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Health Care Forum w/ Dr. Koop, Dartmouth

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REMARKS AND Q & A BY THE FIRST LADY
AT HEALTH CARE FORUM SPONSORED BY DR. C. EVERETT KOOP
DARTMOUTH COLLEGE

DR. KOOP: Mrs. Clinton?

MRS. CLINTON: Are you ready for me? (Applause.)

DR. KOOP: Before I introduce Hillary Rodham Clinton to you, I want to express my personal admiration and my gratitude to her for her leadership in the President's health care reform effort. She has brought to this assignment exemplary energy, unfailing diligence, a breadth of vision, attention to detail, as well as care and compassion.

As America debates these issues, it is not unusual to hear people avoid the issue by saying, "There really is no health care crisis," and others say that "Other issues are more critical, issues like crime, education, and the budget." And it may be true that for millions of Americans who still enjoy adequate health insurance that these other issues loom more important.

But issues like education, crime, and the budget are inextricably connected to the questions of health care reform, and they cannot be solved until we get our health care system in order. Crime and violence must be seen not only as legal and social problems, but as one or two of our three most pressing public health problems.

Education reforms, both in the content and process of education and in the way we pay for it, are long overdue, but education reform is doomed to fail unless our children are healthy enough to learn. And right now one child in four and in some parts of America one child in three is simply not healthy enough to learn.

And our desire to determine the difference between what we really need and what we really want in the national budget must await our determination of what we need and what

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we really want in health care. So, since health care reform is linked to all other pressing domestic problems, it is little wonder that President Clinton turned to Mrs. Clinton to head the effort to reform our health care system.

But I would remind you that with all the well-deserved accolades that Hillary Clinton has received as the First Lady, the press and the public miss the point and the person. It is my understanding that Hillary Rodham Clinton has presented this health care reform to the nation not as the First Lady but as the American citizen whom the President decided he could best entrust with the task that he had placed on the top of his domestic agenda.

Now, I'm not saying that being a friend of Bill was all that difficult. It didn't hurt her chances one bit. But, after all, Presidents have always turned to trusted friends to fill important positions. But I imagine that in this case, that Mrs. Clinton received the assignment as much in spite of the fact that she was the First Lady as because of it.

A highly educated woman, an accomplished attorney, a proven manager, a thoughtful analyst, a champion of children and the underserved in our society, Hillary Clinton didn't surprise anyone who knew her by producing a reform plan of such breadth and depth. That kind of accomplishment was simply to be expected of her.

I also admire her and the President for their repeated statements that the plan that they have offered is open to debate and to amendment, and they welcome suggestions to improve upon it, and that's why I am here, not to endorse the plan, because there are some parts of it that I have questions about, but to moderate a dialogue between this Administration and the medical profession.

And although the plan is complex, even complicated, I especially admire its breadth, and I thank you, Mrs. Clinton, for raising all of the issues so that no matter what finally emerges from the national debate and the legislative process, you have forced us to deal with all of the issues, medical, financial, legal, public, and personal, as well as our responsibility for taking charge of our own health.

No matter what any of us here today think about some of the plan's particular points, we all owe you our gratitude and our admiration for placing the issues and the ethical imperative of health care reform so clearly before us. Thank you very much. (Applause.)

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MRS. CLINTON: Thank you, Dr. Koop. (Applause.) Thank you. Thank you. Thank you very much for your continuing assistance in carrying the message behind the President's initiative as to why we need health care reform and how this issue affects nearly every other one with which we deal in our personal lives, at our community and state levels, and certainly nationally.

And I am delighted to be back at Dartmouth. It's a real treat for me. I heard President Friedman say that this was my second trip to Dartmouth, and that's only because he doesn't know about the ones I used to take when I was at Wellsley, and it's just as well that he doesn't. (Laughter.) There are some things that need to remain just behind the veil of history. But I did actually go to one winter carnival in the old days.

I am also very grateful to the Dartmouth Medical Center, the Dartmouth Hitchcock Hospital and all who were part of giving me an extraordinary morning by touring the medical center and visiting with a number of those who are on the faculty and working there.

And I am also grateful to the medical societies of New Hampshire, Vermont, and Maine for extending invitations to as many of you as are here today and to the extraordinary efforts that are connecting us by satellite and other means with other sites throughout those three states as well as around this campus.

And I want to thank Dr. Koop for arranging that some medical students can be here as well, so that we have the entire continuum of the medical profession represented, and I am delighted that so many citizens were able to join us, too, because this is an issue that deserves the broadest possible national discussion.

There isn't any one perfect answer. There isn't any clear direction that will come as an epiphany to all who worry about the access of our citizens to health care, how we finance health care, what the future holds if we do not move now to deal with some of the problems that are looming as we look on the horizon.

And what the President believed when he set forth on this mission to create an opportunity for us to reform our health care system is that we needed to preserve what works, the finest medical care available anywhere in the world for those who are able to access it, and to fix what doesn't work

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and what, if left unfixed, could undermine the extraordinary successes that we have come to take for granted here in our country.

So, to that end, he put into motion this process that we have been engaged in now since January, which has resulted in legislation being presented to the Congress and which, even more importantly, has created this atmosphere for national discussion.

I want briefly to describe some of the primary features and some of the reasons that lie behind these features of the Health Security Act. There will certainly be many conversations that will be held, formally and informally, in the months to come, and we earnestly urge that people educate themselves to whatever extent possible about the problems and about the proposed solutions.

To that end, there has been published this small volume called "Health Security, the President's Report to the American People," which I would urge you to find a copy of in the local library, in the college library, where I will be presenting some copies later, and in bookstores, because in lay person's terms it does describe the history of some of the features of our existing system that have led to some of the difficulties we are attempting to resolve as well as a description of the President's proposed remedies.

When the President delivered his speech to Congress, he set forth six principles that he said should govern the direction of health care reform. The first of those was security, and the reason that was the first and foremost principle is that this debate about health care reform is not only about those among us who do not currently have health insurance.

It is about all of us because in today's current climate and in today's existing insurance market there is not one person in this auditorium who can be sure that he or she will have health insurance this time next year at a price comparable to what you have today that will cover what you think should be covered and will enable you to exercise whatever degree of choice you want to over who will deliver health care to you.

The reason for that is that our current insurance system has developed over a number of years from the original idea of health insurance back in the late 1930s when the blues began as a way of insuring a community, providing a large pool

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in which everyone was paying into that pool and would receive insurance, to a system now in which hundreds and hundreds and hundreds of health insurance companies compete for your health dollar and do so by putting you into groups in which they can maximize the amount of money they can make out of you.

Therefore, we have preexisting conditions. We have lifetime limits. We have the features of health insurance that today have rendered every one of us, whether we are insured or not, insecure. Furthermore, the idea of health security means that you will always have insurance that is guaranteed, that will provide you a set of comprehensive benefits that is portable. If you move from New Hampshire to Vermont, if you lose a job or take a better job, if your child becomes ill or is born with a chronic condition, you will still be insured.

That is what real security will mean for all Americans, and to that end the President has said that many features of the plan he sent to Congress can be improved upon, can be amended, can be changed, but it is absolutely non-negotiable that we reach a point in this country soon in which we provide health security, which means comprehensive benefits for every American that will always be there for all of us.

That will provide the kind of security that will not only reassure us as patients, as consumers, but begin to provide professionals with the kind of steady reimbursement that now is not available to you as well as eliminating the costs that you are bearing unrelated to the delivering of care, because the second principle, which goes with the first, is that by providing a comprehensive benefits package to every American which sets forth those insured benefits we are all entitled to, we will simplify the system we currently have dramatically.

We will no longer have what has been the trend of the last decade, hospitals hiring four clerical workers for every physician they could afford to hire. The percentage of physicians' disposable income going to overhead costs increasing from approximately 20 percent to nearly 50 percent in many regions of the country; hiring people in your offices or in your billing departments whose sole function is to argue with insurance companies about who pays or what and what the kind of billing codes you have to understand are in order to be reimbursed.

Moving toward a comprehensive benefits package will enable us to move toward a single claim system, will enable

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you to throw away the thousands of pieces of paper that you as a patient or you as a professional are now subjected to. There is no reason why we have to have the most complicated system for reimbursing you who provide care for medical care in the world.

In fact, whenever anyone says to me, "You know, the President's proposal sounds kind of complicated," I always ask back, "Well, would you describe for me how our current medical system operates? Tell me who is covered under what circumstances, for what period of time. Tell me how you are paid for the services you deliver, and just describe for me what we currently have." We could not have designed a more complicated system, one that, unfortunately, makes it possible for too many dollars to be diverted away from patient care to paperwork.

The third principle is savings, and it goes along with the first two. There are enormous savings to be realized in our health care system that have absolutely nothing to do with ensuring quality of care. Some of the pioneering work about how we can make changes and how we deliver health care has been done right at this medical center.

The work that Jack Wenburg and his colleagues have been doing has been pioneering work, demonstrating there are significant differences in costs in regions of our country where we are performing the same kinds of procedures on the same kinds of patients with the same kinds of outcomes but at vastly different costs.

So, we know that there are savings if we change the behaviors of both our patients and our professionals. We also know that there is waste and fraud and abuse which is in large measure fueled by the complexity of the system. I spoke to a large group in Washington a few weeks ago, and a physician in the audience stood up and said, "You know, I agree with the direction of what you are trying to achieve. I just worry that there will always be a way to beat the system."

Well, there probably always will be, because there will always be people who wake up every day rebellious enough to try to figure it out. But at least if we minimize the complexity of the system and provide better information about practice styles and choices, we are going to realize significant savings.

The fourth principle is quality which, of course, has to be the primary feature that drives what we intend to do

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with medical care in the future. Right now, we are beginning to understand more about quality outcomes, and we are beginning to appreciate how important it is to have information that can be shared widely so that both patients and professionals can make better decisions as to what kinds of quality outcomes are likely to be enhanced if they make different choices.

Quality will be enhanced in the President's proposal in several ways. We will be asking that information be reported so that patients, consumers will be able to make choices based on better information about health plans and providers. We will be funding more research, both basic and applied, so that we can continue to build up our research capacity in this country and hope to be able to find answers to many of the problems that we think are within our reach for solutions. So, quality will be a primary emphasis of this plan.

The fifth principle is choice, and there has probably been as much misinformation about this feature as any one in the President's plan, because what this plan attempts to do is to increase choice which, on a daily basis, is decreasing within our medical system.

If any of you are familiar with the trends in employer-based insurance and the desire on the part of many employers in partnership with insurance companies to try to cut costs, then you know exactly what I am referring to, because most of my friends who are physicians and hospital administrators around the country report that almost on a daily basis patients call up and say their employer has made a different decision about who will be the insurer this year, and they are no longer permitted to go to Hospital X or see Dr. Y.

As we sit here today, choice is decreasing in a frantic effort to try to control costs, and the ultimate feature of this system is to guarantee that we will have choice if we pass health care reform, because under the President's proposal, every health region -- we call them alliances; they are like purchasing cooperatives -- that will be established will have to guarantee choices to patients, and there will always have to be guaranteed a fee for service network, the familiar way that many physicians still prefer to do business, but which will become increasingly difficult to maintain in the face of the kinds of changes that are currently going on in the health care system.

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The only guarantee that you will be able to continue a viable fee for service network is in the President's proposal because it will be guaranteed legislatively. This is an important feature because, as things stand now, it is appropriate to give patients, consumers the choice as to whether they wish to have a health plan that is an HMO or a PPO or some other form of network or whether they choose to obtain their services through a fee for service network.

And what we are attempting to do is to take that fundamental choice away from insurance companies and away from employers, whose primary desire is controlling costs, and put that choice where we think it belongs, in the hands of the consumer, so it will be that person who chooses, and then to give more choices to physicians so that instead of being discriminated against by various forms of health care delivery you will have more choices as to how you choose to practice.

And the final principle is responsibility, and this ranges all the way from personal responsibility, asking that all of us take more care of ourselves, to the kinds of public health issues that Dr. Koop alluded to that have to do with violence, and crime, and teenage pregnancy, and our high rates of AIDS and other preventible diseases. But it also has to do with how we will pay for our health care system.

If we believe, as the President does, that universal coverage is necessary for two reasons, first, because in the absence of insuring everyone, we will continue to have shifts of costs from payers, one to the other, we will continue to have far too much uncompensated care that will then be paid for either by increasing health insurance premiums of those of us who are insured or increasing taxes to pay for the public programs, so that universal coverage has an absolute economic imperative to it that cannot be ignored if we ever expect to provide both security and cost containment, and, secondly, it is an imperative because it is the right thing to do, but if you believe that universal coverage is right both economically and on human and moral grounds, there are really only three ways to ensure that such coverage is always there for everyone.

There is the option that some have proposed of a single payer system in which a tax would be dedicated to pay for all health care, and there are many strong proponents of that approach. And the goal of universal coverage which that approach supports is one that is embraced in the President's proposal, but that means of paying for it is not. The second potential way for paying for universal coverage is a way that

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has been proposed by some, most notably Senator Chaffee in the Senate, and that is through what he calls an individual mandate, much as what we do now with auto insurance in some states.

Individuals would be required to obtain health insurance in a hopefully reformed insurance market, because it would be impossible under current conditions for those without insurance or those who have some contribution from their employer to afford health insurance as it is currently structured.

That is an important step forward in the debate about universal coverage, because it recognizes that in the absence of a requirement that people take that responsibility to be insured, we cannot obtain universal coverage. The problems with it, which we are discussing with its supporters, is that we would fear it would undermine the existing employer-based system through which 100 million Americans currently are insured.

If there were a federal mandate that individuals had to be insured but not that employers had to participate, we would worry greatly that employers would drop health insurance for their employees, putting more employees into the pool of those who would have to purchase insurance, and since this plan has a subsidy for those individuals who are low wage, we would fear that there would be a constant increase in the amount of money needed to fund that subsidy.

The third approach for funding universal coverage is the one the President decided to follow, and that is to build on what works today. One hundred million Americans are insured through their employers. By providing a system in which all employers and employees contribute, we would be doing several things.

We would, first of all, be leveling the playing field between those who have taken on that responsibility and their competitors and neighbors who have not. We can walk up and down any street in Hanover or Lebanon or any town in Vermont or Maine, and we can stop and look at stores right next door to one another, and you can point and say, this employer helps provide insurance, this neighbor next door does not, but when the employee of the neighbor who is among the 37 to 40 million uninsured working Americans get sick, they go to the hospital, which is paid for by the premiums paid by the employer and employees next door.

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So we would be establishing as a basic principle of fairness and responsibility that everyone should contribute. And by capping the amount of money that all employers would have to pay, and by providing financial assistance for low wage workers and small employees, we believe, based on all of the analysis we have done, that this would be the most cost effective and financially responsible way to fund a universal health care system.

These principles which we have reached after much work and consultation with people in every state, people like Governor Dean, who spoke earlier, who has been, as a physician as well as a governor, deeply involved in health care reform, leaders like Dr. Koop and those who are here at the Medical Center at Dartmouth, and all over the country, we believe these are principles that should guide the debate for the next months.

There is a lot at stake in health care reform, yet I know that for many Americans it is also a proposed change that raises many questions and some fears and anxieties as well, but there is very little doubt in the minds of any who have looked closely at the trends in our system, at the increasing costs, at the way that larger and larger insurance companies and other corporations are taking over the delivery of health care, that the status quo is not acceptable, that standing still will not preserve what we have but continue to undermine it.

And there is also another feature at stake which was referred to earlier today in my visit at the Medical Center, and that is that health care reform will tell us a lot about what kind of people we are, what our values are, and what we can do together again to try to take a stand for a stronger, more productive America because, you know, when you talk about security you're not talking about an abstract concept.

Health care insecurity keeps people in jobs that they would leave to better themselves but are afraid to because they would lose their health care benefits. Insecurity keeps people on welfare, because if they stay there they get medical benefits. If they get off and go to work, they lose them.

Health care insecurity puts looks into the eyes of mothers and fathers that you as physicians have seen many times but I've only experienced in the last months. I don't know how it must be on a daily basis to be told the kinds of stories that I have been told, but to talk to a family, a

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well-off family living in Connecticut with two healthy children whose third child was born premature with many difficulties, who reached their lifetime limit on their insurance policy of \$1 million within the first year of their daughter's life, who cannot get insurance to bring that baby home to take care of that child in their own home because no one will insure them to provide the kind of nursing and other care that baby would need, and to realize the only way to keep that child in the hospital, in Yale New Haven Hospital was to put her on welfare.

Or to talk to the small business company owners, a young family starting off in Boston who had good jobs but wanted to follow the American dream and start their own business. So they did, but they can't afford insurance because small business is more discriminated against than any sector of our economy.

And I'll never forget that mother looking at me and saying, "I had to tell my sons that this year they couldn't go out for sports because if they got hurt we couldn't afford it."

Or, finally, to be at the Rainbow Babies and Childrens Hospital in Cleveland, Ohio, as I was about two weeks ago and to talk to a group of parents whose children have chronic problems that range from leukemia to cystic fibrosis to cerebral palsy, and to have the mother of two young daughters with cystic fibrosis and a healthy, good-looking 10-year-old son say to me that they had tried everything they knew to get insurance for their daughters, but their father, who was a small businessman, had always helped to provide insurance for his employees, and if he put his own daughters on his policy he could never do that for the rest of his own family, let alone his employees.

But they kept looking until finally, one day, sitting across from an insurance agent, they were told, "You just don't understand. We don't insure burning houses." For this mother to look at me and say, "How would you feel if there but for the grace of God it was you and your daughter, and somebody referred to her as a burning house?"

I can't even imagine how I would feel. But I don't think it's right that anyone, anyone in this country should have to feel that. We have too much to offer. We are on the brink of breakthroughs and medical advancement and research, and we need to begin to do what we know is right, to have a health care system that works for everyone and that gives us

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all the security that we deserve to have. Thank you all very much. (Applause.)

DR. KOOP: Let me tell you what's happening right now. What you see before you is being televised to an overflow room down the hall, and to four sites on the campus at Dartmouth. All of the television sets at the Dartmouth Hitchcock Medical Center are carrying what you see, and this is also available by satellite and is being picked up by the majority of hospitals in Maine, New Hampshire, and Vermont.

I'm going to ask several questions of the First Lady, and then we'll take questions from you. The microphones are in the aisles. But I ask you not to make great big long lines because then you obstruct the view of the people sitting behind and on both sides of you.

The questions that I have to ask of the First Lady today have all come from part of this country up here where physicians are practicing in a certain amount of doubt and uncertainty. And the first two questions that I'm going to put to the First Lady, I'm going to do so in the very language that I received them. And I do that because it expresses the situation so well and it represents what so many of you have told me.

So, Mrs. Clinton, here's number one. Many primary care physicians feel a great ethical conflict as the gatekeeper in which managed care systems put them. That is, we are no longer in the unambiguous position of patient advisor and advocate, but find ourselves also being expected to save the insurance companies' resources.

Indeed, to make it worse, we are given a financial incentive to save the insurance companies money, a situation that is virtually never understood by our patients. How much does it concern you that the system you are advocating threatens the very foundation of a trusting relationship between physicians and patients?

MRS. CLINTON: Well, I think that's an important question, and it is one that physicians are concerned about because of what has developed in the last few years under the title managed care, and I don't think there is any doubt that, as with everything else, there is good managed care and bad managed care, and in many of the examples that I have been told about, primary care physicians have been put in a situation of being a so-called gatekeeper more for financial reasons than for the kinds of services that we want primary

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care physicians to be providing.

We have tried very hard in this plan to avoid that kind of result, and we have done so in several regards. We place a very heavy emphasis on primary and preventive health care and are doing what we can to elevate the role of primary care physicians in several ways.

First, through the comprehensive benefits package that is included in the President's plan, there is primary and preventive health care outlined that will be covered under insurance, and there will be a greater rate of reimbursement than currently exists under the public health plans of either Medicare or Medicaid for primary and preventive health care to generalists who have been identified in the plan.

We want to begin to reeducate patients about the importance of primary care. We want patients to utilize the kinds of service that are only available at a primary care physician level.

At the same time, we want to change the incentives in the system that drive too many people in it now to make decisions that are based more on the reimbursement method than on what is best for the patient. We want to eliminate the interfering relationship that currently exists in which insurance companies basically have to be asked for permission by physicians as to whether tests or procedures should be performed.

Now, how is the best way to do that? We think it is by moving more of our dollars in health care into more organized delivery systems so that physicians are calling the shots, not insurance companies and not government bureaucrats, which is exactly what is happening now and, left unchecked, will happen increasingly so in the future, even in rural areas.

So, we think that instead of the kind of gatekeeper mentality that exists in some managed care systems now, what we are advocating is an elevation of the role of the primary care physician to full partnership with the specialists where, in fact, the relationship between physician and patient will be enhanced, and the autonomy of the physician will be increased. That is the goal that we have, Dr. Koop.

DR. KOOP: The second question, Mrs. Clinton, touches somewhat on your answer. Recent years have seen a mass movement from small, rural, private practices to complex

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organizations, a movement fueled not by a perception that these organizations will provide better medical care, but, rather, by the reality that these organizations are better prepared to deal with increasing administrative hassles and frustrations of regulatory programs such as CLEA and OSHA, Medicare paperwork, and the complexities of multiple managed care programs.

The question really has three parts to it. Do you feel this restructuring of primary care practice is desirable for medical care, or undesirable but inevitable, or undesirable but not inevitable? (Laughter.) If you agree with the latter, how would you hope to reverse the trend?

MRS. CLINTON: I like those questions that end "All of the above" or "None of the above." Those were always the ones I checked on standardized tests.

I think that left unreformed, the mass movement you refer to by which practices are being bought up, hospitals are being merged, insurance companies are determining who patients can seek care from, will continue at an accelerated pace. I think that's absolutely what will happen. I don't think that is desirable. I do not think that is the direction that we want to move in, but which we will if we merely accelerate the existing forces that are currently at work.

I don't think that the kinds of decisions that many physicians are feeling pressured to make primarily on a financial basis are the ones that they should be driven by. I think there is a tremendous opportunity here for physicians and hospitals to form themselves into networks, either preferred provider organizations or fee for service networks or variations on health maintenance organizations in which physicians call the shots, not insurance companies.

And one of my fears is that because of a really fear on the part of many physicians who are themselves not sure what is going to happen in medicine, they will be unwilling to work with each other and with themselves to form multi-specialty clinics, to create the kind of networks that maybe are spinning out from medical centers that already exist.

So that the decisions will be made by professionals, not by business people. That is what my preference is. So in this plan we have money that we would target to physicians to help them to compete with insurance companies, to create networks so that they could be in a position to form health plans that could then try to get the business in a region, and

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I hope that the trend that you describe which is currently going on we can try to overcome by moving on reform now and giving more authority over your practices back to physicians as opposed to what is currently going on in the marketplace.

DR. KOOP: I think the First Lady has made a wonderful point. That is that many rural physicians who practice alone feel that they are now isolated and abandoned. Actually, the President's plan empowers them to join with other like-minded people, and then deal with the alliances that are provided for in the President's plan. In other words, I think for the first time in a long time such people can call the shots in a way they never could before.

MRS. CLINTON: That's right.

DR. KOOP: The next question has to do with managed competition, and, naturally, coming from here, the question is, how will managed competition work in a sparsely populated region like northern New England?

MRS. CLINTON: Well, there are several ways it will work. First of all, Dr. Koop referred to the alliances, and let me just spend a minute talking about these, because I think there has been a considerable amount of misapprehension about what these are intended to do.

As many of you know, in more populated areas, large employers are beginning to call the shots in the health care system of a region, and they are able to do so because they have purchasing power, and they are doing it at the expense, many times, of physicians who are eliminated from the plans which they decide to sign up for, and they are doing it at the expense of smaller businesses that cannot compete for a discount the way the large businesses do.

In several parts of the country, though, we have seen how large groups of individuals coming together are able to get the same kind of price discounts that only the largest employers have gotten for the last several years. We believe that by creating such a purchasing co-op, which we call an alliance, we will enable small businesses, self-employed, and all other individuals in a region to join together in order to get the discount on price that would not otherwise be there for them.

This has only to do with financing health care, nothing to do with delivering health care. This is not to regulate how you decide to deliver health care in a region.

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It is to try to get the maximum purchasing power.

Now, the plans that will be formed in a region will then compete for the business of those individuals who are enrolled in an alliance. So let's take New Hampshire as an example. New Hampshire might set up one or two or three, whatever they decide -- it's up to each state -- how many alliance areas they would need, one alliance, two alliances, whatever was best for you.

That would mean that the people living in a certain geographical region, through their employer, just as they do now, the employer would make a contribution to the cost of health insurance, as would the employee, but instead of it going to a particular insurance company who has come around trying to get your business, it would go into the alliance and then individual health plans, you know, the Northern New England Health Network, the Dartmouth Hitchcock Health Network, the ABZ Health Network, however they were defined, consisting of the physicians and hospitals in the region, would send out information to everybody enrolled in the alliance, and every year each of us would sit down and decide which plan we were going to join this year.

Now, you know what is the closest analogy to this? It's how the federal government takes care of federal employees. This is how your Senators and Congressmen get their health care. The federal government as the employer puts in 75 percent of the cost. The individual employee puts in 25 percent of the cost.

The federal government then holds that money, and it goes out into the marketplace, and it says, "Everybody who wants to bid on federal employees' health care, send us your information and we'll let you all bid, assuming you're qualified," and the qualifications have to do, are they capitalized enough, are they honest, you know, but it doesn't have anything to do with what kind of delivery system they are promoting, and then every year everybody from the President on down to somebody working here in New Hampshire for the federal government gets a bunch of information.

And they sit down, and they say, "Well, this year I think I'm going to go join up with Health Plan X, because I heard from my sister that that was a good one, and that's the one I want to belong to." Or, "I like this information about what they're doing for children in Health Plan Y. I think that's the one I'll join up to."

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So, in effect, what we are doing in rural areas is saying that if you are in the alliance area, as you would be, then you have to have services available, and rural physicians will have the opportunity to do one of several things. You can be part of a fee for service network. I could imagine the New Hampshire Medical Society organizing that for you. And you would then send out information to everybody enrolled in the alliance with the benefits of the fee for service network, but there might be other competing forms of delivering health care, but there would have to be at least three health plans in every alliance.

And what we are excited about when it comes to rural health care is that for the first time there will be reimbursement for you that will be available and stable. We will be folding in the Medicaid recipients into the universal plan. Their rates will be there, and the uninsured will be paid for, and there will finally be a stability to the funding in rural areas that has never been there because we are also going to be raising some of the rates that have been too low for the delivery of health care in rural areas.

And then, in addition, we have got incentives in there for all kinds of technical assistance, all kinds of opportunities for you to link up with people in specialty areas, in larger communities. So, we actually believe that if you look carefully at what's in here for rural practitioners, this will be a big step forward both in ending professional isolation, in providing a steady stream of reimbursement, and in giving you tools to take care of your patients that have not been available to you before.

DR. KOOP: I will now stop representing the rural physicians in this part of the world and ask you a question from the physicians at the academic medical center that you visited this morning. How will an academic medical center like the Dartmouth Hitchcock Medical Center be affected by the proposed increase in the training of primary care physicians and the consequent decrease in specialist training?

MRS. CLINTON: Well, it is true that if you look at our current distribution of physicians in the country, we have approximately 70 percent of our practicing physicians who are specialists or subspecialists and approximately 30 percent who fall into the primary care physician categories.

And the situation among medical students projected out over the next 10 years is that left unchanged, we will have 85 percent of our physicians being specialists and

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subspecialists and only 15 percent being primary care physicians.

Clearly, that is not a good outcome to provide health care to the entire population in a cost-effective manner. Part of the reason we have so many specialists is that we have paid to have those specialists. The Medicare program for a number of years has funded graduate medical education and has funded the training of specialists and subspecialists.

We are going to be changing that to provide more funding for primary care physicians, and most academic health centers that I have spoken with are aware of the need to increase the supply of primary care physicians and are already taking steps on their own, and this will further that change.

And in most areas of the country, for most specialty areas, there will not be a shortage. In fact, Dr. Koop told me the other day in a group of physicians with whom we were speaking what the numbers of specialists would be out in the year 2010, I believe, if we never trained another one in certain categories. They would still be in abundant supply. So, we don't worry about diminishing the supply of specialists, but we do believe we should increase the supply of primary care physicians, and this plan provides an opportunity to do that.

DR. KOOP: We will now take questions from the audience at these two microphones, and this is a good time for me to say something that I think is appropriate.

People tend to compare what they think that they have now with what they think they will have with the President's plan. I would suggest that you compare what you have now with what you will have in three years or five years if there is no health care reform. I think it's far worse. Over here, sir.

Q I'm John Mark Blowen, president of the New Hampshire Nurse Practitioner Association, and I want to say that we as nurses applaud and support yours and your husband's plan and efforts. Many studies have shown that nurse practitioners can and do provide high quality cost efficient care in up to 70 to 90 percent of primary care situations. And we'd like you to speak to the issue of advanced practice nurses in health care reform.

MRS. CLINTON: I certainly will. We envision an

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expanded role for advanced practice nurses in primary care and hope that we can accomplish that in the near future because certainly it is going to take some years to train and retrain a sufficient number of primary care physicians, but with a system in which we are trying to prevent problems and deal with them before they become costly in either human or economic terms. We see a great opportunity to use advanced practice nurses and have provisions in the bill to do so. So that is something we are committed to doing.

DR. KOOP: Sir?

Q Hi. I'm Bob Santulli. I'm a psychiatrist here at Dartmouth, and I also want to say I have great respect and admiration for much of what you are attempting to accomplish. I do, however, have a lot of concern about what appears to be rather discriminatory limitation of coverage for patients with psychiatric illness and, in particular, those with severe psychiatric illness, and I understand that there are recent plans for perhaps even limiting that coverage still further from what was originally proposed.

And I know that there is talk about eventually increasing psychiatric coverage to a parity with that with other medical illnesses, but I think many of us in our field have great concern that that is not likely to happen. And I am wondering if you could talk about the rationale from a health care point of view, aside from just a financial point of view, for offering different coverage for severe psychiatric illness compared to other forms of severe medical illness.

MRS. CLINTON: Well, I'm glad you asked that, because there's been a lot of confusion and anxiety about the mental health benefits that are included in the plan, and I'd like to try to clarify, if I could, because we, of course, think that including mental health benefits as part of the comprehensive benefits package is an enormous step forward for mental health. To require that they be made available is, we think, the first step toward eliminating the stigma and the disparity in treatment that mental health for too long has received.

So, the first point I would make is that we will provide all Americans for the first time coverage for mental illness and substance abuse coverage, and for those Americans who are most seriously ill, there will no longer be a lifetime dollar limit on what their insurance will cover for the treatment of mental health and substance abuse.

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That is another remarkable step forward, because in our survey of all of the plans that we're aware of, even the best benefits package under current insurance often provided like a \$75,000 lifetime limit for a schizophrenic. I mean, that was not acceptable in terms of treating the severity of the mental illness.

What we have tried to do is to start by focusing on those people who need help because of severe and chronic mental illness. We think that's the place to start. And we also believe that by working to try to provide the flexibility that we have in the plan, it will actually enhance the treatment for those who are chronically ill.

For example, the mental illness and substance abuse benefit will give you, as a psychiatrist, and other health care providers the flexibility to tailor their treatment to an individual's needs, and the option of providing up to 120 days of intensive nonresidential treatment represents a new direction in coverage for mental health and substance abuse.

So, we are absolutely committed to covering mental health, because we think it makes good sense for the individual as well as for the system. The bill does not cut the hospital stay in half, contrary to what some people are saying. Up to 60 days is still available for patients who are a threat to their own lives or the lives of others, or if they need to initiate or adjust their medication or receive some other necessary treatment.

There was never a 40-day limit on anything in the plan and there is not now. So, I think that there has been some real misapprehension about what is available. And I know that in particular in New Hampshire there's been some concern that somehow this would disrupt the community-based treatment model that New Hampshire has built up, and actually we see it just the opposite. We see it as enhancing the utilization of that model.

So, we would be glad to have you and others concerned about mental health speak directly to some of the experts who put this together to explain what we have in the plan and how we believe it will work because we consider it a rather significant step forward on behalf of mental health.

DR. KOOP: I am pleased to see that some people are staying on the other aisles, and so, in the sense of fairness, sir, if you would go four from the end in that aisle, and you would go three from the end in that aisle, everybody can see.

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You, three from the end in that, four from the end, you three from the end there. No. You what?

Q I was in the line when I was asked to come down here. I was already in the line. (Laughter.)

DR. KOOP: I am still going to take her first. You can stand there as long as you want until I recognize you.

Q Sir, I was in line. It was my turn.

MRS. CLINTON: Yes, they are lining up over there, Dr. Koop.

Q I was told to come up there, and then come down here. All right?

DR. KOOP: Thank you.

Q All right.

DR. KOOP: Come on back. (Applause.) That's the second time I've been wrong this year. (Laughter.)

Q Well, Mrs. Clinton, it's so exciting for me today to see hundreds of people lining up to you. Having met President Clinton for the first time in Larry Radway's living room at a coffee klatch I find that being on the bandwagon all along is great, but I'm a little nervous now, especially as I was almost asked to sit down. (Laughter.)

DR. KOOP: You made a pretty good speech. Go ahead. (Laughter.)

Q My friends know the only thing I can tell -- I was so impressed to hear a speech without notes. I can't even ask a question. I can tell a joke without notes, but the question I would like to ask is; under Title 5 there's been a traditional public health responsibility to provide services to vulnerable populations such as low income women and children with special health needs.

The draft of the present health care reform plan, as far as I know, calls for phasing out of Title 5, and my question is, how are these children especially going to be provided the very comprehensive and intensive interventions they need under the present plan, especially for the low income families?

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MRS. CLINTON: Right. We are continuing a lot of the services that are referred to generally as Medicaid wrap-around services for the non-Medicaid eligible children, because we recognize that need. We are also continuing and providing a stable funding base for public health, because there will continue to be a public health necessity for a lot of services that will be better suited to be delivered in that context by public health facilities.

Let me give you an example. I had a large group of physicians and nurses and hospital administrators and business leaders from a large city in Ohio who were in to see me, and what they've been doing in preparation for this, in trying to create this health plan that I mentioned before, is coming together with the medical society and a couple of large hospitals and beginning to create these networks.

And they have partnered with the public health facility, the community public health facility, because they know that if there is an alliance in that area there's going to be funding in that area for the first time to take care of these vulnerable populations, and so they really see an economic, again, as well as an ethical reason to partner with the public health facilities.

So we intend to maintain public health. We intend to fund public health for the reasons that you imply, because there are populations that are going to be better served there, but now that everyone will carry with them reimbursement, there will be some populations who will not rely on the public health system any longer.

They will go to your offices, and they will have money to pay you, and they will go to the hospital, and they will have money to pay the hospital, so that we don't know yet how broad a public health infrastructure we need, but we intend to keep funding it and then watching it and seeing how much we will require as we move toward universal coverage.

Q I would like to ask a question very much apropos of what was just said. It has to do with the same subject of special needs children. The plan, as I understand it, says that there will be provided treatment for 60 days as long as a child is improving. Now, there are a million children in this country who will never improve, and you fight day after day after day just to maintain them where they were and keep them from sliding down. Something has to be done about that. Are you all aware of it?

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MRS. CLINTON: Yes, we are aware of it, and we thought we had made adequate provisions in that, and several experts have pointed out some additional things that need to be added, and we are looking at that.

DR. KOOP: Yes, sir.

Q I have often heard the contention that primary care will save us a lot of money in this system as opposed to specialty care, and I'd like to know what the actual data base that that statement is based upon and specifically how it corrects for complexity and severity of care, and, most importantly, with regards to treatment outcome.

MRS. CLINTON: Well, I can't answer that in 30 words or less, but we'd be glad to give you a very detailed description of why we believe preventive care will save us money, and let me just give you a few examples. We know now that a large portion of our population, mostly the uninsured, but not only the uninsured, use the emergency room as their primary care physician.

They enter it late, and they get the most expensive care available for matters that anyone, specialist or not, would agree are not emergency room kinds of treatment. Providing primary and preventive care in the comprehensive benefits package will enable millions of Americans to seek appropriate care for the first time.

Providing insurance policies that will pay for the mastectomy but not the mammography, will pay for the hospitalization of the child but not the well child exam will save money, and there is a ream of cost benefit analysis to that point.

Now, your question implies another question which I often get from specialists, which is, yes, but many primary care physicians may not recognize the severe or complex treatment need that is presented to them by their patient, and is it really cost effective to go first to the primary care physician before going immediately, self-referred if you will, to the specialist?

And again, I would only say that if we have a system in which every American has insurance coverage, and we get Americans to begin to recognize the importance of preventive care, and we get an adequate supply of primary care physicians who know what their jobs are and don't keep patients because that's the only way they can get paid, inappropriately, I just

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don't think that that's going to be the kind of problem that I know many specialists are concerned about.

But we certainly have more than adequate documentation to support the cost benefit of having us move toward more primary care and getting it as early as possible in a person's life, namely, prenatal and early childhood.

DR. KOOP: Sir?

Q Hello. I am Wallace Goode. I am vice president of the Franklin County Medical Society. And we are predominantly a private, solo, small practice group of practices in a relatively poor county on the Canadian border of Vermont, and we care for our patients regardless of their ability to pay, and we work with them financially if they have need.

Our major concern about the corporate integrated networks of managed care, which is one of the centerpieces of the reform package, is that we personally experience that concept now through HMO's, that is, health maintenance organizations. We find that the greatest deficiency that an HMO has is eliminating, limiting, effectively restricting charity patients, uninsured patients, and government program patients such as Medicare and Medicaid from their rolls.

As these corporate systems contract with employers and employees for care, and putting us out of business, who will be left to care for these populations that they don't take care of, which in our county is over 50 percent of our patients?

We suggest the creation of a mechanism that assures that an integrated system of care is required to accept, enroll, and provide the same quality care for at least the same percentage of these populations as for the working and employed persons that they enroll that are residing in a given area, maybe even by zip code.

MRS. CLINTON: Well, let me assure you that the situation you just described, and your legitimate concerns about it, is absolutely accurate today but will not be so after reform. You will no longer have different populations of patients coming into your office. There will no longer be a program called Medicaid. There will no longer be the uninsured. Everybody will have this health security card, and you will not know whether their payment is 10 percent their employers, 80-20 employer-employee, a discount for small

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business, primarily government-supported because they would have been Medicaid eligible under the old system.

So, we are doing everything we can to eliminate the very difficult problem you have just described, which has led to massive discrimination against certain populations of patients, and you also will no longer have to hassle with all the different forms. I mean, many physicians and HMOs as well try to eliminate from coverage people who have complicated reimbursement issues as well as chronic or other difficult problems associated with poverty.

That will be outlawed. There will not be any opportunity to do so, and there won't be the incentive, because everybody will come with a reimbursement stream. So, I believe that we have provided the answer to what is a very distasteful situation for many physicians in the situation you have just described.

DR. KOOP: Sir.

Q (Inaudible.)

MRS. CLINTON: Well, the transition we're going in state by state, so that when New Hampshire is ready to provide universal coverage to everyone, New Hampshire goes in, but it has to be ready, assuming we pass the legislation next year, by 1997. So, if Vermont gets a little bit of a jump start because they've done so much work under Governor Dean, they might be in a year or so before New Hampshire, and every citizen will be in. Nobody will be left out as they move in toward the universal coverage.

Q Hello. My name's Mark Reed. I'm a psychiatrist here at Dartmouth, and I have a couple of questions about the mental health coverage, and I appreciate your presentation today and giving us the opportunity to interact with you.

One concern is the yearly limits on mental health coverage, whether it's 60 days for inpatient or 30 days for outpatient, and what do we do with our patients who continue to be very depressed, psychotic, or suicidal and need treatment?

The second one is that partial hospitalization for substance abuse treatment or, if we want, continued outpatient care are available but they are available in a tradeoff. You can get two partial hospitalization days for one inpatient day. And what this requires us to do with our patients is to

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predict the future, and while many of us are good, we are not that good.

And it's going to put us in a challenging position where we may find ourselves running out of benefits towards the end of the year, and I wonder if you can help us figure out how to struggle with these issues.

MRS. CLINTON: I cannot help you. I am not an expert on how you are going to be able to make those decisions. The reason we have come to that point, though, is because this plan is not providing everything everybody wants, contrary to some folks' claims. We think this is a very solid, 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 mental health benefits as we would like to see included.

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

Is it what everyone would want were they to wave a magic wand and we had 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, because you have lots of people without insurance who have problems. You have lots of people with lifetime limits who have problems.

We are providing a base level of benefits that we think is a very good start, but we have not been able to do all that any would want us to do, and that's part of the continuing challenge that we will confront, but I think we've got a very good beginning on mental health benefits. Thanks.

Q Hello, Ms. Rodham Clinton. My name is Carlos Montegrillo, and I'm an attending psychiatrist at New Hampshire Hospital. But I don't have any mental health questions. I am also an assistant professor at Dartmouth Medical School. I'm much of a supporter of your plan, and I applaud the leadership that you and the President have demonstrated in resolving this national tragedy.

My question specifically asks you to focus for a

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moment on the hospital accreditation and certification process administered by HCVA and the Joint Commission. I am aware that in the report, the health security report to the people you mention the need to simplify the accreditation process and remove duplication and so forth.

However, I see little reference made to the enormous waste of precious resources in keeping up with standards that set by HCVA and JCHO that, in my opinion and in the opinion of most of my colleagues are, at best, irrelevant to the clinical care, clinical practice and quality care, and at worst are demoralizing and destructive forces in the fabric of good clinical care. (Applause.)

I entered the field of medicine and public psychiatry with a pledge to help those in need and in pain, and because of a belief that I could make a difference in the lives of my patients and in our community. However, I am sad to report that the clinical practice today leaves me in a situation where I spend most of my time treating the chart and very little of my time treating those I pledged to care for.

MRS. CLINTON: That's exactly right, and that's why we need to reform this system. And it is so interesting to me, you know, to look at the ways that the federal government has tried to control health care costs in conjunction with accrediting agencies and others over the last 12, 15 years. They have increased micromanagement. They have increased regulation. They have removed discretion. 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 principally 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 paid on the basis of the procedures you perform, the diagnoses you report, and how you then code your bills so that you can get the maximum by bundling as many together as possible.

And that is not a reflection on any physician. It is how the system works and drives you to make these decisions. That has not worked, and it has been done by Democrats, it has been done by Republicans, it has been done by conservatives, it has been done by liberals, and it has been a disaster.

And so, instead of increasing the micromanagement,

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trying to figure out how to be more and more refined, and hiring more and more people at HCVA to interfere more and more with you, to try to control volume while we decrease price, which inevitably will have you, then, 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 more capitated systems, let's give you a certain amount of money and tell you to make those decisions, and let's eliminate a lot of the necessary regulation that has nothing to do with patient care or patient outcome.

But in order to do that you have to recognize you cannot continue the existing fee for service system as it currently exists without having some changes or some kind of agreement among physicians, which is why we advocate changing the antitrust laws, so that you can make those sorts of decisions, because what you have described is what doctor after doctor tells me. You spend your time as a clerk. Fifty percent of the time of nurses is now spent filling out forms. Nurses spend countless hours running around hospitals finding doctors to sign forms for procedures they were ordered to perform which they have now performed.

It goes on and on. And then you do the bills, and the bills go to fiscal intermediaries, 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, but it's going to take changes in the way you think about how your practice and how you behave with respect to the payment stream in order to bring that about, and that's what reform is really aimed at doing.

Q My name is Margaret Sidon. I'm a neurologist. And I work at New Hampshire State Psychiatric Hospital. And I am also the mother of a schizophrenic son and a member of the Alliance for the Mentally Ill. And I was going to apologize for again speaking about mental illness, but then I decided it's about time a lot of people spoke up for mental illness, the mentally ill. (Applause.)

They have been discriminated against, as you know, for centuries, and they have certainly been discriminated against as long as medical care has been available in civilized countries, and I am very appreciative, and I am very understanding of what you are doing and what you are planning in the new system. But it still discriminates against the chronic severely mentally ill.

As a neurologist, if I treat somebody with

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Parkinsonism or multiple sclerosis, I do not believe there is a limit on the number of days they can be hospitalized or the number of visits they can have to their neurologist in the community. That depends on how sick they are.

But if they have a brain disease that causes the emotional and behavioral changes that we call schizophrenia, then there is a cap on their hospitalization and there is a limit to the number of outpatient treatments they can have, and, as I understand it, there is a greater copayment to be required and a payment for the first day in hospital for serious mental illness.

Now, if that's correct, I don't understand the reasoning for it except perhaps some vague throwback to the days when mental illness was thought to be either the fault of the family or the fault of the individual themselves and so in some subtle way they need to be punished. (Applause.)

MRS. CLINTON: No, I'm sure there is that underlying sort of historical and cultural context, but it is really from our perspective much less a question of history as it is of economics. 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 private insurance plans that currently exist that include mental health.

The problem is, there has not been a lot of experience economically that provides the sort of information we need for actuaries to fully evaluate what the costs of the mental health benefit 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 mental 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 stigma, and you are absolutely right. It exists. People don't like to talk about mental health. They don't like to think about taking care of substance abusers. It does make people uneasy. But what our task is is to establish within the universal health care system that this reform plan is aiming to create the basic, fundamental principle that mental health is health.

If we can do that, that will be such an enormous

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step forward, and I regret that the individual issues as a practitioner, as a mother, as a citizen, that would lead you to feel that it's not sufficient will be there. There's nothing that I can do about that. But I think it is so far beyond anything that we have ever done as a nation that I certainly hope we're able to maintain it.

I will tell you that among the many battles we will have is eliminating mental health from the comprehensive benefits package altogether because there are many, many people in this country and in the Congress who do not believe it should be provided as a universal benefit. We are 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 with more experience about how to control costs and render good, cost-effective treatment for substance abuse and mental health.

Q Mrs. Clinton, my name is Dr. Thomas Cochran. And many practitioners and physicians practice very expensive defensive medicine and are buried under this mountain of paperwork which you refer to because of the unfriendly medical legal problem that faces the physicians in this country. What does your plan do for tort reform and medical malpractice reform for the practicing physician?

We have a series of reforms that are being proposed ranging from requiring alternative dispute resolution before any case could go to court, requiring a certificate of merit that actually certifies, which has proven effective in some states that have tried it, that a case is meritorious, beginning work on practice protocols and guidelines so that physicians will have a presumption against any lawsuit that might be brought, limiting attorneys fees.

We have tried to look at the whole range of issues affecting defensive medicine and create some disincentives in the system for unnecessary and frivolous lawsuits and to begin to provide through these practice guidelines protection for physicians so that they don't have to worry about looking over their shoulder.

I think that's ultimately the most effective way to prevent medical malpractice cases so that a physician is armed with the presumption of appropriate treatment because of the working up by the profession itself of what the practice guidelines would be if faced with a certain kind of problem.

And I think that's where the most promising area is,

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and there's money in the plan to begin and do that right away. The physicians here from Maine know that there has been some early success in trying that in Maine, and it's an idea that we want to spread nationally.

Q Mrs. Clinton, I'm Burt Richardson. I'm not a psychiatrist. (Laughter.) I am a primary care pediatrician from a semirural area of Maine, and I've been in practice for 16 years there. I have noticed over the years that what provides the most effective care and the least costly care is a trusting relationship between the parent and the pediatrician or the patient and the physician.

And something that we're dealing with right now is really a heart-rending separation between the provider, the primary care physician and the patient, and this is not at the will of the child, certainly, and not the will of the parent, but arbitrarily by the employer and the way the system is set up.

Choice is offered, but when you ask what is the choice that the employer offers, it's take this plan, which means, we can't have you as a physician or pay \$700 a year and take another plan which could include you as our physician, and that, for most of my families, is no choice.

What kind of guarantee in your health reform package do you have that a physician and a patient can maintain that relationship and through that trust save costs as well as provide really good care?

MRS. CLINTON: Well, the most important thing we have done is to shift the decision away from the employer to the individual, because what you describe is what is happening every day, where employers are posing either no choice or, in effect, such an unattractive choice that it amounts to no choice.

Under our plan, all employers will pay the 80 percent toward the health care, and all employees will pay the 20 percent. It will be taken out of their paycheck, just as now we take out of your paycheck what we pay for Medicare. I am always surprised when somebody says, "We don't want a government system." And I say, "Well, do you support Medicare?" And they say, "Of course." And I say, "What do you think it is?" I mean, it's paid for by a payroll tax. That's how you pay for Medicare.

And what we're talking about here is that you will

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have the employer make the contribution. You just add it to the things that the employer does at the end of the month or every quarter. But the individual will make the choice, and there will be at least three choices, and depending upon what the cost variations are in a region, the individual will have a full range of choosing among what is available.

Now, will some plans cost a little bit more for an employee to join? Yes. And some will cost a little bit less. But we are also trying to make it very difficult for plans to discriminate against physicians, so that you will always be able to join a fee for service network, and you will be able to join probably whatever else you want to join within your region. That will be up to 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 the discrimination that currently exists against physicians. That's the best answer we have to try to deal with what you see every day in your practice.

DR. KOOP: The First Lady is essentially indefatigable, but she has several appointments this afternoon and this evening, so your question, sir, is the last.

Q Tom Dodds, anesthesiologist at Dartmouth. I applaud your efforts and the fact that you have brought this issue to the forefront. I also applaud many aspects of your program, in particular, the impact on patient access and patient security. My major concern is regarding cost. And I have two questions with this double-edged sword.

As I understand it, each health alliance will have a budget cap. What provisions are there to see that these budget caps are not exceeded and, if they are exceeded, the federal budget going further into debt?

My second question is the other side of this double-edged sword, the degree to which the caps hold and are effective is the degree to which there is a disincentive for new technology. And are you making any provisions in the plan to ensure that what is perhaps one of America's greatest industries, medical technology and biotechnology, are not sacrificed because of these caps and disincentives?
(Applause.)

MRS. CLINTON: Let me spend a few minutes talking about this caps issue, because although it's not a question I get asked often, I know it's one on the minds of many

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providers as to how it would work.

Unless New Hampshire, Maine, and Vermont are very different from every other state in the country, it is likely that you have an insurance commissioner or an insurance department. And it is likely that that insurance department has some authority over the health insurers that do business in your states.

And every year or every other year, whatever the timetable is, those health insurers go to your insurance department and say, "We intend to raise our rates 8 percent, 10 percent, 12 percent, whatever." And usually insurance departments may argue a little bit, but in the face of what have been exploding costs for all of these years, they usually grant permission for the health insurer to go to you, the employers, 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 each 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 into the office in the state capitol and insurer Y comes in, and insurer X says, "I want to go up 8 percent," and insurer Y says, "I want to go up 12 percent," because they have many different policies, deliberately designed to confuse everybody, and deliberately designed to pick out different populations to make the most money off of them. The insurance commissioner says, "Well, how do I compare apples to oranges? I mean, I can't say that the 8 percent increase is unfair 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 everyone. 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, and if you choose to have a facelift for cosmetic purposes, you are 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

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Hampshire, Maine, or Vermont. And we will get bids, because each health plan will come in and will say, "We can provide these health benefits at this cost, so that's why we think you ought to join our health plan." And another health plan will come in and say, "We can do better than that. We can provide them at this minus that cost."

And then each individual will make the decision as to what health plan to join. And so we will begin to have what will be real experience about how much it actually costs 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 deliver 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 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 HMO or however you choose to organize yourselves, 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 starting, as we move in reform, with vastly different levels of payment around the country. And 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 always getting more money with their built-in inefficiencies in the system.

So, we have to have some kind of budgetary discipline backstop, much as what the insurance commissioner could 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 by thinking, how can we provide quality health care for the people of northern New Hampshire, or northern New England, then you 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.

So, we actually think your question, your double edge can be answered this way. Yes, we do think we need some

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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. If it is, there is a system by which it's not a big government regulation if you go over a certain level. It's like in your own business. Then you make some cutbacks. But you make the decisions about what it is. You decide.

(End of tape.)