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GSA at Dartmouth-Hitchcock
Medical Center

PHOTOCOPY
PRESERVATION

THE WHITE HOUSE

Office of the Press Secretary

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THE FIRST LADY
QUESTION AND ANSWER SESSION
AT DARTMOUTH-HITCHCOCK MEDICAL CENTER

ANNOUNCER: (Inaudible) I appreciate your (inaudible). One concern is the (inaudible). The second one (inaudible) are available, but they are available (inaudible).

MS. CLINTON: I cannot help you. I'm not an expert on how you're going to be able to make those decisions. The reason we have (inaudible) that point, though, is because we list plans authorizing everybody (inaudible), contrary to some folk's plans. (Inaudible) this is a very (inaudible), good comprehensive benefits package for all Americans. We don't include dental care for adults. We don't include vision care for adults. We don't include cosmetic surgery. We don't include as much dental health benefits as we would like to see included.

We believe that we have to start where we are starting. This has been developed with an extraordinary amount of cooperation with the American Psychiatric Association, the American Psychological Association, the social workers and others that deal with patients that have mental health and substance abuse problems.

Is it what everyone would want (inaudible) wave a magic wand and you'd have all the money in the world? No. Does it remove some of the hard decisions that you as a professional will have to make? No. But you make those decisions every day now. There are lots of people without insurance who have problems. There are lots of people with lifetime illnesses who have problems.

We are providing a base level of (inaudible) that we think is a very good start, but we have not been able to do all that maybe we wanted to do and that's part of the continuing challenge that we will confront. But I think

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we've got a very good beginning (inaudible).

Q (Inaudible) My impression (inaudible) focus on (inaudible) recognition (inaudible). There has been reference made to the (inaudible). In my opinion, and the opinion of most of my colleagues, (inaudible). However, (inaudible) most of my time creating the charts and very little of my time (inaudible).

MS. CLINTON: Exactly right, and that's why we (inaudible). It is so interesting to me, you know, to look at the way that federal government is trying to control the health care costs in conjunction with (inaudible) agencies and others over the last 12, 15, years. They have increased (inaudible). They have increased regulations. They have a (inaudible).

They have interfered with your clinical time and your patient/doctor relationship. Now, why have they done that? They've done that because they have not been able to figure out how to take what is still (inaudible). The last remaining piecework payment system left in America, your ancestors who worked in the mills would recognize this payment system, in which you are paying on the basis of procedures you perform and diagnosis you report and you then code your bills so that you can get the maximum by bottling as many together as possible.

That is not a reflection on any physician. It is how the system works in advising you to make these decisions. That has not worked. It has been done by Democrats. It's been done by Republicans. It's been done by conservatives. It's been done by liberals and (inaudible). So instead of increasing the micromanagement, trying to figure out how to be more and more refined and how to reward more at (inaudible), they interfere more and more with you to try to (inaudible) volume or with the increased price which is inevitably (inaudible) try to figure out how to do more so you can get your overhead paid, we are trying to say look, let's move toward a more (inaudible) system that will give you a certain amount of money and tell you to make those decisions.

Let's eliminate a lot of the unnecessary regulations that have nothing to do with patient's care or (inaudible) health fund. But in order to do that, you have to recognize that you cannot continue the existing fee for

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services that currently exists without having some changes or some kind of agreement among the (inaudible) while they advocate changing the anti-trust law so that you can make those sorts of decisions.

What you describe as the doctor (inaudible), you spend your time as a clerk, 50 percent of the time that nurses now spend filling out forms. Nurses spend countless hours running around hospitals finding doctors to sign forms for procedures that they were ordered to perform when they handed out the form. It goes on and on.

Then you do the bills. The bills go (inaudible) and all these other groups that are paid billions of dollars that have nothing to do with taking care of people. That's what we are trying to get rid of. It's going to take changes in the way you think about how you practice and how you behave with respect to the payment stream in order to bring it about. That's (inaudible).

Q (Inaudible)?

MS. CLINTON: I'm sure there is that (inaudible) cultural context, but it is really from our perspective much less a question of history than it is in economics. Now, there has been a great deal of work that has gone into this package of benefits. The amount of money that is allocated to mental health is equivalent to the very best price insurance plan that currently exists that includes mental health.

The problem is there has not been a lot of experience economically that provides the sort of inclination we need or actuary to fully evaluate what the costs of the mental health benefits are likely to be. So we have chosen to put in as much as we thought we could justify at this time.

Now, there will always be additional insurance available. We are not telling people they cannot buy additional policies to cover that illness. We think there will be a market for those. But, in terms of what every American is entitled to, we have done the very best we can. I regret that there is a (inaudible).

You're absolutely right (inaudible) talk about mental health. They don't like to think about taking care of

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substance abusers. Those make people uneasy. But what our task is is to establish within the universal health care system, in this reform plan, is aimed to create these basic fundamental principles that general health is (inaudible). If we could do that, that would be such an enormous step forward.

I regret that the individual issues that the practitioners and the (inaudible) and the citizens that would lead you to feel that it is not sufficient will be there. There's nothing that I can do about that. I think it is so far beyond anything that we've ever done (inaudible) that I certainly hope that we're able to maintain it.

I will tell you that among the many battles that we will have is eliminating mental health from the comprehensive benefits package all together, that there are many, many people in this country and in the Congress who do not believe it should be provided in the universal benefits.

We're going to have to fight very hard to keep what is in there and then hopefully we will be successful and we will build on that as we move forward and are more experienced about how to control costs and render the cost for substance abuse and mental health.

Q Mrs. Clinton, many practitioners (inaudible) practice various defensive medicines and (inaudible) friendly medical (inaudible). Looking at your plan to (inaudible)?

MS. CLINTON: We have a series of reforms that are being proposed ranging from requiring (inaudible) resolution before any case goes to court, requiring a certificate of merit that actually certifies that it's proven effective and found safe (inaudible) meritorious (inaudible) protocol and guidelines so that physicians will have a presumption against any lawsuit that (inaudible), limiting attorney's fees.

We have tried to look at a whole range of issues affecting defensive medicine. It creates (inaudible) in the system for (inaudible) and privileged lawsuits and to begin (inaudible) through these practiced guidelines protection (inaudible) so that they don't have to worry about looking over their shoulders.

I think that ultimately is the most effective way to prevent a (inaudible) of malpractice cases so that

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(inaudible) armed with the presumption of appropriate (inaudible) because of the working up by the profession itself of what the practice guidelines would be if faced with a certain kind of problem. I think that's where the most (inaudible). Physicians here from Maine know that there have been some early success in trying that in Maine (inaudible).

Q (Inaudible) least cost of care in the trusted relationship between the parent and the pediatrician or the patient and the physician. Something that we're dealing with right now is really (inaudible) in the separation between the provider and the primary care physician (inaudible). This is not at the will (inaudible) parent but arbitrarily by the employer and the way the system is set up.

A choice is offered, but when you ask what is the choice the employer offers, it is take this plan, which means you can't (inaudible) physician or pay \$700 a year and (inaudible) as our physician (inaudible). What kind of guarantee in your health package do you have (inaudible) physician and the patient can maintain that relationship and through that trust save (inaudible)?

MS. CLINTON: Well, the most important thing you have done is shift the decision away from the employer to the individual. What you described is what is happening every day. Employers are posing either no choice or, in effect, (inaudible) what amounts to no choice.

Under our plan, all employers will pay at the 80 percent for the health care and all employees will pay the 20 percent. Take it out of their paycheck, just like now we take out of their paycheck what they pay for Medicare. I'll be surprised if somebody (inaudible). I say well, are you supporting Medicare? They say of course. I said what do you think it is. I mean, it's paid for by payroll tax. That's how you pay for Medicare.

What we're talking about here is that you will have the employer making a contribution (inaudible) employer does at the end of the month or every quarter, but the individual will make the choice. There will be at least three choices. Depending upon what the cost variations are in the region, the individual will have a full range of choosing among what is available.

Now, will some plans cost a little bit more for its

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employees to join? Yes, and some will cost a little bit less. But we are also trying to make it very difficult for the plan to discriminate against the physicians. So you would always be able to join a fee-for-service network and you'll be able to join probably whatever else you want to join within your region. That really helps the physician.

So we think we've increased choice, real choice, by taking it away from the employer, giving it to the employee, and preventing discrimination that currently exists against the physicians. That's the best answer we have to try to deal with what you see every day in your practice.

Q (Inaudible). I applaud your efforts and the fact you brought this issue to the forefront. I also applaud any aspects of your program in particular (inaudible) on patient access and patient security. My main concern is (inaudible) two questions (inaudible). As I understand it, each health alliance will have a budget cap. What provisions are there to these budget caps are not exceeded? If they are exceeded, (inaudible) furthering the debt?

My second question is the other side of (inaudible), the degree to which the caps hold and are effective is the degree to which there is a disincentive for new technology. Are you making any provisions in the plans to ensure that what is perhaps one of America's greatest industries (inaudible) biotechnology are not sacrifices because of these (inaudible) and disincentives?

MS. CLINTON: Let me spend a few minutes talking about this cap because although (inaudible) I know it's one on the minds of many providers as to how it will work. Unless you (inaudible) very different from every other state in the country, it is likely that you have an insurance commissioner or an insurance department.

It is likely too that the insurance departments have some authority over the health insurers that visit in your state. Every year or every other year, whatever the time table is, those health insurers go to your insurance department and say we intend to raise our rates 8 percent, 10 percent, 12 percent, whatever.

Usually, insurance departments argue a little bit, but in the face of what has been exploding costs for all these years, they usually grant permission for the health

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insurer (inaudible) lawyers and say here's how much we're going to charge you this year.

So, in effect, there is a budget. The budget is determined by the individual health insurer with the okay of whoever the regulatory authorities are in each state. That goes on today, but it's not effective because none of us have the tools to compare apples to apples. It's impossible when insurer X comes in to the office at the state capitol and insurer Y comes in, and insurer X is liable to go up eight percent and insurer Y says I'm going to go up 12 percent, because they have many different policies deliberately designed to confuse everybody and deliberately designed to kick out different populations to make the most money off them. The insurance commissioner says well, how do I compare apples to oranges? I mean, I can't say the 8 percent increase is fair or good compared to the 11 or 12 percent increase because I can't compare them because they're different policies.

What we are proposing is that we have a comprehensive benefits policy that is the baseline for health security for everybody. We are not proposing a global budget in which you can't spend any more money than that. You can continue to buy additional health care out of your own pocket for whatever you want.

We don't cover, for example, cosmetic surgery in this. If you choose to have a facelift for cosmetic purposes, you're perfectly free to spend your money to do that. But instead of it being impossible to compare apples to oranges, we will have a comprehensive benefits package that we will be able to compare throughout the state of New Hampshire, Maine, or Vermont.

We will get bids because each health plan will come in and will say we can provide you health benefits at this cost. So that's why we think you'd like to buy our health plan. Another health plan will come in and say we can do better than that. We can provide them this minus that cost. Then each individual will make the decision as to what health plan they want.

So we will begin to have what will be real experience about how much it actually cost to deliver health care in every region of our country because we will be able to compare health plans, how much each of them can afford to

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deliver for the same services and how many are efficient and how many are inefficient and what changes they have to make.

This budget will not go into effect. It is there as a backstop that if the system works as we think it works, which is that through your coming together in a fee-for-service network or an agent (inaudible) or however you choose to organize yourself, you are able to provide those services at a good affordable price that people can pay.

But what you have to understand, particularly here in this region of the country, is that we are (inaudible) and we (inaudible) different levels of payment around the country. So, if we don't have some kind of budget backstop, those regions of the country that today charge three times what you charge to be reimbursed for a coronary bypass or a cataract operation, they will have the advantage of all the (inaudible) built in (inaudible) of the inefficiencies in the system.

So we have to have some type of budgetary disciplined backstop, much of what the insurance commissioner would do today if he could compare apples to apples. But the whole idea behind health care reform as the president envisions it is that once you are no longer being driven by how many forms you have to fill out and therefore how many procedures you have to do, but instead thinking how can we provide quality health care to the people of northern New Hampshire or northern New England, then we will be able to realize the efficiencies that will come from eliminating the paperwork, from having more effective ways of delivering health care by looking at what works and learning from each other.

(Inaudible) your double edge to be (inaudible). Yes, we do think we need some kind of budget discipline in the system to set as a backstop against which practice decisions can be made but no, we don't think that in most instances it will ever be necessary to implement it. If it is, there is a system by which it is not a big government regulation if you go over a certain level, it's like in your own business. Then you make some contracts. But you make the decision about what it is.

You decide, you know, we can't afford to expand this year. We're going to have to be more efficient. Maybe we ought to limit it to what (inaudible) and not treat all

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these people who come into that (inaudible) with coronary bypassing. We ought to put some of them on nutrition changes.

What could be done here that would be (inaudible) medicine and cost effective if the people had an incentive to do it? Right now we don't provide any incentives to make those changes. That's the way we envision this working.

ANNOUNCER: (Inaudible) thank you very much.

(End of tape.)

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