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ABC HEALTH CARE  
BRIEFING

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REMARKS BY THE FIRST LADY  
AT HEALTH CARE BRIEFING WITH ABC

Room 450, OEOB

MRS. CLINTON: Let me thank you all for being here and for doing this with us. And I hope that it is the first of others that follow. We've been unable to have this kind of briefing until the President made the decision that he made, and we're very grateful for this opportunity.

I want to spend a few minutes just talking about the plan. And maybe you've already read a purloined copy. I just wish I had charged for them -- considerable boost in Treasury revenues.

But if I could just describe where we are and then to have an opportunity to answer your questions, and then talk about how we can be useful to you -- in this phase.

There are several general principles that are at the root of this plan that we intend to stand by. There are a lot of details that are in the process of being discussed and negotiated as we sit with people who have very good suggestions about how to make the plan itself work effectively.

But the basic principles are, we intend to reach universal coverage, and we intend to do it as soon as it is feasible to be accomplished. In our plan, that would be 1997. But no matter what happens between now and the time that we actually finish this debate and have a bill for the President, that is an issue that we have to hold to, because we feel so strongly about it.

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Secondly, we believe that in addition to providing universal coverage, it needs to be provided in a way that offers a comprehensive set of benefits for every American so that health security really means something. That is why we are not pursuing the bare-bones catastrophic approach, because what we think is important is to have a comprehensive benefits package that particularly emphasizes primary preventive health care, which has never been done before.

So the combination of universal coverage with a comprehensive benefits package will provide security for every American. And that is the bottom line of what we are trying to achieve, so that no matter who you work for, where you live, whether you've ever been sick and therefore have a preexisting condition, as they say, in the insurance market, you will be covered.

Secondly, we want to obtain savings out of the current system, because we think that the current system does not operate as efficiently as it could, and that there are considerable savings to be obtained that can either go back in the form of wages to employees because employers no longer have to pay so much, or into lower costs, whether it be a procedure or a premium for the insurance. And we believe there are savings in both the public and the private sector, and that those savings should be realized in both the public and the private sector, which is why we believe that we can obtain savings in the Medicare and Medicaid system without in any way undermining the quality and delivery of health care to the beneficiaries of those existing systems. But it goes hand in hand with obtaining savings in the private sector. We talk a lot about how the paperwork hospital has grown much faster than what we consider the kind of care possible. I mean, the last years, hospitals have hired four clerical workers for every doctor that they hire. That is because of the kind of administrative costs built into our system where people are checking one another all the time, and it doesn't translate into one more dollar or one more hour of care at anybody's bedside.

Thirdly, we want to preserve choice in the system. We want people to have a choice of health plans. That is one of the many reasons we are putting together a system that relies on market competition to create other approaches to delivering health care, so that individuals make that choice.

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Unlike the present system where employers pay something for health care and individuals usually pay something for their health care, the employers choose the health plan for their employees. We intend for the employee to choose the health plan, because we think that will make for better informed consumers, and in the long run do a better job of making everybody responsible and controlling costs within the system. So the choice is not only a principle, but it is something we think is related to making the system more responsible and efficient.

Fourth, we want to simplify this system. There is extraordinary amount of administrative red tape and bureaucracy. And one of the things that has amused me a little bit in the last couple of days are some of the people who have said, "Oh, my goodness, they want to introduce bureaucracy to the health care system." Well, we do not have a more bureaucratized system in both the public and the private sector than we do right now. We have so many layers of monitoring and accountability and micromanagement that we believe can be eliminated. We would like to move toward a single form that could be used by the public and the private sector instead of what we currently have, which are 1,500 different insurers, all of which feel that health needs their own forms. That's just one example.

We also believe strongly that we ought to stand on the idea of responsibility for everybody in the system. And that means that everybody should pay something, insofar as they are able, toward their own health care. It also means that employers who have never contributed should contribute. And we've tried to construct a financing system to make responsibility affordable.

We are requiring everyone to participate on an 80-20 proportional share. But that does not mean that an employer could not still continue to pay the 20 percent share for the employee. But the 80-20 would become the norm, which in general it is, although there are variations as to how many people pay to industries. But we want to cap the amount of money that any employer will have to pay for that employer's contribution. We want to do so at about 7.9 percent of payroll. That will realize tremendous savings for companies that are currently insuring.

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There are many companies, even small businesses, who are paying for insurance now, who will realize, we think, in the very first year, at least 15 percent in savings right off the bat. And that will, as we move the system toward a more affordable level of payment, be more extensive for certain industries.

Now, certain small business have never paid for health insurance for their employees. And I have visited a lot of those businesses, and I have sat and talked with employers, many of whom feel they can't afford it, because they are thinking about the way the current market for insurance operates. And they can't afford it in that marketplace.

But if we cap their contribution, if they are a small employer with low-wage workers and we say they will not pay more than 3.5 percent of payroll, and we will be folding in the worker's comp portion of health care and the auto-insurance portion of health care, costs you already bear, so that you will no longer bear those completely, we think this is affordable for the vast majority of businesses, regardless of size.

So those basic principles of security and simplicity and savings and choice and responsibility will finally, we think, enhance our last principle, which is quality. I mean, we are doing this because we think it will improve the quality of care for everybody.

Right now we have very uneven patterns of practice around the country. We have many millions of people without access until the last possible moment, at the most expensive point of entry, the emergency room. We have very little emphasis on primary and preventive health care, which we think is good quality and saves money. And we have a lot of data that there is no direct relationship between costs and quality.

Pennsylvania has collected information about health care now very rigorously over the last several years. And the most striking thing, when I got into this and began to try to understand it, is they had taken a couple of common operations -- coronary bypass, for one -- and they have seen how it gets billed at \$20,000 in one hospital in Pennsylvania

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all the way up to \$80,000 in another hospital, with no difference in outcome or quality.

You don't get better health care for the coronary bypass in Pennsylvania if you pay four times what your neighbor pays if they get it for \$20,000. But that is what happened every day in this system.

An ophthalmologist friend of mine from Arkansas sent me two hospital bills of two hospital 10 miles apart in Arkansas, neither of them a high-tech academic health center. They're community hospitals.

He performed a cataract operation on two different patients. He did the surgery. His nurses assisted. He ordered what needed to be done in terms of tests and procedures. The hospital bill for one of his patients was \$900; for the other patient, \$2,300. Medicare and Prudential in one instance, Medicare and Blue Cross in the other, paid both bills.

He sent them to me and he said, "You know, I'm trying to become more efficient. I did a good job on both of these people. There was not \$1,400 worth of hospital differential in those bills." He said, "I don't think that we are looking at quality in the right way."

And that's what we hope to do.

So those are the kinds of bedrock reliefs that we bring to this. The plan itself has a lot of features in it that we are currently engaged in talking with people about. And many people on the Hill are offering comments. There are many people in groups that are concerned about health care.

We have had -- I recall we've counted 1,100 meetings -- we have met with 1,100 groups in the last nine months -- and many times with some of those groups. And we are continuing to do that, because we don't believe we're coming down with stone tablets. We believe that we have certain principles that are important and a plan which we think will get us there but for which there is a lot of room for discussion. So that's a very sort of quick overview about that.

Do you want to add anything? (Inaudible.)

AIDE: (Inaudible.)

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MRS. CLINTON: What we do now, of course, is to try to layer on more and more bureaucracy to try and figure out what the difference is. What we intend to do in the new system is to say there should be a certain cost for delivering health care in a region. And northwest Arkansas might be less costly than Miami. We know that it is, based on figures available to us.

So what we want to do is form a health alliance in Arkansas. And we will have people paying in their insurance premiums to that alliance, and we will have health plans bidding for the business, for the people in that alliance, much as insurance companies do now when they go to your employers and bid on your business.

Those bids will create an average for what the cost of health care is, based on real market bids about what it will cost to deliver health care. And then instead of saying to those two hospitals, "You've got to deliver a cataract operation for this amount of money, and we're going to look over your shoulder, and we're going to have a hundred people checking your bill," we're going to eliminate all of that.

And instead, we're going to say, "Here's this plan you're now a part of. They have contracted with the consumers in your health plan to deliver health care at this amount of money. You need to become more efficient in doing your cataract operations."

And the hospitals that are more efficient will continue to be so, and the hospital down the road that has gotten away with charging more money will have to become so. But it's --

Q (Inaudible) -- why would it, if it's down there by itself, why would it have to become more competitive?

MRS. CLINTON: Because it's going to be part of the health plan. It is not going to be by itself. It is going to be part of either a hospital plan or a doctor's plan or an insurance plan, so that it will all of a sudden become a network. It will be part of a network of delivering health care.

There will be many different variations on this.

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That hospital and its staff might belong to more than one network. In fact, I think that is likely to occur. But in each instance, where there is now no budgetary discipline whatsoever on the private sector in the health care system, there will now be a ceiling against which they can begin to measure decisions that they make.

And we were talking about this earlier, trying to think of an analogy that you all would maybe understand from your own industry that we could perhaps through out to you. And I was suggesting, you know, the difference between your being told you have 28 minutes or 27 minutes to do the news and you all making the decision, you know, how long is Brit going to be doing this piece and how long is somebody else going to be doing that piece. In the current medical system, we have moved toward a situation where we could tell you what you reported at minute one and minute two. And that's what the Medicare and Medicaid and private insurance companies do now.

You would have to call somebody and say, "Is it okay if I -- you know, if I make this decision."

And they say, "No, we've already decided you've got to make this decision, and then agree," instead of saying, "Look, you all have 28 minutes to fill, and you make the decisions."

So what we want to do now is to say to the private sector medical system, "You've got this amount of money" -- and it's a huge amount of money -- "you make the decisions. We're not going to be layering on the administrative accountability that we have used up until now, which has not worked. And therefore, you will have to be more honest in making those decisions, in allocating your resources."

AIDE: (Inaudible) that what we're trying to do is use the marketplace for this use committee. Because right now, the way it often works, if you were going to go into a store and buy a sweater, and the person behind the counter would say to you, "You have to buy this sweater, and here's how much it's going to cost. And by the way, you've got to come back three days from now and buy that sweater. Then I want to see you next week to buy that sweater." That's today's health care market. And then the bill would get sent to the government, who would pay for it, or some insurance

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would pay for it.

What we're trying to promote is something -- in most cases, what has been possible is what Medicare would do, is it might try to set the price for every procedure and every test and then hand someone a check. And then if the doctors or hospitals needed to get more money from Medicare, they would basically layer in more tests and they charge more. And then Medicare would then pay more, because they pay by the tests or by the procedure.

What we're trying to do instead is set up some (inaudible), where health planners are going to have to compete for premiums, a certain amount of money, a fixed amount of money. And when they're negotiating with the hospital or somebody, they're going to have to say, "Are you neat and efficient? And how come you charge more than that hospital? If you want my business, you're going to have to think about this. And let's get in and talk about why it costs you more." And you're going to try to get some more enforcement going (inaudible).

Q But once the procedure is done, how does it get paid for, on what basis? (Inaudible.)

AIDE: No, basically, that would be something that the health plan and its providers decide themselves. So basically, if you have 50 doctors in a hospital, forming a health plan, they'll form their own system for providing of payment, just as doctors in (inaudible). If you've got partners in a law firm, they'll have internal (inaudible) for deciding who gets paid how much money.

Q (Inaudible) hospital provides its services and how they bill (inaudible).

AIDE: (Inaudible). Okay, the way it would probably work, depending upon who was in charge of the health plan -- let's say that hospital (inaudible) and delivery (inaudible) to people who sign up with (inaudible).

Q A certain amount?

AIDE: Yes, they would then sit down and you'll say, "Okay, how are we going to set up a schedule among

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ourselves to do that?"

Q So, in other words, they're on the hook at that moment?

AIDE: They're on the hook.

Q For whatever sum?

AIDE: Yes. And this is the way it works in some other countries, too. In Germany, where they have a private system, what they'll often do is they'll say -- they'll set aside 25 percent. They're either going to get paid as a group, hospital and doctors. And at the end of the year, their utilization has been such -- they've managed themselves efficiently, then they keep the 25 percent. If they haven't, then part of that 25 percent might go to pay the shortfall.

Q If the hospitals are 100 miles apart -- or put another way, the nearest hospital is 100 miles away from the next nearest hospital, what's the incentive to the first hospital to be competitive?

MRS. CLINTON: Well, a lot, because what we're seeing happen -- let's take Mayo's, which I don't think anybody would question the quality. Mayo's is a staff model. I mean, the doctors at Mayo's are on salaries. What Mayo's is now doing is contracting with doctors in hospitals out in rural Minnesota, so that they're part of the Mayo's network. And so that Mayo's will compete for your and my business if we live in southern Minnesota or in northern Iowa perhaps.

And they will say, "We can deliver quality health care for this amount of money, so therefore that's what your premium costs will be."

So I would go to, you know, Blue -- Blue Hills Hospital, somewhere in rural Minnesota, which is part of the Mayo's network. And Mayo's would perhaps assign a doctor to oversee that small hospital, or they would provide the nurse-practitioners that would be there.

There would be -- what we found when we got into this -- or what I found, because I didn't know very much about the way this worked, is that people who have really

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studied this, who I think are doing the most efficient job -- and I would point to Mayo's, I would point to Rochester, New York, I would point to the Catholic Hospital Association -- they understand the way these networks will work, because what they have found is that individual hospitals competing with their hospital 10 miles -- or even 100 miles away -- in some area themselves cannot be competitive. But cooperating with them, providing different services, so that we have primary and secondary and specialty care all connected up together, is the way that we can more efficiently deliver health care, instead of these individual units, all of which have to ask permission from the government or insurance policies to make decisions they should be free to make themselves.

Q (Inaudible) person you said -- (inaudible) talking about principles, is to reach universal coverage by 1997. And of course a lot (inaudible) upon the comments on that. So things that are not (inaudible) together are going to get pushed this way and pushed that way. How far in the future are you willing to push them?

MRS. CLINTON: Not very far. But we think there's enough give in the plan for that. I mean, we've got deficit reduction by the year 2000 of a considerable amount of money, nearly \$50 billion, which we would -- we would argue could be added to deficit reduction.

Well, in order to get universal coverage completely, if we cut back, for example, on how much savings we could get out of Medicare, we might have to reduce deficit reduction. There's a lot of options within the plan. But the bottom line is we want universal coverage as soon as possible. And we think if we were to enact this plan, you know, by spring of next year, '97 would be realistic.

Q Is the year 2002 too far?

MRS. CLINTON: It's too far for me, yes. I just -- I mean, it's too far for -- for reasons that have as much to do with how much money we're currently spending and how far behind the curve we will once again get -- as for the moral and human costs.

You know, the budget that was just passed, because

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of health care costs that are still going up -- and after the budget is -- as you know it, Medicare will continue to grow at 11 percent a year, Medicaid at 16 percent a year. People aren't getting that old and that sick that fast. But we can keep pumping in all of this money. And from our perspective, the budget deficit, the fiscal underpinnings of hospitals and businesses will be further imperiled the further away we get from universal coverage. Getting this system in economic order depends upon getting universal coverage. And so it's not -- it is not tradeoff for us. That's one of the things we have to achieve.

AIDE: If I can just say two things: One is that the -- you know, when you don't have universal coverage, the companies of people that are now paying pay for the uninsured. When that 20-year-old with no coverage is hit by a car and goes to the hospital to get treated as they should, the people that have no insurance get shifted in their premium. There's \$25 billion of that shift in the system now. Where those of us with insurance are paying for the insured. So you don't get rid of that until you get universal coverage.

The other thing I want to keep emphasizing (inaudible) -- one thing in being told what to do in Washington that has surprised me here is that people don't believe that you can save money, the only way you can raise money is if you tax them. And anybody, whether it's doctors, hospitals, clerks, patients, that we have talked to who have looked at hospitals carefully knows that there is an enormous amount of waste.

We did a two-year study where we followed nurses and technicians and others around on their rounds, hundreds and hundreds of rounds. And we looked at what they did with their time. The average nurse spends close to 50 percent of her time filling out forms and doing other administrative work.

Q Some of those are actually medical records that they have to fill out, aren't they?

AIDE: Well, 14 out of the 19 (inaudible) hospitals we looked at, they are repetitive forms for different insurance companies or for Medicare.

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Then there's a utilization review department, whose sole purpose it is to review the forms and make sure they're in the proper order for the insurance companies and Medicaid.

There's an encoding department that looks at what utilization review does and code them -- like your tax accountants, where you get maximum a reimbursement from Medicare.

Then there is a billing department that has to draw bills in different formats.

And then it goes to what's called outside the hospital a fiscal intermediary that evaluates and kicks back 5 percent of the bills for disputes.

Another copy of the bill goes to what's called a PRO, that (inaudible) whether the care was appropriate. They kick back 8 percent (inaudible) which get disputed. There's a whole consulting industry to advise hospitals on how to deal with disputes with the PROs, since 90 percent of them are denied (inaudible).

Then it goes through something called a super-PRO -- and if it's contracted in California, by a HCFA -- to review the PROs to make sure they did their job.

And that's why a quarter of every -- (inaudible) the new jobs in hospitals are administrative.

So what we're saying here is that when somebody portrays savings in the system, that you're going to take the growth of Medicare from 11 percent down to twice as fast as inflation instead of four times as fast as inflation (inaudible).

And they say, "My goodness, your mother is not going to get cared for" -- we don't think that has to be the case. We think that there is tremendous waste in the system, and it's unfair to raise a general tax for the American people to keep feeding that waste.

Q Well, what reaction are you getting from Congress at this early stage?

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MRS. CLINTON: I feel very good about the reaction that we're getting. We -- I spent a lot of time at Congress last week, and I probably -- well, I met with both Senate committees -- Finance and Labor and Human Resources both I'm sure have something to do with this bill. And I met with the Republican leadership in both houses on health care. And I think it's fair to say that a good number of what I consider to be the kind of reasonable middle ground in both the Democratic and Republican Party are "cautiously optimistic," to use the AMA's term yesterday. They feel very -- they feel good about a lot of the work we've done. They have individual questions to ask. And we've got some issues that we are still working with them on.

But there are so many features that we have borrowed from bills that members of Congress have written. I'll just give you one example. The whole idea that we would budget the private sector by using the average of insurance premiums as the key is an idea that we got from Senator Kassebaum and Danforth. That was in their bill. That is a Republican proposal. And the reason we liked it so much is it was a market-oriented proposal. It was -- it got away from the -- you know, the micro-regulation that I was talking about.

But what -- in our conversations with Senators Kassebaum, Danforth, and others, what they recognized, which some of our other members of Congress don't yet recognize -- is that in the absence of some kind of budget in the private sector, we cannot control the costs. And so I think there's a lot of room for negotiation with Republicans as well Democrats. I'm very optimistic.

Q Well, on the discussion with the Republicans, (inaudible)?

MRS. CLINTON: Well, I think Senator Chafee will introduce a bill -- probably tomorrow -- that will have, I think, about 20 co-sponsors. And he has told us that he would fulfill his obligation to come with a bill, and then we would talk. And I think you won't hear a lot of wild yelling from the people that he's got in his group of 20. They are going, as I understand it, with what they view as an individual mandate, which will mean that they will require

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individuals to have health insurance, much as states require people to go out and buy auto insurance. We don't think that will work as well as having an employer-employee joint responsibility. But once they go with an individual mandate, they're halfway to where we are, too. So there's a lot of room for discussion here.

But I think the big yells will come from people who don't want an employer requirement and people who are scared about reducing the rate of growth in Medicaid and Medicare. But I think that those are both issues that we can work through.

Q Could I focus for a minute on the present chaos and complexity about our health care enterprise? I (inaudible) system currently.

MRS. CLINTON: That's all right.

Q (Inaudible) practiced medicine until 84, and I saw it from that side, a little crazy. But as somebody who is now on our consumer side, I see it --

AIDE: Drive us crazy.

Q Drive you crazy, right.

What concerns me -- I mean, I applaud what you're doing. And I mean, I'm just thrilled, in fact, that somebody is paying so much attention to health care finally. But what concerns me, as I started to read the details of the plan, is that we may be introducing a different kind of complexity as we develop these purchasing cooperatives at state levels.

In fact, the current journal of internal medicine, which will be seeing later in the week, has an article which is titled "Effective of Managed Competition on Doctor-Patient Relationships." And it portrays the possibility that we're going to have a new kind of chaos for a while, where all of these purchasing cooperatives are going to start forming and feeling out their territory, defining their terms. They're going to be changing year by year. Patients, through their cooperatives, are going to be faced with a new set of choices every year. They may have to switch year after year to find

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the best plan as they see it and the cheapest plan.

In the two examples you have cited that work so well -- Rochester, Minnesota, and Rochester, New York -- you have a dominant insurer -- a single insurer, in fact, in the case of Rochester, New York. (Inaudible) case in Rochester, Minnesota -- it's basically Mayo's, operating through medical insurance companies.

Instead of introducing a whole new kind of system that has never been tried at a national level anywhere in the world -- (inaudible) try it in the State of California -- why not build on some of what we have now and try to simplify it, as they have done at Rochester, or as they have done at Mayo's? Why, in fact, open up the door for another complicated system of different purchasing cooperatives?

MRS. CLINTON: Well, I think that's a very -- a very fair question and one that we have struggled with very hard. But the purchasing cooperative will be a static institution. It will be a state-created entity and will largely be a finance collection point of entry.

And what we hope will happen is that the Blue Cross Mayo's will be presenting their services to the consuming public, and then you will choose from among them. So your money will go into the purchasing cooperative so that we can maximize our capacity to get the kind of deals that Rochester, New York, and Mayo's can get.

Over time, what we think will happen -- and it will be a relatively short period of time -- is that there will be a few entities in each marketplace, depending upon the size of the alliance area, that will largely dominate health care. But we don't want to start with that. That's why we reject a single payor. And the "New England Journal" supports single payors, so that, you know, they have a very --

Q This happens to be written not by the editorial staff --

MRS. CLINTON: Right.

Q -- but by some practicing physicians, who make a very good case for potential chaos.

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MRS. CLINTON: Well, I think chaos -- I think there will be a transition period. But, you know, when Mayo's started, it was attacked as socialized medicine. It was viewed as the worst possible way to deliver medicine. And now we all point to it as an example of high quality.

We know that there are going to be a couple of years of transition. We don't think there will be disruptions in the actual service or care, but there will be different hospitals joining up, one with the other. There will be different insurance companies and --

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-- everybody in Minnesota go to Mayo's and everybody in -- we're not going to do that.

Q But to push my question in a slightly different direction, if the theory -- genius of the purchasing cooperatives is to band people together to give them bargaining power, why not use the biggest cooperative of all, the federal government, to provide bargaining power?

AIDE: Well, I think the -- you know, having been in Washington now only about eight months, I think even less of what I did before I came. I think the federal government -- and I don't mean to be insulting, but I think -- I doubt the federal government's capability to organize that well.

Q I wasn't even talking about organizing. I was simply talking about bargaining or the budgeting --

AIDE: (Inaudible.)

MRS. CLINTON: Well -- no, go ahead.

Q -- naturally to promote health.

AIDE: No, no.

MRS. CLINTON: But my -- buy my answer to that is more that if you look at Medicare, in and which we do (inaudible) -- I mean, everybody pays into the federal government -- all of us around the state who are contributing

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to Medicare through our employment -- and the federal government then determines it. The political pressures, the kinds of choices that are made to run Medicare, that keep the costs going up when the need does not go up as fast as the costs are going up, are what we want to avoid.

I mean, we don't want members of Congress to setting the rate for delivering a cataract operation in Fayetteville, Arkansas. We want the market in Fayetteville, Arkansas to set that. And if we went to a Medicare-for-everybody system, where the federal government set it and then bargained, it would just -- it would one week.

Q Yeah, I happen to agree with that, at the federal level. But logically -- I just asked the question. But if you go back to your examples of Rochester, Minnesota, and Rochester, New York, what you do have is basically a single payor at the local level.

AIDE: And here -- I think this is what we are tending towards, that health alliances -- and some criticize us -- but the health alliances essentially are going to be at the local level, because what --

Q As they shake down, (inaudible)?

AIDE: Well -- but they're going to (inaudible), you know, 60-70 percent of the people at large corporations, and some of them may still operate their own purchasing. But (inaudible) effective. But essentially we're doing exactly that. And then -- and with quality, what has happened in Rochester and so on.

And then there will be health plans competing with each other, and institutions forming health plans. And that also will shake down to a certain number in a given area.

The thing we don't want to do is to have the government be able to select who that is going to be. We want to give the consumers a choice and let them select who, you know, the providers' networks are going to be.

Q So in a sense, you're going to encourage and enforce what may be described as a multiple single payor system?

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MRS. CLINTON: Yes.

AIDE: I think that's probably a good way to put it.

MRS. CLINTON: Yes, I -- I mean -- because you understand all this so well. But we're also giving, in the legislation, the opportunity for a state to be a single-payor system, because in -- and some of our conservative supporters in both parties are very worried about that. But our perspective is in -- like a state like Montana, with 880,000 people in that huge land there, there's no competition in far northeast Montana. And it will help the consumers and help the physicians in the hospitals if we give Montana a choice to be a single-payor system. And then what they'll do is they'll collect all the money, and they'll basically have a budgeted fee-for-service network for every doctor and every hospital, and everybody is a part of it. And they just watch their costs better, because they'll have a budget (inaudible).

AIDE: (Inaudible) change with any (inaudible). The organization will be consumers would want a piece of it. But the main thing that is going to change the system is when you take away the right of insurance companies to compete by trying to find only healthy people to insure. And the way insurance companies compete now is trying to find people who won't possibly get sick while insured, and that's where they make money. Because in any given year, it's 10 percent of the people spend 70 percent of the health care dollar. And so, when you take that away from your rates, as we're going to do, in forming the insurance model, so now you have to take everybody, and you have to take (inaudible) people and so on. Then the only way you can compete is on the quality and on effectiveness and efficiency.

Q (Inaudible.)

AIDE: (Inaudible.)

Q Let's get back to the cataract operation.

AIDE: Yes.

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Q (Inaudible) doctor in Arkansas who did cataract operations. The doctor is part of an alliance.

AIDE: Right.

Q Are you going to have some kind of point-of-sale transaction or negotiation with the hospital, or what is (inaudible)?

AIDE: No, that's all (inaudible) by the networks, decided (inaudible).

Q You mean, beside the poor, that (inaudible) end --  
AIDE: Oh, sure. Sure.

Q -- price of the cataract operation (inaudible)?

AIDE: Sure. And basically -- you know, when you set your premium as a health plan (inaudible), it's just like if you think of it as a group of 50 lawyers in a company and they're setting their prices, and they (inaudible) you and you get paid every year. And they have some (inaudible) ensure quality. In this case, we'll have an experiment (inaudible) quality, but basically it's pre-agreed, and they decide what they're going to bid as the premium.

MRS. CLINTON: But really, the point --

Q So that within the alliance then, there is a --

MRS. CLINTON: Right.

AIDE: There will be a fee scale (inaudible).

Q Well, is that --

AIDE: (Inaudible.)

Q (Inaudible) into Rochester, but not (inaudible).

AIDE: (Inaudible.)

Q But it will be (inaudible) health plans.

MRS. CLINTON: But it will be decided by the people

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delivering the services, instead of an insurance executive or a government official, so that in the example of the cataract, the reason this ophthalmologist said it to me is that he is outraged because he is trying very hard to be more efficient, and he has actually made some changes in the way practices. He has no control over the hospitals that he practices in, in terms of how they spend their money. But from his perspective, he and the other doctors who practice there should be involved in making decisions about how --

He said, "A cataract operation should not cost that much money. We should spend that money on others that are more serious, that I also do. So we should be able to do that more efficiently."

Now, when that hospital, as part of the network, bids out its services to determine whether you want to join them or not, since the rate is what their premium will be, he will have some input, as will every other doctor. And it won't be based on, you know, some theoretical baseline or insurance company projection.

It will be based on this guy and this guy and this guy all sitting down and saying, "Here's how much we think we can deliver health care for in this region of the country."

AIDE: Right now, the House Ways and Means Subcommittees sit and decide how much you've got (inaudible) Fayetteville, Arkansas. That's crazy, the bargaining that goes on there. It has very little to do with what goes on in (inaudible).

Q See, I (inaudible) all the way to the senior encounter -- I guess is the most efficient kind of computation (inaudible) --

AIDE: The problem --

Q -- move it closer.

AIDE: You move it closer. And the problem is you can't create a pure market on the computer monitor. We've not moved the managed competition solution the way the purists would have us do it, because we don't think it would work. It's not really a market.

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You can't -- when you get appendicitis, you don't sit down and say, "Well, let me get the Yellow Pages and phone around and see where I want to go, which MRI (inaudible)." (Inaudible) to your health plan.

It is not a pure market. What we want to do (inaudible) subsidy that. We want to move the decision closer to where, you know, the providers generally are. And then we want to give the consumer a chance to vote with their feet (inaudible). so that if they're not happy with what they're getting, they can move to another plan. We don't think that there will be a lot of change that takes place (inaudible) instead. But if you want to give the option (inaudible) change.

Q There are two things that confuse me on the savings (inaudible) one, and those are the people who currently are in the bureaucracy who are (inaudible) insurance (inaudible) prices. And under the new system you, instead, have a lot of people who (inaudible) national health board, (inaudible) alliance (inaudible) HMOs. And I just wonder what the difference in numbers are to -- so that you can achieve the savings (inaudible) that you're talking about?

And also, in the -- in bringing the cost of Medicare, if (inaudible) as the planner suggests, that one of the things that you do is to reduce the amount of (inaudible) physicians get (inaudible) seems to be done every year in the budget reconciliation, that cost is not really a savings -- at least presently it isn't, because it happens in -- shift to the private industry. So how do you avoid that?

AIDE: Well, to the latter question, by capping the rate of growth to the private sector as well, (inaudible) you avoid cost-sharing. And that's why AARP and other groups who we called, said, "Well, if you're going to cap the rate of growth on Medicare and Medicaid, we won't oppose that as long as the private sector piece is also capped, so you won't get the cost-sharing." And we think that will solve that problem.

But the other one, you must understand that even when we're -- they have a funny language in Congress (inaudible), talking about these updates, on decision papers and things of this sort. And they say, "Well, why

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(inaudible) provide us for an update." Well, "provide us with an update" means that physician costs will go up 6 percent. So it's -- you know, there's a logic in propelling that whole system forward. It's growing, you know, three, four times inflation now. And because -- when you actually go in to spend a lot of time in the hospital and physicians' office, as we have done, it doesn't translate into better patient care. It sort of translates into more tests, better (inaudible), it translates into more administrative (inaudible).

What we believe on that (inaudible) of using the market forces to a greater extent -- it's very (inaudible) -- is that they're going to have to search for those efficiencies if they're going to be competitive. And if you have a basic quality standard that they have to meet, the basic benefits package they have to deliver, they can achieve the efficiency (inaudible). And there is not one expert or either nonexpert or one participant in the system literally we have talked to who will not describe to you example after example of (inaudible).

Q But everybody (inaudible).

AIDE: The first --

MRS. CLINTON: But we don't -- we don't intend to have a big -- a big staff (inaudible) --

Q Okay. I'm sorry.

A

MRS. CLINTON: -- for the national board or the alliance --

AIDE: It's like a board meeting. The national board is going to be like a -- in a sense, a board of directors.

Q How about the local ones?

AIDE: The local ones --

MRS. CLINTON: They shouldn't be that (inaudible).

AIDE: They shouldn't be, no. They're -- if you

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look at CALPERS, which is an example of purchasing --

MRS. CLINTON: Yes, that's the California pension system.

AIDE: -- it operates with one-half of 1 percent administrative costs -- and compared to one of the insurance companies, which are around 10 and 15 percent. I mean, if you look at what large companies out there who self-insure, they're usually around 5 or 6 percent. What we have built in, to be conservative with our numbers, is about 2.5 percent administrative costs, compared to CALPERS' one-half of 1 percent, because our alliance is a little bit more than 1.

But right now -- I used to run a small business, and our rates, even where we had a relatively healthy population, were 30 and 40 percent higher, because we were small, than the big business (inaudible). And the reason for that was because the average administrative costs for processing a smaller group like ours was about 30 (inaudible). So when you bring those small groups all together into a purchasing alliance, you're going to cut the administrative costs dramatically, compared to what exists today.

Q Could you focus a little on the (inaudible) quality (inaudible). I don't quite understand (inaudible).

AIDE: Well, let's -- let's talk about (inaudible). One of things that has frustrated (inaudible) in this is that we spent more time by far on this whole effort, on issues of quality, than on almost anything else. And often reporters would come to hearings who just didn't know (inaudible) the fact (inaudible) six or seven (inaudible).

And when I say this 10 years from now nobody is going to remember the fact that (inaudible). (Inaudible) didn't even know it was going to happen (inaudible) doctor (inaudible) quality and so on. So we spent a lot of time on this.

What we're looking to do is three things with quality. One is that we want to get away from the kind of micromanagement of the processes, which we have learned throughout industry doesn't work to improve quality. It just

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adds costs. We kind of describe a cookbook, 10,000 pages on, you know, pick up the scalpel this way and do this and do that. I mean, that's the way our quality system works now, with Medicaid and the PROs. It's computative, and it micromanages processes.

Instead, what we've learned is that if you move more towards total quality management, where you specify outcomes, and then you leave more authority to people to achieve those outcomes on the front lines, which they know best, and then you measure how they're achieving them, and you publish that information, and then you work with them on improving, that you get better quality.

So what we're going to do is increase the investment in what's called outcomes research. For example, you have three different ways to do a certain kind of heart surgery. Let's measure some data on the effectiveness of each way, and then let's make that information available to physicians around the country so they can see the difference.

Q Well, why is that not going to discourage, for example, experimental surgery? Why -- I mean, you talked about surgery in certain centers, the quality.

AIDE: Well, I think part --

Q Maybe you've got to insure the quality of operations. If you want to sell us --

MRS. CLINTON: Well (inaudible) -- let me say there's a lot of -- there is a lot of information about that out there. And I go back to Pennsylvania, which has collected all this data.

They go in and what they have done is they say, "Okay, these patients are basically all white males between the ages of 60 and 70, and they've all had coronary bypass operations. And let's find out how quickly they recovered, whether they had any kind of relapse, how well they're doing three months, six months after the operation."

There are a series of questions to ask about this operation and applying it over a large population.

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And what we found in Pennsylvania -- and which they've now done for several years -- is you go in and you measure that kind of quality, by not just going in and saying what went into the operation, and what degree the doctor had, but instead, what came out -- I mean, how quickly did this person recover. You find that there's very little relationship between costs and quality outcome in our system.

Q Let me give a very -- a very crude example of -- when you take one of these (inaudible) in San Francisco, let's say, whether there may a very high incidence of AIDS, which is going to have a very poor outcome. In other words, everyone who goes into that system comes out dead. And there is an absolute -- how do you measure the quality?

AIDE: I think -- (inaudible). I think basically when you do these kinds of studies that are done to develop outcome, you practice guideline (inaudible). You basically control for your populations carefully, so you don't have, you know, here's what happened with AIDS patients, here's what happened with (inaudible) 60-year-old heart patients. So you've got a little better specificity in the work that's done.

But the important thing is -- is two things: One is that you basically have that type of information available and that you're also measuring what happens. And then secondly, that you get the consumer involved, because today, the quality system, we have never asked the consumer what they thought or what happened to them. And so the consumer survey -- part of what a health plan has to do to basically have published as part of their quality report card. These quality report cards that each health plan issues will have, you know, a list of 20, 30, 40 pages that need to be reported on and will do their consumer survey. And then that information will be published and they'll -- and if the -- the connections will be there with the research that is already out there, so presented with it. And we know that if you have high immunization rates, (inaudible) that certain (inaudible) outcomes. Okay, one of things that (inaudible) my report is how many of your kids five years old (inaudible).

MRS. CLINTON: But going back to the AIDS issue, and particularly with the way you've linked it with

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experimental treatment and therapy and drugs and the like, there will be, we think, even more incentive for better treatment and even experimental treatment, because you will have more broadly shared information and a collection point as to what works when.

What I've been frankly shocked by is how little -- as much as is written about medical activity, it's not very widely disseminated and shared in terms of being put into practice. So that you've got the treatment, for example, of AIDS patients in Rochester, New York, which is equivalent to and better than the quality you've got in places like Miami, which have much higher costs of treating those patients, because they -- they have created more efficient and effective and quality-driven ways of treating them. And so there's -- that information now, there's no incentive.

And I don't want to pick on Miami, but literally you could give people in Miami better health care on average by giving them a one-way first class ticket to Mayo's or Rochester, New York, because they are charged so much more for the same kind of treatment they would get in one of those other places. Right now there's no incentive for Miami to change its practice patterns, because the system just keeps paying them for what they do.

AIDE: Thank you. But one of the things we've learned -- and this is very important -- we have learned it everywhere in administration -- is that a good quality system and more efficiency go hand in hand. They're not contradictory. Because what happens is that when you have poor quality, you've got to do it again, and that costs a lot.

And if you look at one recent study in New York that was done on 10,000 cases, there were about 9 percent of the cases where an in-hospital error lengthened the stay and caused extra procedures and so on.

Another example, 23 percent of all admissions of elderly people to the hospital come because two drugs, prescribed by different doctors, counteract with each other and cause (inaudible) problem.

That's all poor quality control that costs money.

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And so when you get to a more integrated care, where, you know, I'm not seeing five specialists who never talk to each other, but they're, you know, in some way in relation to each other, and I have a good quality outcome system, you cut down on those hospitalization (inaudible).

Q What will this plan do for the great American middle class, the people who work, earn a living, buy their own health insurance? What happens to them?

AIDE: Well, the middle class buy their health insurance (inaudible). Usually, the people who are --

Q (Inaudible)?

MRS. CLINTON: No.

AIDE: No. The companies (inaudible).

MRS. CLINTON: I mean, the vast majority.

AIDE: (Inaudible.) But basically, the companies will pay at least 80 percent usually.

There are three things that are good in these programs. Suppose I have good health insurance. I'm, you know, reasonably comfortable with it, I'm happy with the health insurance I have. (Inaudible) that. What's in this for me?

There are three things that are in it. One is that if you lose your job -- which, you know, 50,000 IBM workers thought they were on the payroll last month -- if you lose your job, you still have health insurance, which you don't have (inaudible) guarantee.

The second thing is that in over 50 percent of the companies now that provide health insurance, the employer chooses only one health plan (inaudible). Under our system, he'll have -- at least have a choice, a choice of doctors, a choice of plans.

A third thing is, as we (inaudible), for 20 years middle class workers have been up wage increases to pay for health care increases that have gone up twice or three times

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as fast (inaudible). When you get the growth in health care costs under control, you've got a better chance to get wage increases. So basically, people who have insurance now are going to be saving money, and they're going to have more security. And that's why this is such a (inaudible) issue (inaudible) because most people say, "Well, I have (inaudible)." And then they say, "I want the system to change." And the answer is because they're insecure about what they have, with good reason, because (inaudible) in the next few years will lose it, one way or another.

Q (Inaudible) next spring (inaudible).

MRS. CLINTON: Yes, I do think it's realistic. I hope what happens between now and then is that we get bills introduced and reported out by the end of the year and we start the debate after the first of the year. And I think that is realistic.

Q Could you go back to the insurance companies? I'd like to ask (inaudible) whether or not it is, one, too complicated to sell to the American people (inaudible)? You can see how hard it is with some of us.

Could you go back and explain the insurance company -- you said -- Mr. Magaziner -- can you take away the right of insurance companies to insure the health of people (inaudible)?

MRS. CLINTON: Yes. Well, right now they do what is called "experience rate," which means that they go into the prospective pool of the to-be-insured and determine, based on what the health profiles of the people in the pool are, what your costs will be.

And if you've ever been sick before, if you have a relative who you're responsible for, a dependant, if you have any kind of chronic condition, you then raise the risk of the entire pool, and that is based on the experience of the insurance companies as to how much it costs to insure various people.

It used to be that insurance was sold on what was called "community rating." You looked at the entire community, and the insurance companies made a little bit of

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money on a whole lot of people, and it all went into the pool together.

What insurance companies increasingly have made their money is trying to eliminate from coverage as many people as possible or to raise the costs so much in order to cover what they view as the risks of insuring a person with any kind of illness. And for many people, that has resulted in the cost of insurance becoming prohibitive or their having to raise their deductibles to a very high level in order to be able to afford any insurance.

And when we look at the entire country, we have this kind of old-fashioned view about insurance, which is that, you know, healthy and sick, old and young, we all ought to be in the same pool together, because all of us at some point are going to be sick and, for sure, we're all going to be old, and that we ought to bear that responsibility mutually. And we think that by eliminating the incentives the insurance companies have had to write people out of coverage or expense it too high, we will cover more people for less costs over the long run. Everybody will be in the system.

Q So how will they resist you in this? And how will you prevail?

AIDE: Well, they've already resisted us. You can see in the TV ads. I'm pretty sure of it, but I think -- I think that they -- there are going to be a certain number of insurance companies who are going to have to change health insurance, change the business they're in, and they'll succeed. They'll go either to managing care in some way -- effectively. Or they will go to doing a lot of the administrative functions and subcontracting their administrative capability. Those that don't make those changes are not going to succeed in this new environment.

The way they're going to define this -- and you can see it -- they'll say that we're limiting the choice of insurer --

MRS. CLINTON: (Inaudible.)

AIDE: -- without (inaudible). They'll say that

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we're limiting the choice of our insurers, and they're not (inaudible).

Q Do you plan (inaudible) text (inaudible)?

MRS. CLINTON: Yes.

AIDE: Yes.

Q As part of the total -- global budget, or --

AIDE: It is the global budget.

MRS. CLINTON: It is. That's what it.

AIDE: That's what is. It's not really a global budget, because we're not going to tell people what to do with their after-tax money. What you do with your after-tax money is your business as an American. What we're going -- what we're saying is that there is taxpayer money in tax-preferred health insurance -- that, along with Medicare and Medicaid, (inaudible). But it's not a global budget in a sense.

Q But I want to mention that Peter said in his introductory comments (inaudible). You tried to explain the present system; it is unexplained. I mean, you cannot explain why some people get insurance coverage at certain rates and -- you know, how do you try to explain how it works?

MRS. CLINTON: What we try to do is to take what people are most familiar with, which is getting their insurance through workplace, choosing their own health plan, their own doctor, and build on that. So it is not a radical departure at all. I mean, for most people, what they do is not going to change.

You know, if Franklin Roosevelt had had to sell Social Security by talking in this detail, we would still not have Social Security. But times were different. And he just basically said, "You've got to put some money in, and then you're going to be taken care of when you're old."

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You're going to put some money in this system. You're going to put it in in the workplace, where most Americans put it in now. You're going to sign up for health insurance. That's all there is to it.

Now, if you were to talk about how to explain the Social Security system today, we'd have rooms full of regulations that have been written since that went to effect. Just as of now, there are rooms filled with insurance regulations at the state level, the national level, and Medicare and Medicaid -- we've got tons of regulations in the system.

We actually don't think it's going to change very much for the individual, how they interact with it on their local level. But, yes, there will be some changes in where the money is actually processed and the kind of accountability provisions we want in it. But the individual on the street, in the office or workplace -- it's not going to change.

AIDE: I mean, to explain to somebody in today's system that how much you pay for health insurance depends not just on how old you are, whether you're sick or you have a child that's sick, or whether you have somebody else in your company that's sick, or whether you work for a big company or a small company, or whether that big company has struck a good deal with an insurance company or not, or -- all those things, which have nothing to do with you, determine how much you pay for health insurance and whether you can get it, and what kind of policy you can get. We're simplifying that, but it's still not as simple as, you know, it could be.

Q (Inaudible) to the members of an alliance, just their calculations, it ends up costing (inaudible) and handling (inaudible).

AIDE: The health care providers? You mean the health plans?

Q (Inaudible)

AIDE: The same thing that would happen today, that basically if you have a group of 50 doctors in a hospital and they get together, they say we're going to do this for a

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premium, then what would happen, as it would be in Germany or elsewhere, is that they may make less money then.

Q Right. But let's suppose it has been very severe, and the (inaudible) -- one state is --

AIDE: Well, again, I --

Q -- financially insolvent.

AIDE: I think the --

Q (Inaudible) nationally, I suppose, is what it means.

AIDE: You can do that. There will be a reserve fund, which -- as there would be in any insurance practice. There's got to be a reserve fund, which will be built into this, solvency standards, and things of this sort that will protect against that type of eventuality. But ultimately, it's a health plan, just like a law partnership or anybody else (inaudible), a group of partners coming together. They make less money if they don't do as well, if they guess wrong or whatever.

And if you look at physician incomes, you know, they've gone six times as fast as the average income in the country for about 15 years now. Under the current projections, they're projected to continue to go up six times as fast. So basically if you can't get some productivity, they can't get better productivity, maybe they'll go up three times as fast or two times as fast. I mean, that's what will happen (inaudible).

Q (Inaudible) that there is none, meaning at least productivity (inaudible) --

AIDE: We think --

Q -- and orthopaedic surgeons are not (inaudible) --

AIDE: There has not been --

MRS. CLINTON: There has not been, but there should be.

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AIDE: -- but there should be. And that's what we're trying to get at. And if you look at this administrative book, you take the average doctor's office, 15 years ago, 25 percent of all the money taken in by a doctor's office went for administration. Today 48 percent goes for administration in the average doctor's office. And a lot of that, if you walked in and they've got now, you know, a whole -- lots of people with computers dealing with 20 different insurance companies, and each one has its different forms, chasing down claims -- is this covered, is it not covered, disputes between insurance companies. All that is going on in the doctor's office. We're going to help simplify a lot of this. We're going to give them tools that (inaudible).

MRS. CLINTON: Or eliminate it -- eliminate it.

AIDE: Yes, one reimbursement form. All insurance companies will have to use the same reimbursement form. That's going to allow doctors to be more efficient.

Q Have you got that paper-hustling little anecdote written down anywhere? I couldn't keep up with it (inaudible).

MRS. CLINTON: Sure.

AIDE: I'm sure I gave you that.

MRS. CLINTON: Yes. Yes, in fact, we'll -- because --

AIDE: And we'll let you go in here. Do you want to go in here? I mean, do what we did, go into the hospitals, and we'll suggest the hospitals --

Q (Inaudible.)

AIDE: -- and interview the nurses about what they do with their day and interview the people in the utilization departments and the reviewers and (inaudible). Now, it's not even just the people that are pure bookkeepers. It's the nurse on the floor.

I remember a nurse crying when she was talking --

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when she said, "If I wanted to be a bookkeeper, I would have gone to bookkeeping school." She said, "I can't take care of my patients, because I've got to fill out all these damn forms every day."

I mean, that's what's going on in this health care system.

Q I'm still not clear on who setting the quality standards and how they're being (inaudible) by consumer (inaudible).

AIDE: The national board will set a quality report card. And that will be a group of, you know, as we've got them now set, would be -- well, it is not going to be a massive bureaucracy. It will be dealing more with the records. There will be -- groups that are like NIH and others will be doing health quality outcomes research. What will the board will do is approve, let's say, 20 or 30 or 40 standards, in consultation with health plan doctors and others. And then those will be standards that health plans will have to report on. And so there will be information collected to (inaudible).

Q Who will they report to?

AIDE: The reports basically will be driven off of what is known and called the encounter point, so it doesn't involve new paperwork. And the reporting will go to what we see as a series of quality foundations in each alliance that will be set up within the alliances. And those foundations basically will be providing for the consumer. They're like nation clearinghouses. They will collect information on --

(The tape recording of the briefing was concluded.)

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