in intensive conversations with people from all over the country because this has been an area that's been left to the states. And those states have a variety of approaches to it. And we're trying to make sure that we have the best information about what really does work in what state -- (inaudible) --

But we do intend to address medical malpractice. That will be a -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: We have looked at that issue very closely for exactly the reasons that you just outlined. And even in urban areas, Senator, -- (inaudible) -- We have a 100 percent differential in medical costs if you compare, for example, Los Angeles with Rochester, New York or Miami with Rochester. And what we are trying to figure out how to do is that given where everybody is now and the fact that they are charging more in Miami then they're charging in other places and the like, how do we begin to try to get an accurate estimate of what medical costs truly are to try to move towards a more level playing field because those differences in costs, as best as we can tell, are there no matter whether you hold constant population characteristics, indices of wellness and sickness.

You go and you try to figure out everything that could possibly explain why they would charge so much more in one town than they would in others. To move too quickly toward some kind of level budget that tries to treat everybody the same, we don't think is practical. So, therefore, we do have to phase it in. And we have to have incentives for changing practice patterns because that's what's really at the root of a lot of difference in price.

That in addition to some of the disincentives that the federal government has imposed on rural areas. The difference in Medicare, for example, those are all the things we have to look at closely. So, we are planning on recognizing that disparity is there and our likelihood -- (inaudible) -- that we can move toward will be in the legislation so that they really are -- (inaudible) --

Now, with respect though to rural care we have to do some other things, some key things for people in rural areas. We have to build up their -- (inaudible) -- We're looking very hard at ways of doing that. And there are some very good ways of -- (inaudible) -- different personnel -- (inaudible) -- so that you

don't need to have a physician on duty -- (inaudible) -- There are lots of things we can do that can help expedite better delivery of care in rural areas of your state while we move toward a more level budgeting field.

SENATOR: -- (inaudible) --

MRS. CLINTON: And for exactly the reason that -- (inaudible) -- point out. Because if we did a better job both examining and then curing the defects of our children, we not only help our children we save us all money. And, you know, we did the same thing in Arkansas, Senator, where we have the health department and volunteer doctors and nurses and dentists go out and examine these children. And I remember in one county we examined one day 154 children, and I think 128 of them had abscessed teeth. And they'd never been to a dentist before. And I remember thinking to myself how on Earth can you expect them to learn anything in school when they've got these abscessed teeth.

So, it's not just health issues. There are a lot of other issues that have to do with education and the like. So, we're very -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: We are going to emphasize primary preventive health care. I wish we could pass a law that would make people have a better diet and exercise but I don't know that we could get that done. But we're sure going to try to get them to go to their physicians and to go to have exams where they can be told.

SENATORS: -- (inaudible) --

MRS. CLINTON: Yes, sir. Yes, sir.

Well, of course, we could also have you travel around and be a living example of what nutrition and exercise will do. If you'd be willing to do that, I could put you on the road. (Laughter.) -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: -- (inaudible) -- if we could wave a magic wand and lower medical costs -- (inaudible) -- we -- (inaudible) -- We are spending so much more over and above the CBI definition of inflation that that's what we're trying to achieve. We're trying to bring down the costs so that they are more comparable to what the national growth would be in most other -- (inaudible) --

What we've got to help the American people understand is that why should the health care system be immune from the market, from common sense expenditures that family, businesses and government should be making if they really cared about costs. And so we really are talking about different pots of money. It's going to go up about $110 billion if we just sit here, going up every minute that we sit here.

We think we can begin to stabilize it and then -- (inaudible) -- did this 20 years ago we were spending eight percent of GDP instead of where we now are spending 14 percent and rising. We've got to start -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: Yes. My assessment is that we can stabilize it and we can -- and that's a huge savings -- (inaudible) -- that saves the money the Chairman was talking about. We don't then continue to 10, 12, 14 and 15 percent increases. We stabilize it and then begin to drive it down.

SENATOR: -- (inaudible) --

MRS. CLINTON: Right.

SENATOR: -- (inaudible) --

MRS. CLINTON: Right, that's what our goal is. And the other thing that keeps reminding -- (inaudible) -- is that while we sit it here it builds up $110 billion a year we haven't covered one more person and 100,000 Americans loose their insurance every month. So, it's not as though we are in even a stable situation -- (inaudible) -- frequent costs.

SENATOR: -- (inaudible) --

MRS. CLINTON: Well, -- (inaudible) -- Let's see what it would mean in terms of doctor's income. We say a doctor who makes $200,000 a year. Instead of next year making $212,000, $213,000 they might make $205,000 or $206,000. That's not a big tax cut if you look at it from the American people's point of view -- (inaudible) -- margin between the inflation increase and what we consider medical hyperinflation saves this country a bunch of money. It saves a lot of companies a bunch of money in the short-term -- (inaudible) -- in acute care and the first thing we have to do is stabilize our vital signs, stop this absolute hemorrhaging of money that's going out. -- (inaudible) -- and then let the competitive system work so that we can begin to give it a better balance and deal with the problems -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: Well, it's a voluntary -- if the drug companies and AMA and others that we will hold our prices to inflation-plus whatever it would be -- you've got the federal government, you've got the state government, you've got insurance companies, you've got lots of other uncompensated care -- (inaudible) -- we know that.

So, that what we will actually get will probably be a little worse than that. Even -- (inaudible) -- if we don't then follow with a system that works we will see the same thing that always happens when you take off that kind of -- (inaudible) -- people make up for lost time. We've got to construct a system in which that making up for lost time can't occur because you've got all these checks and balances -- (inaudible) --

The other thing, too, Senator, is that we -- (inaudible) -- administrative -- (inaudible) -- to do what they do in Germany, for example. In the German government -- (inaudible) -- when their health care percentage of GDP went from 8.1 to 8.3. So, they had mechanisms in place to immediately -- (inaudible) -- and negotiate with plans and negotiate -- (inaudible) -- position so that they could begin to try to cut it back because they didn't want it to get out of control.

You know, we don't have anything like that in place right now. So, I think that's the reason why people look at this closely and come back with some kind of short-term cost controls preferably of a voluntary nature or stand-by authority, if that's what we can work out with the -- (inaudible) -- of the economy. But even there -- (inaudible) -- not everybody will participate -- (inaudible) --

SENATOR: -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: -- (inaudible) -- hospitals from working together. -- (inaudible) -- everything we can to encourage collaboration and cooperation among different sectors of the medical community. -- (inaudible) -- opposite end of the problem. Senator Metzenbaum talked about -- (inaudible) -- often times monopolistic practices that the inside of hospitals pretty much determine who is going to be able to be radiologists, for example, and how much they'll be paid. So, we have to deal with this on both ends -- (inaudible) -- We have to open up the competitive process but we have

to do it in a way it doesn't unfairly penalize people who are cooperating together.

And that's one of the reasons we need -- (inaudible) --I would argue because within a budget those decisions will realistically be made. In the average health plans we're looking at there will be a number of hospitals cooperating. They will have to take on -- maybe they'll take on a different population basis but just as likely they can take on different specialties and they can take on different kinds of high-tech equipment. And they have to be free to do that. So, we're going to change these laws.

SENATOR: -- (inaudible) --

MRS. CLINTON: Yes, removing some of the -- (inaudible) -- kind of prohibitions that stand in the way --

SENATOR: -- (inaudible) --

MRS. CLINTON: Yes. And preempting some of the -- there is a state antitrust law. There are -- (inaudible) -- and we're having -- (inaudible) -- antitrust division we're getting -- (inaudible) -- coming up with some specific proposals.

SENATOR: -- (inaudible) --

MRS. CLINTON: Let me check on that, Senator, and I'll get back to you on that. I don't know. Do you have a suggestion on that?

SENATOR: -- (inaudible) --

MRS. CLINTON: In fact, I think that -- (inaudible) -- whole antitrust section of the legislation will be is a series of -- (inaudible) -- for certain kinds of activities that -- (inaudible) -- would encourage better health planning and better cooperation among health -- (inaudible) --

Let me get the latest -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: I don't know, sir. I'll find out.

SENATOR: -- (inaudible) --

MRS. CLINTON: Yes, we are considering that. We think that that has a lot of -- (inaudible) -- removed the burden, the -- (inaudible) -- or the onus -- (inaudible) -- the individual position

for negligent acts not for both negligence or malicious -- (inaudible) -- those are beyond the pale. But for the kind of -- (inaudible) -- that happens it also provides, we think, a deterrent effect that would enable the health plan to be -- (inaudible) -- supportive of peer review and peer discipline.

SENATOR: -- (inaudible) --

MRS. CLINTON: That's right. That's exactly right. And I think that we're talking a lot about this with physicians groups to see what their feeling about it is.

SENATOR: -- (inaudible) --

MRS. CLINTON: Not if you also mandate arbitration. You have to go through a mandatory -- (inaudible) -- resolution that you have to go through before you can even think of getting into -- (inaudible) -- I think it will do two things. I think it will eliminate many, many cases from the courts and I think it will also -- (inaudible) -- it will enable these decisions to be made at the lower level cases that are now not -- (inaudible) -- by anybody. You know, there are a lot of people who have got minor problems that they don't get any recourse for so this will be a way of helping them because they will be in the system.

SENATOR: -- (inaudible) --

MRS. CLINTON: That's exactly right. I mean what we want to do is to encourage physicians and hospitals to do a better job policing themselves. And -- (inaudible) -- our ultimate goal is to minimize malpractice. We don't want to have to remedy it, we want to try to prevent it as much as possible. And that's why we're trying to focus on what we can do to change the culture in which medicine is practiced so that we get more encouragement on people being willing to -- (inaudible) -- take on their colleagues and being willing to band together and say we don't want to practice with this person. Right now there's very little incentive -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: We think, Senator, there are two ways that are built into the system. One is that-- (inaudible) -- in such a way that rural areas will be -- (inaudible) -- as urban areas. It may be that the physician -- (inaudible) -- becomes an employee of an HMO if he stays in -- (inaudible) -- because that HMO is responsible for the population in -- (inaudible) -- Right now we're losing a lot of physicians out of rural areas because they're not linked to an integrated delivery network. They're out there on their own. They

pick up the phone and they refer to a specialist they went to medical school with but they're not part of a continuum of care.

And I think that we actually believe that much of what they -- (inaudible) -- about this, Mayo is setting up satellite clinics and contracting with rural physicians and they're all part of the Mayo network. But they are still in their same office on the same Main Street in Strawberry. I think that's going to be a boon for rural areas.

-- (inaudible) -- delivering health care, I think, is just -- (inaudible) -- There is now very good work being done in extremely rural parts of Texas, for example. An interactive video, -- (inaudible) -- in your -- (inaudible) -- network of care will enable them to be multiplied many times over.

So, I am very sensitive to rural health care issues because of my own experience in Arkansas and travels that I've done with you and others. And I honestly believe this is going to be a big net plus for rural areas. I am actually more concerned about the under-served urban areas than I am about the under-served rural areas. I am more concerned about how we're going to deal with the TB epidemic in a reasonable way which -- (inaudible) -- health -- (inaudible) -- I think rural health care is actually going to benefit from this.

SENATOR: -- (inaudible) --

MRS. CLINTON: Yes, we -- well, I hope that we're making progress. I consider this whole research -- (inaudible) -- but I know, for example, that you and Senator -- (inaudible) -- hearing about -- we were laughing at how relatively minor adjustments in terms of the federal budget -- we could literally find a cure for a lot of neurological diseases by the turn of the century, which would, of course, save us billions of dollars -- (inaudible) -- to do that. So I think that language is one -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: -- (inaudible) --

SENATOR: -- (inaudible) --

MRS. CLINTON: Oh, no, no. -- (inaudible) --

SENATOR: -- (inaudible) -- (laughter) -- portion of these individual plans a person has -- (inaudible) -- and how that trust fund -- appropriately -- (inaudible) -- airline tickets -- That would give us -- (inaudible) --

SENATOR: -- (inaudible) -- apprehension -- in spite of the fact that they are -- (inaudible) -- bothers me here just a little bit -- (inaudible) -- all of this talk about how we're going to do this and do that -- don't lose sight of the fact that our there today -- (inaudible) -- we're at Miami or maybe in Philadelphia, there are places that -- (inaudible) -- and there's a reason -- government and politicians -- the issue of geographic disparity. The importance of you mentioned the word -- (inaudible) -- very, very important. But thinking beyond dollar targets -- (inaudible) -- so that we can demonstrate -- (inaudible) -- they'd be a lot better off or to -- (inaudible) -- performance target is going to be -- hopefully that will get community such and such that are high priced today and --(inaudible) -- The bottom -- (inaudible) -- because you and I could -- everybody here can say -- (inaudible) -- high quality care for a -- (inaudible) -- start with the whole -- (inaudible) --

MRS. CLINTON: What we -- (inaudible) is a lot of different models and -- (inaudible) -- be sure that you don't -- (inaudible) -- maximum amount of competition and responsibility so that they can help create or -- (inaudible) -- not so that they can -- (inaudible) -- what we're looking towards is an atmosphere at the state level that frankly does permit some experimentation so that we can watch each other and see how they -- (inaudible) -- because the tragedy of the Mayo Clinic is that there aren't very many imitators. Now if it works so darn good, got high quality at low cost why don't we have 10,000 of them? The reason is because we've never had a system -- (inaudible) -- Mayo brothers who did it against tremendous opposition when they first started and called socialism and you know all of that. And there's no incentive for people to go in that direction. We're hoping that in this new endeavor there will be adequate to create that kind of high quality for care -- (inaudible) -- and that really is the idea between a common health -- (inaudible) -- is basically invite people to serve the market that they have so that it might be in some states you have three or four different population areas and in another state only one or two given the size of the population.

You would have to be willing to cover this million people or this geographic areas. It could mean you take the high paying as well as the low paying or the racially and ethnically diverse combination and you would have to be willing to abide by certain quality standards, offer the benefits package -- but that's how you piece all that together, there would be a certain amount of discretion. -- (inaudible) -- they had a couple of different ideas. They were going, for example, to the minority dental community in New Orleans and asking them if they would essentially become contracting physicians so that they could cover that population that they -- (inaudible) --

In other parts of Southern Louisiana they were setting up satellite clinics that they themselves would run but they would administer all of that and everybody would be a part of the integrated delivery network. -- (inaudible) -- health plans -- (inaudible) -- we do want to require that there be a fee for service options available in every specific area now. But that will require some differences in the way that they deliver medicine in order for them to be cost effective. So the accountable health plans would have to be some broad federal requirements, so we want some variety. Now, for example, -- (inaudible) -- I wouldn't be surprised if the purchasing coop in San Francisco gave some -- (inaudible) -- acupuncture with probably a -- (inaudible) -- facility as a participant when they need to -- (inaudible) -- Well, acupuncture won't be an option in Arkansas, but it would be for the Chinese-American community of San Francisco. So those are the kinds of varieties we want to encourage -- (inaudible) -- follow the -- (inaudible) -- on setting those -- (inaudible) -- but there will be a number of plans families -- (inaudible) -- and what the typical responsibility -- is to take the Kassebaum plan which would be a plan, for example, that you as an existing HMO would come an say, here are the services we are offering in this basic medical package and we can guarantee we will serve this population that you require us to serve because we've got contracts or clinics or whatever and here's what we're offering. Now, the Jeffords plan might come in and what we are is not an HMO, we are a network of fee-for-service physicians and we think a lot of people in this area would prefer to have a total fee-for-services instead of an HMO system particularly the elderly people, but we know we can manage it because we've got these kinds of guidelines. So there will be a number of plans that can be certified as being eligible. Then when it becomes the enrollment time -- I mean, I have as an employee made my contribution, my employer has made the contribution. I then enroll in a plan.

You know, Senator Durenbeger was saying that federal employee benefits plan gives you this wide variety of plans to go with. There are problems with it but it's analogous to what I will do now as citizens. I don't have to -- if my employer issues a notice that says, my brother-in-law, Joe, is a doctor in this health plan, I like to be free to go there and I don't have to -- (inaudible) -- I can go into any plan I chose. And then the next year, if I'm not happy, because maybe the plan I chose hasn't got it's act together and so when I go to the physician I wait three hours whereas my sister down the block can go on a different plan, she gets in, she gets better care, feels more satisfied, I'll join this one. And you know that's the way to --

SENATOR: -- (inaudible) -- I just wanted to add -- myself, Pete Domenici and others. I think the key here -- (inaudible) -- I think the key to Tom's question about what's going to happen out in the rural areas -- (inaudible) -- yes, I mean, -- (inaudible) -- run into a lot of doctors who feel like they've lost their power to make -- (inaudible) --too greedy to try and make a lot of money. You could run into a lot of people who feel like they've been excluded -- (inaudible) -- health care physicians -- (inaudible) -- the key to me is what -- (inaudible) -- in terms of whether or not the network -- whether or not somehow this would be -- the relationship to these -- (inaudible) -- whether or not networks -- (inaudible) -- independent of -- (inaudible) -- gobbled up by large insurance agencies. -- (inaudible) -- huge chain -- (inaudible) -- you don't really have the sort of choice that you say you have. -- (inaudible) -- some large chain. -- (inaudible) --

MRS. CLINTON: I agree with that and I have spent a lot of time talking to a lot of people who know a lot more about all of this than I do and most recently had a long conversation with several people from the -- (inaudible) -- Hospital Association who -- (inaudible) -- president -- two years -- seemed to pretty much include an integrated delivery -- (inaudible) -- and from their perspective, as well as mine, we believe that will create more opportunity. Now, will there be -- we will have to guard against abuses, will we have to guard against shoddy people not delivering what they're supposed to deliver and how many -- (inaudible) -- yes, we probably will. And we have to do this, we have to create competition in systems where there was none, where we have to make sure -- (inaudible) -- but if we -- (inaudible) -- we are going to create employment in health care community, number one; we're going to be taking care of people but we're going to be asking these people to pay for it for a change instead of uncompensated -- (inaudible) -- and I think we're going to inspire a variation among big networks that they will actually learn something from. And that is what -- that is my hope.

Now, some of the large insurance companies are very supportive of this plan because they believe that they know how to manage care and then they will have a big piece of the market -- you know, some of the criticisms that you and others have rightly voiced about the what the net result will be. But -- (inaudible) -- that country in which there are so many different approaches to the -- (inaudible) -- that I really believe if we let individuals states have enough flexibility to encourage different kinds of a -- (inaudible) -- health plan, we're going to see some real variety and we're going to find out what works. And I don't know any other way to really move towards a good universal system that delivers high quality care in a short-term -- (inaudible) -- to come up with different approaches. So that's the basic, you know, answer to your

concern that it's going to be dominated. Right now, we've got Medicaid and Medicare run by the government and we know there are problems there but what we're trying to do is to set up a system where we avoid that on the front end and where we learn from it.

SENATOR: -- (inaudible) --

SENATOR: -- (inaudible) -- unless some of you want to respond, I think we're about out of time.

SENATOR: -- (inaudible) --

MRS. CLINTON: -- (inaudible) --

SENATOR: -- (inaudible) -- and all that.

MRS. CLINTON: I agree with you -- (inaudible) -- We're still looking at this -- this is my personal feeling that I really believe that we need to move toward -- (inaudible) -- as soon as possible means -- (inaudible) -- it would be a tragedy if Medicare stayed outside of this system and this system was working and really holding -- (inaudible) -- health care but in Medicare because we hadn't gotten a handle on it was still growing at this huge hyper-inflation rate. So, I think we need to move -- and I think we've got a very good argument in offering a -- (inaudible) -- and long-term care to seniors -- (inaudible) -- that their interests are well taken care of.

SENATOR: -- (inaudible) --

SENATOR: I think we're all enormously grateful, I think all of us want to try and find ways to -- (inaudible) -- and help particularly the time barrier -- (inaudible) -- (break in the tape) -- meet with Mrs. Clinton on the health care issue. All Americans understand that health care reform is necessary. The administration understands it, the Congress of the United States understands it. And we know that there are billions of men and women and children across this country that are not covered and they need the peace of mind of being covered. And there are millions of Americans who are working and they are just a pink slip away of not having any health insurance and they need the peace of mind of being covered. The administration's program is going to give the insurance a code that do have health care -- (inaudible) -- better health care program.

And -- (inaudible) -- last -- of the administration's program is that at last there will be an important effort to cut back on the increase and doctors bills and hospitals bills and -- (inaudible) -- I think all of us on the committee understand -- this is the Republican and Democrat alike -- that there is a necessity to cover all Americans and that it is -- (inaudible) -- necessity that

we have a containment of the costs. It's clearly differences on how best to get there but I think speaking for all of us we feel that Mrs. Clinton is certainly been available to listen at recommendations and suggestions and respond to many of the ideas brought by the members of the committee, Republican and Democrat alike, which is really reflective of what the concerns -- (inaudible) -- America have been in contact with all of us over the period we've -- (inaudible) -- this issue. The time I've been in the United States Senate there has never been -- (inaudible) -- a major responsible figure on a public policy issue that's been as available or as acceptable as Mrs. Clinton has been to all Americans, as well as to the Senate and the Congress and that is something that all of us are very grateful for of her.

Today is just a continuing process for the better understanding about the directions the administration programs and we are enormously grateful to Mrs. Clinton for the two hours that she took with us answering every type of question that all of us had -- (inaudible) -- direction this administration needs to go. -- (inaudible) --

SENATOR: -- (inaudible) -- Senator Kennedy said. We have worked for some time on -- (inaudible) -- I too -- (inaudible) -- Mrs. Clinton's dedication, endurance and perseverance. She has extraordinary patience in listening to all of us give our thoughts on what direction they should go. And -- (inaudible) -- all of us -- (inaudible) -- President Clinton has said one of our top priorities -- (inaudible) --

MRS. CLINTON: I want to thank Senator Kennedy, Senator Kassebaum and the other Democratic and Republican members of the committee who met with me who very eloquently expressed their points of view and their wide range of interests. This particular committee has a number of interests that we talked about in depth relating to the research to something that has great health care benefits if pursued, the concerns that were expressed also about professionals who deliver health care and how we can get a better mix so that we are not relying just on specialist but have a much broader range of primary preventative health care professionals, quality issues about how to be sure that every American no matter where that American lives in the urban areas or rural areas can be secure in knowing that he or she will have access to quality health care.

I was -- as always I'm very impressed by the expertise, the experience and the insight that various members offer to me on this complex issue and I want to thank them.

SENATOR: Thank you.

Q Mrs. Clinton, -- (inaudible) --

Q Step up to the mic --

Q -- (inaudible) --

SENATOR KENNEDY: -- I think that Mrs. Clinton has stated repeatedly they're doing cost assessments as well as savings that will be achieved by this program and has spelled out parameters of those -- and those are -- (inaudible) -- parameters to our committee. And I would assume -- the bottom line figures are going to be available and they'll be discussed by the members of Congress. We talked as well and cut the cost of doing nothing -- and that would be about $150 billion a year if no steps are taken. The best estimates now are about $700 billion is the next four and a half years and we take no steps at all and that doesn't buy us one more band-aid and it doesn't cover the children who are not covered. It doesn't cover workers who are not covered and the 65 million Americans who are under-covered. So I think it will be important that we finally are able to assess the total savings and the costs.

Q Did you talk about -- (inaudible) --

Q What kinds of cost control are you talking about?

MRS. CLINTON: We talked a lot about how we could try to control the exploding growth in costs in the health care system. Various senators expressed the ideas that they had. A number of the senators with whom I just met have introduced their own health care legislation in the past and they're very knowledgeable about the different methods available to control costs. But I think all of us are agreed that that's one of the primary reasons we're engaged in this is to look for the most successful way that we can to try to control the growth and then bring it down to the affordable.

Q Will they be mandatory or voluntary?

MRS. CLINTON: We didn't talk about that.

THE PRESS: Thank you.

Q -- (inaudible) --

MRS. CLINTON: There haven't been any decisions made --

Q Thank you all.

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THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript May 6, 1993

REMARKS OF THE FIRST LADY
TO SENATE SELECT COMMITTEE ON AGING

Capitol Hill

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

Q Open heart hearing --

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

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

Q -- (laughter) --

Q We believe in amnesty -- conversion --

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

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

MORE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SENATOR: (Inaudible.)

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

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

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

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

Would you give us a little of your --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SENATOR:That's no excuse.

MRS. CLINTON: Thank you, Senator.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MRS. CLINTON: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. CHAIRMAN: One more question.

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

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

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

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

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

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THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript May 7, 1993

REMARKS OF THE FIRST LADY
TO THE BUSINESS COUNCIL

Williamsburg, Virginia

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

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

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

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

I'd like to give you just one idea of how difficult this has been and why it is so imperative that we follow through on what we have started. When I began this process, I learned very quickly

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you all very much. (Applause.)

I would love to be able to answer your questions or to describe further what we are thinking about, if any of you want to pose a question. And I would appreciate it if you identify yourselves, if that would be all right.

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

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

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

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

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

Let me just give you a few examples. We have had for the last year a system through Medicare, which has subsidized the graduate medical education of specialists. It is not, therefore, surprising that the specialists are now outnumbering by a substantial majority primary and preventive health care physicians. We need to change those incentives so that we can provide more of the kind of personnel that are required not just in rural areas but across the nation.

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

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

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

Q -- (inaudible) --

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

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

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

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

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

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

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

Why is that happening? Is every hospital administrator in America a crook? No, of course, not. The reason it is happening is because we have so much uncompensated and undercompensated care being delivered in hospitals that you and I and our insurance companies are therefore billed, and the Medicare system is therefore billed, to be able to pick up the slack. That difference between the

$100 and the $1,100 for the foam mattress pays for somebody showing up who is uninsured at the emergency room and being treated for something they should have been treated for all along at much less cost to the primary and preventive health care system.

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

Q -- (inaudible) --

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

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

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

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

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

result is 40 percent of the rehabilitation beds in this country have been closed in the last -- months. How does your benefit package deal with these important diseases?

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

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

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

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

Twenty-five or more years ago, actually in the late 1960s; I think it was a combination of a Johnson-Nixon policy -- we made the decision to deinstitutionalize the severely mentally ill. And we were going to have home-based and community-based care for

them. We did the first part of this, and we never did the second. The results are lying on the streets and in the parks of every one of our cities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

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THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript May 11, 1993

REMARKS BY THE FIRST LADY
DURING HEALTH CARE FORUM

Morgantown, West Virginia

6:30 P.M. EDT

MRS. CLINTON: Clap when you think it'll make the Senator and me feel better. How's that? (Laughter and applause.) We're trying to promote health care here. (Applause.)

SENATOR ROCKEFELLER: Now, when you read your tickets when you came in, at the very bottom lefthand side, it said that, by virtue of being here, you have to be flat-out for passing health care reform this year. Anybody who is for 1994, out. (Laughter.) Only 1993.

MRS. CLINTON: That is what he has been saying to me ever since the election, I think, before I ever even got this assignment. Your senator has been preaching and teaching and reaching out to everybody who will listen about how important this is. I think he deserves a big hand, because he's trying -- (applause.)

SENATOR ROCKEFELLER: Mrs. Clinton, I notice we have the Speaker of our House of Delegates and the President of our State Senate right here in the second row.

MRS. CLINTON: While we're still waiting and they're checking our mikes, there's somebody else here who I think deserves a hand, because I'm a great fan of hers and have known here for a long time when Jay was your Governor, and that's Sharon Rockefeller. (Applause.)

SENATOR ROCKEFELLER: Just a comment to all the staff here that have put in hours and have really made an effort, my thanks for all you've done. Thank you very much. (Applause.) And if you don't thank them before the show starts, then you may not see yourself on TV, or hear yourself. (Laughter.)

MODERATOR: The following special program is sponsored in part by West Virginia Bankers Association, West Virginia Hospital Association, Warner-Lambert Company, United Mine Workers of America, and West Virginia University.

From the Health Sciences Campus of West Virginia University in Morgantown, West Virginia Speaks: Our Hopes for Health Care Reform. A special program with First Lady Hillary Rodham Clinton and United States Senator Jay Rockefeller.

MR. D'ALESSANDRI: Good evening. I'm Robert D'Alessandri, Vice President for Health Sciences at West Virginia University. Welcome to our health care forum: West Virginia Speaks: Our Hopes for Health Care Reform.

Tonight we will have an opportunity to talk with the leading national policy makers about what we in West Virginia hope health care reform will accomplish.

I want to thank Hillary Rodham Clinton, Chair of the President's Task Force on Health Care Reform, for coming to West Virginia to listen to our thoughts on this important subject. All of America has been impressed with Mrs. Clinton's energy, sense of mission and willingness to listen to all sides on this important subject. I hope she will find more support here tonight for the changes that need to be made.

We in West Virginia are very fortunate to be represented in the Senate by Senator Jay Rockefeller. Senator Rockefeller arranged for tonight's forum. Even before health reform was at the top of the national agenda, Senator Rockefeller already was a major force for reform. Through is work leading the Pepper Commission and the National Commission for Children, he has tirelessly raised the issues of the need for affordable health care for all. He is absolutely committed to improving the health of West Virginians and the health of all Americans.

The plan that the Task Force is preparing is expected to be presented to Congress soon. This is an opportune moment to relay our desires on this important issue to the White House and Congress. Tonight we are going to hear from people in all areas of our state about the most pressing issues with health care reform. We will hear about the need for universal access to health care for some of the 350,000 West Virginians with no health care coverage. We will hear about the problems health care providers face in trying to care for the uninsured. We'll hear the concerns small businesses have about health care reform and how the costs of reform will affect them. And we will hear the special problems that rural areas face in attracting health care providers to care for a fragile population.

We will be going live to Raynell, New Martinsville, Martinsburg and Cabin Creek to hear from West Virginians who will talk about their health care. And we will hear from labor and business leaders here in Morgantown about the issues involved in health care reform.

The reforms the Clinton administration proposes will have an impact on each and every American. How and when health care will be available to every American and how much it will cost us to achieve that goal are still outstanding questions.

Health care reform presents us with many opportunities. This is an opportunity for West Virginia to let our national leaders know what our concerns are.

Thank you, Mrs. Clinton, and thank you, Senator Rockefeller, for giving us this opportunity.

SENATOR ROCKEFELLER: Bob, thank you very, very much. That was much too generous. I want to thank West Virginia University; I want to thank you, Bob D'Alessandri; Neal Buckler, the President of the University. I want to thank everybody who is going to be participating, particularly in the four counties that we'll be talking tonight.

I cannot tell you how happy I am that Mrs. Clinton is here tonight to share with us not just here, but all across the state on television and radio, what we in West Virginia are faced with in terms of health care problems. And when you think of it, Mrs. Clinton and the President put together a task force of 500 people that have been working now for months and months, and it is so important, I think, that they do what they have been doing so expertly, which is to go out into America and listen.

It's a terrible problem, health care; we all know that. I mean, last year, for example, 1,200,000 people lost their health insurance. And, of those, 1 million of them made between $25,000 and $50,000 a year. This is a problem for working America, mainstream America. It is crushing our families, it's crushing our state government, it's crushing our federal government. It's a terrible problem for small business.

So what I am really grateful for is the concern of Mrs. Clinton, coming to West Virginia to listen precisely to what our problems are, because our problems, in many ways, might be like others, but maybe they're a little bit different. And we want to look at some of them in depth tonight.

And, Mrs. Clinton, I want to tell you that we in West Virginia are very grateful to you for coming.

MRS. CLINTON: Well, it is I who am grateful. This is a wonderful opportunity. I always like coming to West Virginia and didn't really have to think very long when Senator Rockefeller suggested this opportunity, which is a very unique one, to be able to hear from people all over one state, talking in-depth about the problems that are affecting not only West Virginians, but all Americans.

I'm very grateful for the kind of help and cooperation that I have received from Senator Rockefeller who has been in the forefront of talking about the need for reforming our health care system -- not just because it's the right thing to do, not just because we will help millions of Americans who are really on the edge right now -- those who are insured, but could be wiped out because their insurance doesn't cover everything, those millions who are uninsured, generally everyone who is feeling insecure about health care today.

But it's also the economically smart thing to do -- to reform our health care system now before it consumes $1 out of every $5 that Americans will make by the year 2000. So it's a great treat for me to be back in West Virginia to have an opportunity to listen and to learn and to take that back with me to the President as he moves forward toward announcing a comprehensive health care reform for our country.

MR. D'ALESSANDRI: Thank you, Mrs. Clinton. And let's move right to Raynell, West Virginia. Craig and Vicki McClung, can you see us and hear us?

MR. MCCLUNG: Yes, sir.

MR. D'ALESSANDRI: Okay, we're going to go to the tape first.

VIDEOTAPE SHOWN:

MODERATOR: The town of Raynell in Greenbrier County has deep roots in West Virginia tradition. Coal is still important here. So are lumber and farming. People value cooperation, self-sufficiency and family life. The work ethic is strong, but times are tough in this region and the unemployment rate in Raynell is now close to 15 percent.

Raynell stands outside the mainstream of urban America. And most people here like it that way. School sports are an

important part of family life. Many believe that such activities cultivate family values and stability. Raynell Medical Center is the heart of the health care delivery system for this town of 1700 people, and the surrounding area.

It's estimated that between 250,000 and 300,000 West Virginians have no health insurance. That means usually they aren't getting the care they need. And when they do seek medical attention, it's often not until a health problem has reached crisis proportions.

Craig McClung had a good job in the coal industry until a serious accident in 1988 ended his career. He's currently unemployed. And except for a son with spina bifida, who is eligible for Medicaid, his family of six has no health insurance.

MR. D'ALESSANDRI: Craig and Vicki, can you hear us? We're with Jay Rockefeller and Hillary Clinton.

MR. MCCLUNG: Yes, sir.

MR. D'ALESSANDRI: Oh, that's great. Craig, maybe you could just catch us up a little bit in terms of what losing health insurance and your accident and everything, what that's meant to you and to your family.

MR. MCCLUNG: Well, I had been employed in the coal industry for 12 years, and that I fell 65 feet on December 14th, 1988. But for the grace of God and from fine doctors at Plateau Medical Center, I was --

MR. D'ALESSANDRI: Yes, you go ahead and just take your time. When you went to that hospital, they fixed you up. But you still -- you went back to work, but you still couldn't stay with it, could you, because the pain was too bad.

MR. MCCLUNG: Yes, sir. That was what has happened.

MR. D'ALESSANDRI: And how has that affected your life? And, Vicki, you, too -- what's that meant for your family and for your children?

MS. MCLUNG: Well, when we had health insurance, health care wasn't a major concern. But when we lost our health insurance, it became a major worry. Last summer, I found out firsthand what it was like whenever you a problem arises and you have no insurance. I woke up one morning with severe pains, and since I have a brother who has had kidney stones, I knew the symptoms I was having, but in the back of my mind, I kept knowing the cost that would be involved. And so I put off going to the doctor until the last possible minute.

Luckily, I only had to spend one night in the hospital. But because of that one-night stay, we're having to pay out about $100 a month -- have be, and will be for the next year. So it's a big worry.

MRS. CLINTON: Vicki, this is Hillary Clinton. How are you?

MRS. MCCLUNG: I'm just fine.

MRS. CLINTON: I'm glad to meet you through satellite technology like this.

When Craig had his accident and was injured so badly, did the insurance initially -- the worker's comp and the insurance -- did that cover your expenses; but then when he couldn't go back to work, then you lost your insurance? Is that what happened?

MRS. MCCLUNG: That's right, ma'am.

MRS. CLINTON: And how long have you as a family been without insurance?

MRS. MCCLUNG: For about four years now.

MRS. CLINTON: And have you had any medical needs that you, in addition to the one you just described to us for yourself and for Craig and the children, have gone unmet because of no insurance?

MRS. MCCLUNG: Well, just maybe some routine health check-ups, like eye care and dentistry and preventive medicine more. Luckily, we've been pretty healthy.

MRS. CLINTON: That's a blessing, isn't it?

MRS. MCCLUNG: Right.

MRS. CLINTON: Now, in the introduction they mentioned that one of your sons had spina bifida. Is that right?

MRS. MCCLUNG: Yes, ma'am.

MRS. CLINTON: And how is his medical treatment covered?

MRS. MCCLUNG: Right now it's covered by a medical card. Up until Craig was hurt, we always had health insurance that covered

all of his needs. But when he was hurt, luckily he qualified for a medical card, and it's taken care of his surgeries and necessities.

MRS. CLINTON: So you've got one of your children that's eligible through the state, but then your other three are not, for any of their care and treatment?

MRS. MCCLUNG: Right.

MRS. CLINTON: When you were talking about the kidney problems, you said that you postponed going as late as possible. If you had had insurance, would you have gone in earlier, and is there any reason to believe it might not have been as expensive or you might not have been hospitalized overnight?

MRS. MCCLUNG: My brother has had to be in the hospital several times with kidney stones. He's had surgery, plus he's had to have them blasted. And so I knew how expensive it could be. The major worry I have now is that his has reoccurred real often, and I just hope I'm fortunate in that I don't have that happen again.

SENATOR ROCKEFELLER: If you had to tell Mrs. Clinton the one thing that you'd like to really see happen in health care reform in this country, Vicki, what would it be?

MRS. MCCLUNG: Preventative health care. I would like to be able to take the kids for well check-ups and not wait until they're sick.

MRS. CLINTON: Is this a problem with your friends and neighbors in Raynell? I heard when they were introducing your family to us that unemployment's up to 15 percent. Are there a lot of people you know without health insurance right now?

MRS. MCCLUNG: Yes, ma'am. Several. The way it stands right now, the ones on welfare are the ones who get to go and have their kids checked for well care, and -- you know, they get more care.

MRS. CLINTON: Vicki, you have made a very important point, and it's something that I get upset about every time I think about it. Because what we have done is to tell people that if they work and try to make a decent living for themselves and their families, if they're unable to work but they keep trying and they keep going back trying to get something to support themselves, they're out of luck; if they don't have health insurance, that's their problem. If they just stop, if you all just stop and just kind of gave up and went on welfare, you'd have preventive health care for your boys, wouldn't you?

MRS. MCCLUNG: That's right.

MRS. CLINTON: I mean, that is just absolutely backwards from what we ought to be doing in this country and, yet, we're doing it, we're sending the wrong signals and we're not doing a very good job taking care of people.

SENATOR ROCKEFELLER: Vicki, can I ask you -- Brandon has his health are through the Medicaid; on the other hand, your other children don't. What is it that you worry about? I mean, what is it like to be a mother with four children, and for three of them there's no health insurance whatsoever? I mean, don't you wake up at night sometimes just worrying about an accident, and what would you do? What would you do?

MRS. MCCLUNG: Well, my boys have always been involved in a lot of sports, and when we lost our health insurance I was constantly saying, no, you can't go skating, or, be careful when you're playing soccer for the fear something would happen to them. And then I realized it's not their fault that we have no health insurance, and we just have to pray that they won't have any problems.

SENATOR ROCKEFELLER: But you never really have -- you never go to sleep at night with a sense of peace of mind, do you -- either of you, Craig or Vicki?

MRS. MCCLUNG: No, sir.

SENATOR ROCKEFELLER: Well, we're awfully grateful to you. It's a hard thing, I guess, I would assume, to just open your lives up to so many people all across West Virginia. But by doing so, you're speaking for hundreds of thousands of our people, and that's incredibly important. And it's so important that the First Lady of our land get to hear what it is that you have to say.

MRS. CLINTON: Well, I think it's especially important. Because, you know, there are a lot of people who talk about the uninsured in America, and they say, "You know, the uninsured are people who don't want insurance. The uninsured are young people, and they don't mind taking risks. So, why do we have to worry about insuring the uninsured?" And I hope that your willingness as a family to come forward and say, "Look, here we are. We are the uninsured," will help some people see this problem in a more realistic way, and they will quit saying that people who are uninsured don't really need health care, because I don't know what they think they are, some kind of special super people when they're just people like us.

And, as Senator Rockefeller said, 1,200,000 Americans lose their health insurance every year, and most of those people are just like your family -- they're people who have worked hard, they're people who try to do their best and, through no fault of their own -- an accident, a layoff, a plant closing -- they find themselves without health insurance. So today, you're really speaking for millions of other Americans, and I really appreciate that.

SENATOR ROCKEFELLER: Vicki and Craig, could you introduce your four children to us so we can just see them and meet them?

MR. MCCLUNG: Off and to my left is my oldest son, Brandon, our youngest son, Brent, our next to oldest son, Brian, and our middle son, Brad.

MRS. CLINTON: Where did all those Bs come from, Craig and Vicki. (Laughter.)

MR. MCCLUNG: From their mother.

MRS. CLINTON: I like that. (Laughter.) Well, "B" is for "boy." That makes a lot of sense. I think that's great.

SENATOR ROCKEFELLER: We really thank both of you very much. You've shared yourself with, really, the whole country, and we're very, very grateful to you.

MR. MCCLUNG: Thank you.

SENATOR ROCKEFELLER: Thanks so much for letting us into your lives. And I know now that Linda Amon, who works at C & P and who represents the communication workers, I know that you have some comment that you'd like to make, Linda, and we look forward to hearing what that is.

MS. AMON: Okay, thank you. Thank you, Senator. And welcome, again, Mrs. Clinton to wild, wonderful West Virginia. With many companies downsizing, jobs relocating to Mexico or overseas, retirees facing health insurance cost-shifting, many West Virginians could very well find themselves in a similar situation, just as the McClung family. Even those who are fortunate to have health insurance are not adequately covered in the event of a catastrophic illness or accident.

I am very pleased to tell you that West Virginians have the highest per capita of homeownership in the United States.

However, one serious illness or accident certainly could make any of us homeless.

Virtually, all the strikes over the past six to eight years in our industry have been over health care issues. Last year, our CWA members that are employed at Century Cable TV here in Morgantown, have seen their family insurance copayment almost triple, resulting in many members having no choice but to drop their health insurance, because, you see, they no longer could afford to keep it.

CWA is on record as supporting the single-pair concept for universal health care. We're hopeful that health care issues will be addressed to Congress, and it will be as fair as possible to all parties, particularly the working people and retirees. Thank you.

SENATOR ROCKEFELLER: Linda, thank you very much. That was a going point, and we're very grateful to you. And now we're going to go to New Martinsville in Wetzel County.

VIDEOTAPE IS SHOWN:

MODERATOR: New Martinsville in Wetzel County is an industrial town in a rural area. Along the Ohio River are chemical and manufacturing plants and service industries. The river itself is busy with commerce as heavily-laden barges sail north and south. The steep ridges that wind back from the river are home to livestock farms and dense woodlands. Many residents with a lack of transportation and long distances, can make access to health care difficult.

Wetzel County Hospital is the center of the county's health care network. The hospital and community physicians provide substantial amounts of charity care. Like many rural hospitals, it faces a continuing challenge to provide a high level of services in the face of severe financial difficulty.

Dan Dunmeyer has been administrator of Wetzel County Hospital since 1987 and has guided it through several financial crises.

SENATOR ROCKEFELLER: Dan Dunmeyer and Dr. James Kamersi, this is Jay Rockefeller and Hillary Clinton. Can you hear us all right?

MR. DUNMEYER: Yes, we can.

DR. KAMERSI: Yes, we can.

SENATOR ROCKEFELLER: All right, Dan. I don't know if you're sitting in the emergency room there, but what percentage of folks that come into your emergency room, Dan, are people that just don't have health insurance?

MR. DUNMEYER: Senator, we serve quite a few patients in our emergency room that do not have insurance or are uninsured or underinsured. The percentage seems to have been growing the last five to six years. Our volume has increased overall. But what we have experienced is fewer people being able to pay. So it's a dichotomy of things -- volume increases, but dollars have decreased.

SENATOR ROCKEFELLER: Dan, if you had to say what was wrong with our current health care system, what would you say to Mrs. Clinton and to the rest of us?

MR. DUNMEYER: Well, I think there's a number of issues. We can't fragment out approach. Coming from a small rural hospital approach in a small rural community, it is easy for me to say that the focus needs to be on primary care, therefore allowing access to care. There's a whole lifestyle issue as well, trying to educate our children to improve their nutritional aspects, their exercise aspects, and take more ownership and responsibility for their own lifestyle. So those two predominant issues -- primary care and wellness -- there's other issues, such as reimbursement or financing and being able to expand programs that reach out into the community. But I think the emphasis should be on primary care.

SENATOR ROCKEFELLER: Let me just ask Dr. Kamersi -- do you find that the folks in that area that don't have health insurance are, in fact, reluctant to seek care, that they kind of put things off? What is the effect in that area of just not having any health insurance? What happens in people's lives?

DR. KAMERSI: I think there are many people who are reluctant because they feel they can't pay for their health care, so they will put things off until they end up having to be in the hospital or go to an emergency room where they don't know someone so they don't feel bad about accepting free care. So it does lead to increased costs, especially for them.

MRS. CLINTON: Doctor, I'd like to ask you and Mr. Dunmeyer to expand, if you will, on what you think the best ways we could improve primary care in a community such as yours and other communities like yours around the country. What are some of the different approaches that you think would work? How do we increase the supply of primary care physicians and others, nurse-practitioners, nurses, physician's assistants and the like, so that we have better access in the rural areas?

DR. KAMERSI: I think one very important way is to look at what it costs me to provide care. So, some help in making it easier for me to provide care, and looking at that cost issue will help me provide care to more patients. I think that's the primary --

MRS. CLINTON: Could you explain that, Doctor? When you say what it costs you, could you describe a little bit more what you mean by that?

DR. KAMERSI: Well, within the last several years, the primary control has been to try and reduce reimbursement. But the other side of the equation, my expenses, have not been looked at, specifically. So, it continues to cost me more to provide care, plus insurance processing is a significant expense for my practice.

MRS. CLINTON: Are you primarily reimbursed as a primary care physician through Medicare and the other third party payers?

DR. KAMERSI: Yes.

MRS. CLINTON: So you, then, are in the same position as general internists and family physicians and pediatricians and others who are really at a disadvantage because you don't get reimbursed appropriately for your -- in the office kind of work, your clinical work, whereas, if you were doing procedures and tests and surgeries, you'd be reimbursed at a higher level? Is that your experience?

DR. KAMERSI: That has been the experience, and I think the expense in processing those claims is the same for a primary physician as it would be for someone either in a larger institution or a consultant.

SENATOR ROCKEFELLER: You know, both to Dan and to Jim, I hear so much about the hassle factor. I have a first cousin who practices family medicine up in Portland, Maine, and he actually had to sort of -- after 14 years or 15 years, he just kind of quit for a year just to get his burners going again. He was just so distressed about paperwork and filling out forms and the so-called "hassle factor." Can you tell us a little bit about that from both of your points of view?

MR. DUNMEYER: I'll start, Senator. I believe my numbers may be off, but there's close to 1500 different insurance companies. Every one requires different information on each of those pieces of paper. So, yes, I think one simple approach is to have that uniform billing to make it easier. There is no reason why a hospital our size should have to have as many people specializing in

Medicare reimbursement and Medicaid reimbursement, and the other third party payers when it would be most, or more simple to just have one form to complete and go on our way.

MRS. CLINTON: That is one of our goals. We want to streamline reimbursement, eliminate all of these forms, have a single form which everybody is required to use, and I think it would be one of the greatest improvements we could make in the very short-term. Because you would find it so much easier to run your hospital, and most physicians would be freed from the responsibility they now face of hiring people to hassle with insurance companies, to respond to inquiries and to fill out those forms. That's the fastest-growing part of medical care is the paperwork part of it.

DR. KAMERSI: I think if you would talk to our clinical staff, our nurses and technicians are tremendously frustrated with removing themselves from patient care to do paperwork. So we could applaud that effort of streamlining our paperwork.

MRS. CLINTON: Great.

SENATOR ROCKEFELLER: If everybody in America had health insurance, and everybody in Wetzel County and all the counties throughout there that use your hospital, you wouldn't have so-called "charity care." Either you as a hospital administrator or Dr. Kamersi as a physician -- in other words, when people get health insurance and they have health insurance, that means they can pay their bills. And that's not all bad, is it, for a doctor or a hospital?

DR. KAMERSI: Obviously not. I think, if I may, that a perfect segue for a point that I would like to make, this hospital, like most hospitals and physicians, do not turn patients away. We take it upon our mission to treat everyone who comes to our facility. So we've accepted that responsibility of uncompensated care; but universal access, that, too, would be a great help.

MRS. CLINTON: But, you know, one of the really sad parts about that is that your willingness to treat everyone and to, in a sense, do so at a cost to your hospital has meant that, for many hospitals, you've had to try to shift those costs because you couldn't run on empty for very long. And so, it's the private pay insurance, it's the Medicaid, it's the Medicare system that pick up the payment for individuals who cannot afford the entire cost or only a part of it. And I often have conversations with people who are so angry about their hospital bills -- and I'm sure you've had conversations like that -- where somebody points and says, $50.00 for two Tylenols, or $1,100 for a foam rubber mattress that I could go down to the wholesale store and buy myself for $80.00.

But the problem, of course, is that hospital administrators like you are put into an impossible position. I mean, once you do what we want you to do, which is to take care of sick people who can't pay for it, that money has to come from somewhere, so we're caught in a vicious circle that, as the Senator points out, if we had universal coverage, everybody would be paying their fair share again.

MR. DUNMEYER: That's right. When they live across the street from you, it is hard to turn people away.

MRS. CLINTON: That's right.

SENATOR ROCKEFELLER: Dan and Jim, we're incredibly grateful to both of you for sharing part of your frustrations and your evening with the First Lady and myself. And we really thank you.

And we have also here in our audience in Morgantown, Dr. Bernie Westfall, who is president of this whole West Virginia University hospital system.

Bernie, we welcome any comment you might have.

DR. WESTFALL: Thank you, Senator. Mrs. Clinton, it is a real pleasure to welcome you to the health sciences center here and to speak to you about the health care system as it relates to a university referral hospital. Obviously, you have a great deal of insight into cost-shifting, and that's one of the things that I've wanted to talk about.

As you might expect, here at the University Hospital we treat large numbers of very, very sick patients. And many of these patients come here from long distances, and many of them do not have insurance. And to give you a very direct example of the outcome of that is that, for a patient who has insurance that's admitted to West Virginia University Hospital, they will pay approximately $500 more per day on their bill in order for us to cover the cost of the free care that's provided at the Ruby Memorial Hospital here. And that, of course, means that hospitals that provide a lot of care to uninsured patients have to charge more. And that's the way the system is currently financed, and there's a lot of inequities in that.

We certainly are proponents of a universal coverage. We believe it's the only way to make a -- put all hospitals on even footing and to eliminate this business and this confusion about

shifting these costs to the patients that can pay. There's nothing fair about that.

The one concern that we have is that getting to universal coverage for all of the people in this country that do not have insurance is going to be a very expensive proposition, and we know that. Our concern is that you may be forced, in looking at health care reform, to phase it, to begin with trying to fine-tune the payment systems and to get rid of the insurance bureaucracy, which we favor, but then we may have to delay or phase-in the coverage for everyone.

That would mean that, for a hospital like ours, we would be at a great competitive disadvantage during that phase-in period. And I'm sure that you're aware of this, but we want to restate it from West Virginia and from the Ruby Memorial Hospital here. It's very important.

SENATOR ROCKEFELLER: Bernie, I hate to interrupt you, but we've got a lot of people on the line and I really apologize to you, but we need to thank you very, very much and we need, now, to go to Martinsburg, West Virginia.

VIDEOTAPE IS SHOWN:

MODERATOR: West Virginia's historic eastern panhandle is one of the state's most affluent and rapidly-growing areas. Just an hour from Washington, D.C., it's becoming populated by people who commute to the capital for their jobs.

Martinsburg, in Berkeley County, is the area's largest town with a population of about 14,000. The region is the center of West Virginia's fruit growing industry, and the seasonal employees who work the orchards pose special health care issues.

Industry has found the panhandle's flat terrain, mild climate and accessibility to East Coast markets attractive. The large companies, which nearly always provide health insurance for their workers, health care reform may bring relatively minor changes. But small businesses worry that required coverage for their workers may be too expensive.

Berkeley Upholstery in Martinsburg is a manufacturer of custom furniture that currently has 18 employees. It's a family business now in its third generation.

SENATOR ROCKEFELLER: Mike Ellens and Jerry Keith -- Mike, we know that you're the business owner there. And, Jerry, you've been working and we also know that you're a Vietnam Vet.

Mike, maybe you could talk to us a little bit as the owner of a small business what it means, the problems of health insurance, in trying to get -- or, the frustrations of it. If you could just talk to us as representing a typical small business in West Virginia.

MR. ELLENS: Good evening, Senator, and Mrs. Clinton. During the five-year period, from 1982 to 1987, we found our employee and employee dependent health care insurance coverage increase a total of about 32 percent. In the next five years, from 1987 to 1992, it increased in excess of 500 percent. We had one carrier fail, and the second carrier got hit with two major claims and became very recalcitrant to deal with, ending up forcing us to go to the West Virginia Insurance Commission on at least three occasions to settle claims.

Anticipating another 50 some-odd percent increase in premium, we shopped for other carriers but found because of the small group, and we have an old group -- average age is about 53 and our oldest employee is 81 and many have pre-existing conditions -- many carriers did not want to deal with a small group, and those that did were reluctant to do so because of the age and the pre-existing conditions or wanted to exclude employees.

This has basically been our problem with trying to provide our employees with insurance. And we have found that as the cost increased a family now is in excess -- was approaching $7,200 a year, we've had to reduce coverages and shift more of the cost over to our employees.

SENATOR ROCKEFELLER: Maybe I could just butt in there with Jerry, and if you could talk, Jerry, to Mrs. Clinton and myself and to West Virginia about what your health care insurance problems have been let's say over the last five or 10 years. What have been the frustrations for you?

MR. KEITH: Basically, my frustrations come out to be that the big industry is offered all kind of incentives and discounts. When it comes to the smaller industry, there's no incentives, no discounts and, quite often, no insurance offered whatsoever to us. Here at Berkeley, we've seen our costs keep rising and rising. Every time they've rose, we've had to lower our coverage and raise our deductible to be able to afford it. And, finally, in the past year or so the company has had to add a certain portion of this cost onto us individually right on the paycheck at the end of the week.

This is getting harder and harder on all the people here, and they've had to ask themselves an important question -- can I afford this insurance and, possibly more important, can I afford

not to have health insurance? We talked about this earlier and they -- some of the people here asked me what I thought was a reasonable cost of health insurance. And I can't answer it in dollars and cents but I can tell you I don't think it should be the highest number in my monthly budget. I don't think it should be higher than my house payment. I don't think it should financially burden small industry out of existence, and I don't think it should financially burden me to the point that I can't enjoy my good health for the fear of a possibility of bad health.

MRS. CLINTON: Jerry, that's an eloquent, eloquent statement. (Applause.) You have said so well what I have heard all over America because more than two-thirds of our small businesses like Berkeley do insure and they have run into exactly the same problems that you both have described tonight. And it's just heartbreaking because it's clear from listening to both of you that this is a company where people talk to each other, where they stay employed for long periods of time, where your oldest worker is 81, where there's a real sense of community as well as a job. And yet what you have faced is what small business has faced in the last 10 years. There is no excuse for it.

And among the reforms that the President will propose are the following: There will no longer be the kind of disadvantage that small business has encountered. You will be part of great, big pools to buy insurance and you will get all the breaks and all the discounts that the big guys have been entitled to, and they won't be able to play you off against one another the way insurance companies have in the last few years; so that it got to be more like how few people could you insure for how much money instead of how many people you could insure for a reasonable return.

Secondly, people will not be denied insurance coverage because of their age or a preexisting condition. They will be eligible for reasonably priced insurance because they are Americans. And that is something that is very important to us, particularly when it comes to people who have been working hard and have been disadvantaged, as you have described.

So one of the things that I feel very comfortable telling you both tonight is that for companies like yours that have suffered and struggled to try to maintain insurance and found it more and more difficult and more and more expensive, I think that the kind of reforms the President will propose will make it not only possible to insure everybody, but will do it at an affordable cost that will be bearable to both the company and the employee. And that is our primary goal in trying to make sure that companies like yours and individuals are no longer disadvantaged the way you have been.

SENATOR ROCKEFELLER: Jerry, just not having health insurance -- I mean, you know a lot of folks like that. I mean, let's get down to it. There's a sense of self-esteem, isn't it? A sense of helplessness when people don't have health insurance?

MR. KEITH: Oh, it's definitely helpless. I think basically they've lost a lot of faith in the system. You know, some of these people have paid into something for -- a pool supposedly that we've had for 20 years and they've been paying in monthly. And now that they're getting a little bit older, it seems like the system has copped out on them. You know, it's left them standing after paying for it for all this time.

SENATOR ROCKEFELLER: Mike and Jerry, I hate to say this, but we're going to have to go to another part of the state. Mrs. Clinton is incredibly grateful that you've just been -- both of you -- so straight with us and you shared your experience with all of West Virginians, and I think people can identify with what you're saying. We're awfully proud of you, and we thank you very, very much.

And I know now that Steve Roberts, who is President of the West Virginia Chamber of Commerce, has a very short comment that he wants to make. (Laughter.)

MR. ROBERTS: Mrs. Clinton, thank you very much for coming to West Virginia and listening to our ideas and listening to our problems. We invite you to return soon. And Senator Rockefeller, thank you for your outstanding and extraordinary leadership in this important issue.

The West Virginia Chamber of Commerce hears from companies like Berkeley Upholstery often, and the story is very much the same. We believe in universal access, but we believe that in order to have universal access, that costs must be controlled first. We believe in cost control measures that include preventive medicine, education. We certainly love the idea of uniformity of claims and form administration. And we're particularly intrigued with the idea of employer buying groups. Pool buying groups make so much sense. And yet, in a state like West Virginia, which is rural in nature, there are some problems in figuring out just how to do it. So we'll be eager to work with you and to hear what comes from Washington so that perhaps we can put together employer buying groups in West Virginia and participate in those kinds of savings as well.

SPEAKER: Steve, thank you very, very much. And Mrs. Clinton, we're going to go on now to Cabin Creek, West Virginia.

VIDEOTAPE IS SHOWN:

MODERATOR: Cabin Creek runs through a long, narrow gap between two mountain ridges in southern West Virginia. The settlement, which spread out for miles along the creek, are mostly former coal mine company towns. Most of the mines closed years ago, and the economy has never recovered. Several thousand West Virginians live along Cabin Creek. Many are elderly, others work at small businesses, or commute long distances in their jobs. A large number are unemployed. The community has worked long and hard to keep health care available. A health care center was begun was union and community activists in the 1970s, but it was difficult to attract and keep physicians. And the clinic struggled financially.

In 1991, the Cabin Creek Medical Center closed for several months, leaving the area with no primary care. West Virginia Governor Gaston Caperton worked with the state's three medical schools to reopen the clinic. It's now a training site for medical students and provides care to some 6,000 people from three counties.

SENATOR ROCKEFELLER: Jane Hughes, can you hear us all right?

Q Yes, I sure can.

SPEAKER: Okay. And Daisy Austin, can you hear us, too? And Holly Hartman? All right. Good. We're very glad that you're with us. Jane, I'm just wondering if you could tell us what it was like when, in fact, the Cabin Creek Clinic just flat out closed. There was a period of time there where it was just closed. What happened? What happened in the community?

MS. HUGHES: Well, you know, so many people depended on Cabin Creek Clinic tremendously. Up here transportation is a problem. You can't always get a ride to a doctor somewhere else. The bus only runs up here once in the morning and once in the evening. It's not like other places. And myself personally, I have transportation. But at one point, I had a very sick baby and I had a newborn at home. My son awakened with over 105 temperature. And the clinic was closed and I had to have someone to drive me about 30 minutes. I was just so scared. And then I had to have somebody to keep my newborn. So if the clinic had been here that would have never happened because I would just have come right up here.

SENATOR ROCKEFELLER: Holly Hartman, let me just ask you a question. You want to be a primary care physician, and here you are in the heart of rural West Virginia. And the odds say that you can't do it, in other words, that you just can't make enough money or that there's just -- you owe too much when you get out of medical school and yet you want to do primary care. What can Mrs. Clinton

and the President of the United States and others do to help people like you practice primary care?

MS. HARTMAN: I think a lot of the issues that have been discussed already in the program about reimbursement, decreasing the cost of paperwork and insurance are all things that would greatly encourage students go into practice in rural care. Rural care is interesting in that it has an aspect of human care that no other specialty does -- you can follow a family for three generations, you can perhaps deliver a child, follow that child through it's childhood years, but there's also so many drawbacks to rural care as far as the reimbursement, quality of life issues in a rural area.

I think what the Clinton's need to do -- is the bottom line is patient care. So they need to change things and make it more attractive for physicians.

MRS. CLINTON: Now, Holly, that's a good way of putting it. I mean, all of the issues we've talked about are very important: reimbursement, forms, cost containment, all of those are very important. But those are a means to an end, and the end is quality patient care. I mean, the end is how do we provide better care for Americans so that they can be healthier, which then will have the impact of making our health care system more efficient as it moves through time. And what you've said is so significant because I hope we measure everything we're going to propose in terms of what is the impact on patient care. And I believe that if we look at our problems honestly and ask that question we will come back to the points that you made. We will support rural clinics because they make sense and they'll be tied into delivery networks so that they're not out there all by themselves as some kind of little outpost, but they're part of an extended system of care that, you know, stretches from Morgantown to Cabin Creek, and where physicians are going to be supported to do the kind of quality patient care you're talking about.

SENATOR ROCKEFELLER: Daisy, if I could just get you there on screen for a moment. You've been a teacher for 41 years, Daisy Austin, you're a member of the board there. And you're a senior citizen and I've known you for a long time and I love you dearly. Now what is it, as a senior citizen, that you'd like to say to President and Mrs. Clinton about what we ought to be concerned about in our health care reform?

MS. AUSTIN: Hello Senator Rockefeller and Mrs. Clinton. I'm so happy to be able to speak for the senior citizens. As you know I am -- I have been here almost eight decades. So I've gone through a lot. My greatest desire is that the senior citizens be taken care of in the manner that they like to live in.

For example, I've lived at my home for about 43 years. I built the home and raised many, many children there. I would like to stay in my home when I become disabled and perhaps have some system in place that I could have a para-professional or someone to come in and help me to maintain my home and live happily. I would like to live there until the Hallmark Hall of Fame would recognize me for my 100th birthday. (Laughter.) So please help me. (Applause.)

MRS. CLINTON: Well, I have some kind of a feeling that may very well happen. (Laughter.) You know, one of the -- one of the issues that Senator Rockefeller and I have talked about a lot together in this issue of long-term care, because you're absolutely right, if we provided more support for older Americans to stay in their own homes. to be helped at home, maybe when that were no longer possible to move in with people and be helped in a small setting, we would be doing a great service to our older Americans. And we also would be saving money. Right now what we do is to say, you're either on your own or you're in a nursing home. Nothing in between -- we're not going to help you with any of these other needs. So I think what you're saying makes a whole lot of sense. Probably the Senator and I are going to have to call you to come down to talk to some folks in Washington about how much sense that makes.

MS. AUSTIN: I'll be glad to.

MRS. CLINTON: Good, good. (Laughter.)

SENATOR ROCKEFELLER: Cabin Creek has been losing population over the years, Daisy, and any of the rest of you that want to comment on this. Is Cabin Creek -- is the clinic there meeting the needs of the health care folks or is it not? What do we need to do for Cabin Creek in the southern West Virginia area to help on health care?

MS. AUSTIN: This facility is first-rate and it has been recently renovated and painted and it could be a hallmark for preventive care, in particular, because a great work had been going on here for a couple of years in order to work in that place. And then, two, you know, we serve parts of -- County and Boone County, all of the lower Chesapeake and across the river --. We have a great outreach here, so this clinic has a great need for this vicinity.

SENATOR ROCKEFELLER: Jane Hughes, and Holly Hartman, and Daisy Austin, God bless all of you. Mrs. Clinton and I are so grateful, we didn't have -- there's more we wanted to talk about, but we just don't have the time to do it. Air time is going to run out on us, but we really thank you for sharing with us, for being so

honest with us, and we wish you all the very best. And we'll be seeing you very soon.

Here in our audience, Dr. Donald Westin, who is West Virginia State Director of Health, has a comment, I expect, good doctor, and we welcome him.

DR. WESTIN: Senator Rockefeller, Mrs. Clinton, it's a privilege to describe, very briefly, some initiatives on training health manpower. In 1991, Governor Caperton and the legislature put through a rural health initiative. We've got a Kellogg Grant to really turn the university system, our three medical schools, our nursing -- school to the rural areas.

We now have over 110 rural health care facilities, clinics, rural hospitals, networked into 12 networks for rural health education of where all of our health science students -- 1,200 -- will spend a minimum of three months training in these rural health sites. We believe this is an amazing direction. A lot of commitment has come from the state legislature. But also it's a big partnership with the communities, because the communities are equal partners in this. The oversight responsibility at both the local level and the state level is with the university system and the communities.

Just one last thing about keeping health professionals and that's economic development for these areas, the quality of life is the key issue. Thank you.

SENATOR ROCKEFELLER: Thank you very much, Don. Mrs. Clinton, I hate to say it but we've come just about to the end of our time. And I want to thank so much each of the people that talked with us from the four different sites in West Virginia. It's technologically a very difficult thing to do, you know, all of a sudden you have the camera staring you in the face and you've got to talk to the First Lady of the United States. That's not easy, but people have done it and, of course, we in West Virginia are very forceful in our thinking and in our views.

I really want to thank you and I know that Mrs. Clinton does also. I want to thank very much the TV and radio stations that have carried this live. It's a remarkable thing. It's never happened before in the history of West Virginia that we have so many people tuned in and listening to a serious discussion on health care. I want to thank West Virginia University. I want to thank our audience here in Morgantown, the Speaker of the House and the President of the Senate and all the many good people.

And let me just make a quick closing statement, Mrs. Clinton. This is just desperately serious stuff. It makes me very

angry sometimes to hear people talking and trying to figure out what it is the task force is doing in Washington, D.C. Well, let me tell you what they're doing. Mrs. Clinton has brought together -- first of all the President takes the First Lady for the first time in American history and says I want you to take charge of this, the most important problem that we have other than our economy itself. And this White House Task Force has been working now for months, 500 people, 60 physicians, all over the country. And they're in a position right now, in fact, where we're beginning -- they're beginning to come down to their basic decision making.

Mrs. Clinton views this, as I do and as I know our people in West Virginia do, as really a matter of life and death for our country. It can be said fairly and it can be said accurately, there is no way that we can reduce the budget deficit in this country unless we get the cost of health care under control. There is no way we can call ourselves good West Virginians or Good Americans unless we know that every single West Virginian and every single American has health insurance.

And the hard part is that we're going to do all of that and we're going to do it this year. This is a real national calling, and I'm just calling on West Virginians to support what it is that the Clinton administration comes out with in the way of health care reform. Will it be complicated? Yes. Will it be important? You better belief it. Will it be worth fighting for? Absolutely.

Most of all, Mrs. Clinton, obviously I really thank you, I mean, the whole country wants to see you and you've come here to West Virginia. And we're incredibly grateful and maybe you should just -- we've got about three minutes left. (Laughter.)

MRS. CLINTON: You know, I like coming to West Virginia. We have pretty good results when we come to West Virginia. (Laughter.) It always makes me feel good. I may come back permanently. (Applause.) Everything that Senator Rockefeller has just said and that we've heard from people here talking about their own experiences really points to the need for change.

And one thing we haven't said is what the cost of staying where we are is, the cost of doing nothing, of throwing our hands up and saying, you know, we've heard all these problems and they're all so difficult and, gosh, I just don't think we should tackle something that complex. Well, while we sit here for the next minutes and hours and days, our health care costs will continue to go up; more and more people will lose insurance; more and more people will worry at night about what will happen to them; and our country will spend over a $100 billion more next year that will not give one more ounce of care to anybody who doesn't have it already. So

there's not really a choice if we're going to really pull together as a nation.

And what I have so appreciated is how interested Americans are. I laughed the other day and said we have 250 million Americans and I think we have 250 million experts because everybody takes this so seriously. And what we need, as Senator Rockefeller has said on so many occasions, is for all of us as Americans to say to ourselves, what kind of country do we want to live in? What kind of people do we want to be? What kind of future do we want to have for ourselves and our children? Do we want to be a country that takes care of each other again, that permits doctors and nurses to take care of people instead of fill out forms? Do we want to see our children be healthier, instead of declining in health as they're currently are? Do we want to see older Americans live with more security in their own homes wherever possible? I think most of us answer those questions, yes. And the way to get there is by doing what we're doing tonight: listening and talking honestly to each other and then acting together.

I really appreciate all that I've heard, and I'm looking forward to working with your Senator and your other elected officials to make health care a reality in West Virginia and America this year, Senator.

SENATOR ROCKEFELLER: Absolutely. (Applause.) Thank you, everybody. Thank you very much and good night. (Applause.)

END 7:45 P.M. EDT