

HRC TESTIMONY

HOUSE WAYS AND MEAN COMMITTEE

9/28/93

HOUSE ENERGY AND COMMERCE COMMITTEE

9/28/93

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

9/29/93

HOUSE EDUCATION AND LABOR COMMITTEE

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House Ways & Means

EXECUTIVE OFFICE OF THE PRESIDENT

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TO: (See Below)

FROM: Jeffrey L. Eller
Office of Media Affairs

SUBJECT: HRC Transcript from A.M. Hill testimony

**THE REUTER TRANSCRIPT REPORT
HEARING OF THE HOUSE WAYS AND MEANS COMMITTEE
SUBJECT: THE CLINTON HEALTH CARE PROPOSAL
CHAired BY: REPRESENTATIVE DAN ROSTENKOWSKI (D-IL)
WITNESS: FIRST LADY HILLARY CLINTON**

**LONGWORTH HOUSE OFFICE BUILDING, ROOM 1100, WASHINGTON DC
TUESDAY, SEPTEMBER 28, 1993**

REP. ROSTENKOWSKI: (Sounds gavel.) The committee will come to order.

Mrs. Clinton, I want to compliment you. I hope that you set the pace for the rest of the cabinet when they testify before our committee. It's very unusual that a witness comes in early to testify. (Laughter.)

Today the committee embarks upon an historic mission to ensure health security for all Americans. Tragically, far too many Americans are afraid to seek the care they need because they can't afford it. Without health insurance, any encounter with the health care system presents a devastating financial burden to most American families.

Last Wednesday, our president outlined six simple basic objectives for the reform of our health care system. They are security, savings, quality, simplification, choice, and responsibility. The president then challenged the Congress to enact reform legislation that achieves these goals. Today I pledge that I will commit all of my energy and resources to meet this challenge and to enact health care reform legislation before this Congress adjourns next year.

Many are skeptical. But it can be done. It would be a tragedy for this country not to do it, to fail in this endeavor.

It is appropriate that we begin an historic task with an historic event for this committee. Today it is my extreme pleasure and honor to welcome to the committee the First Lady, Hillary Rodham Clinton. This is the

first time that a first lady has testified before the House of Representatives' oldest standing committee.

Mrs. Clinton, you have developed a very significant, comprehensive proposal. You and your staff are to be congratulated. At the same time, you and I are both aware that many members of Congress and many Americans have honest concerns about the plan you have developed. These concerns must be addressed during the legislative process.

As just one example, I have concerns about how your plan will affect the many small employers in my district. We must assure that health care reform does not impose an unfair or crippling burden on struggling small employers, while recognizing that many employers can and should meet their obligations to help their employees pay for health insurance.

This and other issues will have to be carefully analyzed and solutions developed. We expect to work closely with you as we go through this process.

Before you testify, I will ask Congressman Bill Archer to make a short opening statement to be followed by short statements by Congressmen Pete Stark and Bill Thomas, chairman and ranking minority member of the Health Subcommittee.

Mr. Archer.

REP. BILL ARCHER (R-TX): Thank you, Mr. Chairman. And welcome to the committee, Mrs. Clinton. I join Chairman Rostenkowski in that sincere welcome.

Yours has been a unique role, really, in shaping the administration's national health care proposal, and your appearance today is certainly unique in the history of this committee.

I'm glad we can now begin to explore the details of the president's proposal, and so thanks for being with us as we start this process.

No other issue touches the lives of each and every American so personally and so directly. Clearly, the current system has problems that need to be addressed, and we all agree on that. We must provide for security of health care coverage, protecting those who change jobs or have a preexisting condition. We need to reduce the growth of health care costs and simplify and streamline the system. We need to ensure that individuals take greater responsibility for their own health care decisions. Above all, we must maintain the quality of care and guarantee Americans the right to choose their own doctors and their health plans. Sometimes you don't know the benefits that you have until you lose them.

There are fundamental disagreements, however, on how we achieve these worthy goals, and this is the room in which many of those decisions will be made. So it's fitting that we begin the process right here. There are a number of reform proposals on the table, as you know. They take a variety of approaches. None of the others place such reliance on an overwhelming new bureaucracy as the plan that you've laid before us, and it is very complex, as you know.

And you understand it extremely well, but it has never been tried anywhere else in the world. Our task is develop a package that has the broad support and the confidence of the American people, and I must say that I have sincere concern as to whether massive government intervention arising from dozens of new government agencies can achieve that consensus.

I was born and raised in Texas, and I've lived there all my life. But today I'm going to join my colleague, Mel Hancock, and adopt Missouri as my temporary residence. Someone has to show me why we should put at risk the health of our people and that of our economy, which is embodied in such a complete, incredibly complex overhaul of our health care system without an empirical pilot program test. There are 10 million Americans employed in health-related fields today. Nearly all their jobs would be changed to some extent under your plan, and many would be eliminated. We don't yet know how many jobs, particularly in small business, will be lost as a result of the \$275 billion tax increase in the recent budget. And now the administration is talking about employer mandates and a new tax on small businesses as health care costs are shifted to that job-producing sector of our economy.

I'm personally genuinely skeptical about the claim that the president's plan will create new jobs at all. Because evidence is that it will do just the opposite. Martin Feldstein (sp) last week estimated the president's plan will cause a 6.4-percent decline in worker take-home pay, \$115 billion decline in aggregate wages, and the disparity between the administration's in-house analysis and Dr. Feldstein's is certainly alarming.

You know, we've got to reflect back, too, that Lyndon Johnson was told back in the '60s, according to a Washington Post article last week, that the Medicare program would only cost a half billion dollars when fully implemented.

Health care reform isn't a product to be packaged and sold like a toaster on the Home Shopping Network. We've got to know how it works, what it will really cost -- both government and the private sector, and how those costs are going to be paid for, and we must be sure the American people read the warning labels and that the information that they're given is accurate. And that's what this committee is all about. I know that's why you're here today, not as the first lady per se, but rather as lead architect of the administration's approach to health care.

I do believe this process will ultimately result in changes to our health care system that will benefit the American people, and I intend to do my part to help bring that about. And I commend you for personally taking on what I think is the single most daunting domestic problem facing this country in the next ten years.

REP. ROSTENKOWSKI: Mr. Stark?

REP. STARK: Thank you, Mr. Chairman, and good morning, Mrs. Clinton. It's an honor to join Chairman Rostenkowski and the members of the Ways and Committee to welcome you to our committee this morning.

The administration has put forward a bold and comprehensive health plan which embraces the goals of universal coverage, cost control, and a fair way to pay for it. For years, we've struggled to address the problems of health care system, and only intermittent, incremental and limited successes have been ours. At long last, we have a president and a first lady in the White House who understand the need for a comprehensive solution and are committed to real reform.

The ball now comes to our court. It's up to us to enact a plan that will achieve the goals enunciated so well by you and the president. This will be the most important and far-reaching challenge ever tackled by any sitting member of Congress.

The president's plan includes many positive features which I support and will work to retain in the final legislation. In particular, I support the president's courageous decision to impose responsibility for financing on all individuals and all employers.

None of this will work unless we limit the rate of growth, however, in public and private health spending.

Of course, in a plan as complex as has been suggested, there are areas in which there may be some questions and doubts. For example, I don't believe that states should be given the primary responsibility to enact, implement and enforce the provisions of the national plan. Our California governor, for instance, the Honorable Pete Wilson, has already issued a release to announce that the president's plan is unnecessary and he will oppose it. So much for his concern for millions of Californians with no health insurance.

I can't in good conscience ask my constituents to put their health security in the hands of a governor who appears to have no desire or commitment to carry out President Clinton's plan. We must have a definitive federal plan from which any state may opt out if they match or improve upon the federal standards of cost, quality and coverage.

I look forward to continued cooperation with the administration over the next year to resolve the technical differences and to achieve significant reforms in our health care system. Thanks very much for being with us this morning.

REP. ROSTENKOWSKI: Mr. Thomas.

REP. BILL THOMAS (R-CA): Good morning, Mr. Chairman.

Mrs. Clinton, I join my colleagues in welcoming you here today to discuss the president's proposal for health reform. I commend you and the president for undertaking this enormous task.

The president's proposal for health care reform has laudable goals --health security for all, controlled costs, improved quality, less bureaucracy and waste -- goals, I think, that we can all agree upon. We could, I'm sure reach agreement quickly on several important aspects of the president's plan, including insurance market reform, administrative simplification, antitrust, malpractice reform, and the reduction of fraud and abuse.

There are, however, for me several areas of concern. First, I believe the regional alliances as currently structured will result in micromanagement of health care plans and providers participating in those plans. The proposal delegates a tremendous number of functions to the regional alliance, and I share the concern of my colleague about the governing board, which will not include representatives from the health care community whose participation will be critical to the success of any plan.

Second, I doubt the assumed effectiveness of premium caps for controlling the growth of health care costs. Furthermore, I believe that this policy could result in a harmful reduction in health care quality.

Third, this plan contains an employer mandate that will likely compromise to a degree our economic recovery.

Fourth, I'm concerned that the plan relies too heavily on Medicare and Medicaid cuts that in all likelihood will be unattainable. The remaining financing elements are equally problematic. Senator Moynihan called them a fantasy. Regardless of the nomenclature, the mandatory premium payment will have the net effect of a payroll tax.

Fifth, I worry about the plan requiring states to perform critical responsibilities that will be all but impossible for some states to meet.

Sixth, I'm troubled by the potential of this proposal for stifling innovative new technologies and treatments.

While each of these concerns is serious, none is insurmountable. The American people are counting on us to sit down and work out our differences. I'm optimistic that we will not disappoint them, but we do need to be honest with the American people about what meaningful reform will entail. We need to be honest about the financing of these changes. No new benefits until after real savings have been achieved, no desserts before the vegetables.

The American people desire and deserve a health care delivery system that will hold costs down and keep quality high. Each of us believes we have the answer. All of us need to dedicate ourselves to the proposition that we will not let the good or the better slip away because it does not meet our particular definition of the best.

Thank you for putting health care reform in the spotlight. Together, we can turn promise into a reality.

REP. ROSTENKOWSKI: Let me close out the opening statements, Mrs. Clinton, by saying that in my opinion, we have already come an enormous distance in this long journey. The president has succeeded in changing the debate from whether we should have reform to what type of reform it should be. He has put a bold and comprehensive plan before the Congress. Now, it is up to us to respond with the same sense of urgency and commitment which he has demonstrated. I intend to do no less.

Mrs. Clinton, welcome to the committee. After you have spoken, members will be able to ask questions. However, because you must leave by noon, I will ask the members of the committee to observe a limit of one question in order that the question and your response will take no longer than two minutes for each member. Mrs. Clinton, please proceed with your statement.

MRS. CLINTON: Thank you, Mr. Chairman.

I want to thank you and all of the members of the committee for the many hours of meetings and consultation, review and good advice that you have provided us throughout this process. It has been a real personal pleasure for me to get to know many of you personally and to work with you and to watch all of us move toward the realization that health care reform must be achieved for the good of our country.

During the past months, as I have worked to educate myself about the problems facing our nation and facing American citizens about health care, I have learned a great deal. The official reason I am here today is because I have had that responsibility. But more importantly for me, I'm here as a mother, a wife, a daughter, a sister, a woman.

I'm here as an American citizen concerned about the health of her family and the health of her nation.

Like so many Americans, I have seen first-hand the strengths of our health care system as well as its frailties. I know what it's like to be overwhelmed with forms and regulations and confusing medical choices when a family member is dying. I know the anguish that comes when it is impossible to weigh choices or make rational decisions, to understand what the government regulations or insurance fine print might say. I know the frustrations that are felt when judgments about health care too often seem divorced from common sense and human experience. I know from my own experiences and from the conversations I've been privileged to have with thousands of our fellow citizens across this country that something is wrong with our health care system and that it needs to be fixed.

I realize that we all have our own perspectives on how to solve the health care crisis. Each of us brings our own personal perspective to this issue.

Let me say, though, that when the president set up the health care task force and began this journey, he was committed to a simple principle: to build on what works in our current system and to fix what is broken.

Throughout this process, we have not lost sight of that goal. The president's plan honors and preserves the high quality of care Americans have come to know -- our unparalleled doctors, nurses and other health care professionals, our hospitals and sophisticated technology. It also honors and preserves every family's ability to choose a doctor and other care givers. But we must acknowledge that parts of the system are broken and if we go on without change the consequences will be even more costly for millions of Americans and even more disastrous for the nation in both human economic terms.

While we do look forward to the discussion on the details of the reform, and I am so grateful for your willingness to engage in this process with the seriousness and commitment you bring to it, the president will insist on certain overriding principles: security, simplicity, choice, savings, quality and responsibility. Each detail we discuss should be measured against how far a resolution of that detail moves us toward achieving one or more of those principles.

We may disagree on the exact formula for achieving reform, but I hope we can, and trust we will, agree on one thing from the outset: that when our work is done, when the Congress has done what only the Congress can do to bring all of the disparate voices of America into these rooms to hammer out the choices that confront us, every American will receive a health security card guaranteeing a comprehensive package of benefits that can never be taken away under any circumstance.

I have listened, as you have, to thousands of ordinary Americans across our country talk about health care. I know about the tragedies of hard-working families and innocent children who are locked out of our health care system for all the wrong reasons. As a mother, I can understand the feelings of helplessness that must come when a parent can't afford a vaccination or a well-child exam or cannot pay for that x-ray or prescription for a sick child.

As a wife, I can imagine the fear that grips a couple whose health insurance vanishes because of a lost job, a layoff or an unexpected illness. I can see, as a sister, the inequities and inconsistencies of a health care system that offers widely-varying coverage, depending on where a family member lives or works. And as a daughter, I can appreciate the suffering that comes when a parent's treatment is determined as much by bureaucratic rules and regulations as by a doctor's expertise. And as a woman who has spent many years in the work force, I can empathize with those who labor for a lifetime and still cannot be assured they will always have health coverage.

If we put ourselves in the position of people around our country who face these issues every day, if we recognize that the upcoming debate is not about any one set of citizens but about all of us, if we recognize that every single month, 2.25 million Americans who are insured lose their insurance for some period of time, then we know when we talk about security, it is not about security for someone else; it is about security for all of us.

I've had a rare opportunity to meet with literally thousands of Americans across our country. I've sat in living rooms talking to farm families in Iowa. I've sat on loading docks talking to uninsured workers who've worked in the same place for 10, 15, 20 years without insurance. I've sat in hospital waiting rooms talking to doctors, nurses, pharmacists. I've had a unique opportunity to hear firsthand about what is right and what is broken.

I have read letter upon letter of the more than 700,000 that we've received from citizens all over the country who took the time to sit down and share their concerns.

The president's plan is not the product of any one person's work, nor even of the group that he asked to do it. It is literally the product of the work of thousands of people who shared their ideas, their research, and their personal experiences and time with us. Their overriding message to all of us is that Americans can no wait for health care reform.

As we sit here today, literally hundreds and hundreds of Americans will lose their health care insurance. Hundreds and hundreds of families will make a decision to postpone getting that primary or preventive health care because they cannot afford it. Thousands more will show up at the doors of our emergency rooms to seek help because it is the only place available to them. Business owners both large and small will be struggling with insurance premium increases and trying to figure out how to keep doing the right thing for themselves and their employees.

The task confronting us is complex, but it is urgent. The American people rightly are watching all of us. They are impatient, but they are also hopeful. They want change, they expect change, they deserve change. And they want to see the government at the highest levels work for them. They want to know that we have heard their stories.

Last week, the president outlined for Congress a plan that will provide health care for every American, health care that can never be taken away. As the president said and as he believes, this is not a partisan issue, it is not an ideological battle, it is a problem to be solved that affects all of us. And if all of us put it beyond politics as usual, open ourselves up to look at whatever evidence comes our way to scrutinize that and to analyze it, we will respond to the needs the American public have.

I know that you on this committee share these goals. As stewards of the public trust, this is your responsibility. And I'm looking forward over the next weeks and months to not only working with you, but to watching you craft the most important social policy that our nation will have confronted in many decades. This is the chance for the Congress, this is the chance for all of us to make a difference for every American no matter how rich or how poor, whether employed or not, whether living in the country or the city. This is a chance to make a statement that we know what is important in our country and we're about the business of getting it done.

Thank you very much.

REP. ROSTENKOWSKI: Thank you, Mrs. Clinton.

I want to underscore the fact that I'm going to try to limit the question to one question and an answer in a two-minute frame period.

Mrs. Clinton, last week at the White House when we met, the president made the observation that he would have a bill to submit to the Congress in the next two or three weeks. Is that still the same time frame?

MRS. CLINTON: That's what we're trying to accomplish, Mr. Chairman.

REP. ROSTENKOWSKI: Thank you very much. Mr. Gibbons will inquire.

REP. GIBBONS: First of all, Mrs. Clinton, a very fine presentation, and I am -- I believe that the system that has been put forward by the president satisfies security problems -- health security. It satisfies the quality of choices that are provided for individuals. I am concerned that as a nation we're spending 14 percent of our gross domestic product for health care which doesn't measure up very well with the other industrial competitors we have out there in the world.

What I want to hear from you is how do we expect to achieve national savings in this program?

MRS. CLINTON: Mr. Gibbons, let me begin by asking the chairman if I can have more than a minute to respond to that -- (chuckles) -- because I think that not only is that a critical issue for the country to understand and work over, but it is the key issue for this committee, whose responsibility extends to matters of financing and revenues.

Let me begin by saying that the primary source of payment for the health care system will remain as it currently is -- employers and employees contributing to their own health care. And I think it's important to stress that there will be additional revenues coming from employers and employees who do not now make contributions into any kind of health insurance plan.

We have adopted this approach because we believe it builds on what is already available for most Americans. More than 90 percent of Americans who are insured are insured through their employment, and rather than creating any new system, we have built on that system.

However, we are also very sensitive to the fact that many businesses and individuals will face some burdens that they have never had before. That is why we intend to provide discounts for lower wage employees and small businesses and those that employ low-wage employees so that we can keep the cost of health care that will be required to as low an amount as possible.

Now in order to achieve that, we believe there are savings in both the private and the public systems that can be realized and better used, and let me just give you one example of that. Currently, because we have so many uninsured Americans who do show up at the emergency room to achieve care at the last possible moment, we provide -- as you well know on this committee -- something that's called disproportionate payment to hospitals that have a disproportionate burden of individuals who are neither privately nor publicly insured.

Once everyone is insured, we will no longer have to be spending those federal dollars to reimburse hospitals that will now be able to obtain reimbursement through the insurance that everyone will be required to have. That money then can be used to help provide the kind of support and subsidy for low-wage workers and their employers that will enable everyone to be in the system. So, we think that it's these kinds of reallocations within the system that will make a difference. And we could go on, but my red light is on, Mr. Gibbons.

REP. ROSTENKOWSKI: Mr. Archer.

REP. BILL ARCHER (R-TX): Thank you, Mr. Chairman.

It's pretty hard to get into this health care thing in ten-second soundbites. I agree with you, Mrs. Clinton, that we need to do something now to solve some of the real problems for coverage and for preexisting illness and portability and that sort of thing. Can you tell the committee what the timetable is for the implementation of your program? I understand that the first state will not be required to come on board until 1996. Is that correct? And if so, when would it be fully implemented under your program across the nation?

MRS. CLINTON: Mr. Archer, it will depend, of course, as to when the legislation is passed and becomes law. Assuming that we are able to do that before the end of this Congress next year, we do believe that having two years to set up the system while we have some transition reforms, including some of the insurance market reforms you talked about, would enable states to start meeting their obligations starting in '97. Some states, as Mr. Stark pointed out, are more willing and also more ready to meet those obligations, and we expect they would be coming into the system before others. We would like, however, to have all the states in by the end of '97-'98, somewhere in that area. We will look at those years, though, and the phase-in, depending upon what the final legislation looks like. But we are firmly committed to the belief that the sooner we can achieve universal coverage, the better our system will function, both in terms of the savings we can derive from it and the overall economic impact at both the federal and state budgetary levels.

REP. ARCHER: Thank you.

REP. ROSTENKOWSKI: Mr. Pickle.

REP. J.J. PICKLE (D-TX): Thank you, Mr. Chairman.

Mrs. Clinton, we are proud to have you here today and proud of your leadership. Now, I'm deeply concerned about the effect it will have on small business and about how we pay for it, but I think that's going to be a common denominator through this whole hearing.

So, I want to jump ahead and ask you a question down the line about the alliances where, under the state program, if you're under 5,000, they'll all pool their resources. Now, in my district, many of my employers are using a third-party administrator. They contend strongly that they save 30 to 40 percent. They're lean, they're mean, and they're local. Yet, your plan would say any under that level of 5,000 would be done away with. Now, they're doing locally exactly what you want to do nationally. And it seems to me that it's not enough to say, well, you pool it, they can do it cheaper. We ought to have an alternative. So, I'm speaking now for the third-party administrators. Why don't we have a choice, an alternative?

MRS. CLINTON: Mr. Pickle, there will be roles for third-party administrators in the new system. Their roles, though, will be attached to the accountable health plans.

What they will be doing is working with accountable health plans, the providers, those who are actually delivering the services to make sure that the services required to be delivered are done so in the most cost-effective way. Because, you're right, what third-party administrators have been able to do is to serve as kind of an intermediary between the purchaser of insurance and the provider of services. What we would like to do is see their expertise located in the accountable health plan arena, where they can continue to help the providers work to get their costs as low as possible to be efficient.

REP. PICKLE: All right. Now, Mrs. Clinton, I don't see anywhere in the proposed plan a specific provision where the third-party administrators can operate along the lines you say. I hope we can make that clear, because to me they are making a real savings, and we ought not to do away with that choice if it's a practical approach to take.

MRS. CLINTON: Thank you.

Q I thank you.

REP. ROSTENKOWSKI: Mr. Rangel?

REP. CHARLES RANGEL (D-NY): Thank you, Mr. Chairman.

Madam First Lady, if I had more than two minutes, I would spend more time congratulating you and the president for having brought this issue to where it is. I think what we're saying in the Congress is that the nation knows we have to do it and we've never got to this advanced stage before. Now the question is: How do we do it, how do we pay for it, and how do we reach a consensus?

I'm concerned about the impact on medically-underserved communities, as well as what we call just disaster communities. The illnesses that are related to poverty, drug and alcohol abuse will not even allow us to be considered to be entering any risk pool. In addition to that, my state -- and the question I'm asking now -- suffers an inequity in the distribution of Medicaid funds. It's a 50- 50 split, where some states get up to 75 percent of reimbursement. And there's hardly a relationship between the cost of our care and the income of our people along poverty lines. In this plan, have you considered a more equitable split between the federal share and the state share?

MRS. CLINTON: Well, Mr. Rangel, let me just quickly say, as to your first about underserved communities, because it's related to the share that would be required for Medicaid, we share your concern. And that is why we want to have large pools in which all risks are rated at the same community level and you do not, therefore, eliminate whether it's an individual with a preexisting condition or a population area with a concentration of medical problems from coverage.

We think by pooling all people in these large risk pools, which is the way insurance used to be done, where we were community rated instead of experience rated, we will fairly bring in people who up until now have been denied insurance or rejected for it. And I think that will be particularly beneficial in underserved urban and rural areas which have a disproportionately high number of uninsured people, because even in your district, Mr. Rangel, there are many, many hardworking people who cannot get insurance. They are not privately insured and they're not publicly insured. They will all have insurance streams now that will go with them, which will enable them to be better taken care of.

As we fold in the Medicaid system, we will not be distinguishing any longer between Medicaid recipients and others. The Medicaid stream will follow the Medicaid recipients into the overall alliance, but they will not be identified as a Medicaid recipient.

And because they will no longer be in what is an ancillary health program only for those who are means tested and eligible, they will have the benefits that will flow to all Americans, and we think that will eliminate some of the problems we've had in the past about states having to pay a certain percentage and the like because we will bring more resources into the entire insurance coverage pool.

REP. RANGEL: Will the --

REP. ROSTENKOWSKI: The time of the --

REP. RANGEL: -- formula change?

MRS. CLINTON: I'm sorry; what?

REP. RANGEL: Will the formula change at all?

MRS. CLINTON: For the initial period, we're looking at a maintenance of effort, but we think that that can be made to work because of the new funding that will come in through the public health system, through identifying providers as essential providers and having them part of the network of care, and I'd be glad to put that into more detail for you.

REP. RANGEL: Thank you.

REP. ROSTENKOWSKI: Mr. Thomas.

REP. THOMAS: Thank you, Mr. Chairman.

Mrs. Clinton, the president's plan not only changes the health care system but envisions a \$91 billion reduction in the deficit, as well. It's clear that this plan could shift from a deficit reducer to a deficit increaser in the twinkling of an eye if Congress votes benefit increases in the plan but doesn't vote the Medicare and Medicaid reductions. Can you join me today in promising the American people that no new benefits will be adopted and implemented until after real and sufficient, banked savings have been achieved?

MRS. CLINTON: We think, Mr. Thomas, the savings go hand in hand with the benefits. Under the president's plan, the reduction in the rate of increase in Medicare and Medicaid would be used in part to fund new benefits, namely, prescription drugs for the elderly and a beginning on a long-term care proposal.

They go hand in hand. One doesn't precede or follow the other. But clearly, in answer to your question, if we did not have the reduction in the rate of increase in the public programs, we could not offer those benefits.

And I would only add one additional point. As we reduce the rate of increase in the public programs of Medicare and Medicaid, we have to have some means to try to restrain the growth in the private sector, otherwise we will merely have cost-shifting.

So either savings in the absence of some effort to control in the private sector or no savings and new benefits would not work under our plan.

REP. THOMAS: If we vote the benefits and don't vote the reductions, we will have failed.

MRS. CLINTON: Unless you have another revenue source, Mr. Thomas, but you're right. If we do not bring down the rate of increase and vote the benefits, our plan would not be able to support that.

REP. THOMAS: If we do it in that order, I'm with you.

REP. ROSTENKOWSKI: Mr. Stark will inquire.

REP. PETE STARK (D-CA): Thank you, Mr. Chairman.

Mrs. Clinton, our committee and the Health Subcommittee are very proud of the success of the Medicare program. It's popular, it has an overhead of only three cents on the dollar, and it leads the nation in reducing the burden on providers in the use of electronic billing. It took the lead in initiating hospital cost containment in the '80s, and real growth in hospital spending was only 3.2 percent last year as opposed to 5.4 percent nationally. In the first full year of physician payment reforms, Medicare spending for physician services grew only 4.3 percent, about half the rate of the private growth in physician spending. Overall, Medicare is a program about which the federal government and the federal employees who run it can be very proud.

Now, you mentioned personal reference, and my reference is my mom. And she's concerned that you want to cut 200 billion bucks out of Medicare from providers and beneficiaries.

She knows she's going to get a pharmaceutical benefit and some minor increase in long-term care, but she'll have a benefit that's worth about thousands of dollars less than mine and yours under this plan, and her costs are going to go up -- Part B premium and her Medigap.

I said, "Mom, trust me. Trust Mrs. Clinton." But what can you add to reassure mother? (Laughter.)

MRS. CLINTON: Well, let me start -- I have a mother, too, Mr. Stark, so if we can't pass the mother test we're not going to be able to succeed, are we?

REP. STARK: (Laughing.) We're in trouble! (Laughter.)

MRS. CLINTON: I do want to say that this committee, and particularly your subcommittee, certainly do deserve an extraordinary amount of honor and respect for what has proven to be our only universal health care program, namely for those citizens over 65. And I think there are many good lessons to be learned from the efforts you have engaged in over the years to make the Medicare program even better.

What I would look to, though, and what I will tell my mother and hope to tell your mother is that one of the struggles that you have had, and the federal employees who have run the Medicare system, is that although it is a system that does provide care, it does so at very different rates in different parts of the country. And we have countless examples of this, which you know better than I, where you have, for example, Medicare recipients in a city like New Haven, Connecticut being served at one half the cost as a Medicare recipient in Boston just 100 miles away. You can look at a 300 percent differential in the service cost provided to Medicare recipients between Miami, Florida and Milwaukee, Wisconsin.

Now, there is something that is not working in the Medicare system to make the delivery of health care to our mothers cost-effective while remaining high quality. And what we believe is that as we begin to organize our health care delivery system better, as we put some of the initiative into the hands of physicians and hospitals to make some of these choices and move away from what we've tried to do, which is to tell them exactly how much to charge but then give them a big bump if they say they're in an area that costs more even though it's hard to justify that differential in cost, that we can reduce the rate of increase in the Medicare program without in any way undermining quality.

Now if all we were to do, though, is to say go out and reduce it without on the private side trying to make some of these changes which the Medicare people have been on the forefront of trying to figure out how to initiate and reward, that would not work. So they go hand in hand -- the changes in the public system and the changes in the private system.

But I feel very comfortable telling my mother that the kind of care that I want her to have can be delivered in a cost-effective, high-quality way, and there are many places around this country that are doing a better job, and we need to be rewarding them and we need to be changing our system so that more providers do that instead of what is currently much too costly care that has no discernible difference in quality in the Medicare system.

REP. STARK: Thanks, I'll pass it on.

REP. ROSTENKOWSKI: Mr. Jacobs.

REP. JACOBS: When Otis Bowen was secretary of HHS, he made a study of the cigarette tax. The cigarette tax then was one-fourth what it was in 1952 on account of inflation. In real copper pennies, it is still substantially less than it was in '52 before anybody knew the dangers of the use of tobacco. Teenage smoking fell off 17 percent merely and apparently as a consequence of moving the tax up from 8 to 16 cents per pack. I say that for the Record because I know that this is part of the proposal to do even more.

Somebody said in a town meeting to me last night, "Well, what if people quit smoking? We wouldn't be able to collect any tax." And I said, "Horrors," -- (laughter) -- "that would really be a substantial loss to the nation, wouldn't it? How much would you pick up in cost -- health cost savings?"

The president mentioned violent crime as a health problem and some critics have taken him to task for that. I agree with him. I'm a former police officer. I know what he's talking about except for the ones who are doing it. And by chance, you and I corresponded in the late 1970s about early intervention -- childhood intervention of cognitive training to break a chain of educational deprivation in the early years of life, and I submit that that very program is probably the best housing program, probably the best crime program, and probably the best health program if you believe -- and I know you do, as I do -- that an ounce of prevention is worth lots of billions of dollars.

My point is that in 1988 in the welfare reform, we adopted an amendment which require HHS to have pilot programs in the ten AFDC regions which would cost practically nothing, giving college credit to students who would participate on a voluntary program of visiting in poor homes for the purpose of helping the moms and the ultimate purpose of inculcating correct linguistics and, well, really, social grace. That has never been implemented. It was not implemented during the past four years. Secretary Shalala said before the committee at the beginning of the year, I believe, that she would implement it. Is she going to?

MRS. CLINTON: I --

REP. ROSTENKOWSKI: How about a one-word answer, Mrs. Clinton.

MRS. CLINTON: Yes. (Laughter.)

REP. ROSTENKOWSKI: Mrs. Johnson.

REP. NANCY JOHNSON (R-CT): Thank you, Mr. Chairman, and welcome, Mrs. Clinton. Whether the payroll tax cap holds or increases as social security taxes have an other such taxes, and whether the global budget is a benign backstop or a hostile and arbitrary eroder of quality and access depends on whether your plan will in reality develop the savings you anticipate.

As a member of the Health Care Subcommittee that has struggled hard to control the cost of Medicare, and rarely seen us be able to exceed 2 percent -- I think maybe one year we got as far as 3 percent -- it troubles me that in the single year between '95 and '96 you're going to assume we're going to be able to control -- reduce Medicare costs for 4 percent and that over three years we're going to be able to more than cut them in half. And the same you're assuming in Medicaid. Now, those are two programs that Congress has 100-percent power over in recent years, and they have -- the costs in those two programs have risen far faster than in the private sector, where there have been very creative and aggressive efforts at both prevention and wellness programs and a lot of things that have progressively cut costs.

So, given your assumptions in those areas, could you back them up? Because, when coupled with your assumption that growth will be 5 percent in the economy, I wonder whether or not we will be able to avoid an absolutely skyrocketing payroll tax or the global budget as a heavy-handed backstop to make your projections came true.

MRS. CLINTON: Well, Congresswoman, I think that those are very important questions, but the way that we look at this is starting from a base that is much higher than it needs to be. When we spend 14 percent of our GDP, we know we're spending more than we need to spend. When we have a Medicare program that, even after the budget, will grow at 11 percent and a Medicaid program that will grow at 16 percent next year, when neither the populations nor the morbidity statistics affecting those populations groups are growing anywhere like that, we know we can get savings.

Now, the real issue is: How much and how fast? When can we realize them, and how much can they be stabilized over time? And I think that the lessons that we've learned in the private sector in those areas where we have been successful in beginning to get a handle on costs should be applied to the public sector. And I just want to make one quick example of this, because I this is a very key point. I brought with me just one of the millions of pieces of paper that we've looked at over the last months. And it's a consumer guide to coronary artery bypass graft surgery that is put out by the Pennsylvania Health Care Cost Containment Council.

Now, this group here in Pennsylvania, before the president was even elected, had been collecting information about this particular operation and others. If one looks at this and realizes that, if you first of all take the differing costs so that the cost of this particular surgery ranges from \$21,000 to \$84,000 in one state and then if you look at the mortality in each of the hospitals that charges somewhere between 21 and 84, there is no quality difference between the 21,000 and the 84,000. In fact, if I remember correctly, the 21,000 actually had a better-than-average survival rate and quality outcomes than some of those at the upper end.

There are so many lessons to be learned. There are no incentives in our current system overall in the private or in the public to move physicians and hospitals toward making decisions that will result in better-delivered, higher-quality, cheaper coronary bypass surgery, when if we had a system that, in both the Medicare and the private sector, began to push toward making some of those decisions, we could actually in the state of Pennsylvania provide more coronary bypass surgery at a cheaper cost than we currently are to more people and retain quality.

And those are some of the issues that we want not only the country to be talking about but we want our whole reform, through using market and competitive forces, to help move providers toward making those decisions, and that's why we don't think any kind of budget cap would truly be enforceable in most instances but would serve as a backstop so that there would be some overall budget discipline but much of the work will be done in the doctors' offices and in the hospitals as better information becomes available so that these better decisions can be made.

REP. ROSTENKOWSKI: Mr. Matsui will inquire.

REP. ROBERT T. MATSUI (D-CA): Thank you, Mr. Chairman.

Mrs. Clinton, I would like to commend you, the president and your staff for the tremendous job that you and all of you have done in terms of putting this package together. I think it's a tremendous package. It's not only a first start but it's a basis upon which all of us can add to make sure we have affordable health care in America during this session of Congress.

I'd like to ask you a question regarding the mandated benefits.

We're going to receive a lot of opposition from so-called small businesses on that particular issue, and I think it's essential to this program if, in fact, we continue to have health care delivered on an employer-based system as you have proposed, it's my hope that during the course of this debate, you and the president and others that will be speaking on this will explain to the American public the benefits and the justice involved in making sure that all employers insure all their employees, because now there's a cross-subsidization, as we know, insurance premiums go up, because of the fact that some employees are not covered by their employers.

Perhaps you can comment on that because I thought your explanation at the conference we had at the beginning of our session from the August recess was very, very helpful to many of us.

MRS. CLINTON: Well, Mr. Matsui, as you pointed out, what we have is a situation in which the majority of our businesses, both small and large, do provide some insurance. For them, the cost is not only the direct cost that comes from making their contribution to their employees' insurance, but it is the indirect costs they assume because other businesses do not provide any assistance for their employees.

Now, if you go down any Main Street in America, you can go by a store where they provide insurance and then a store that doesn't and then a store that does, and you can just go on down the block. Well, when the employees of the store that does not provide any insurance and there's no opportunity because of the wage level of the employees for them to enter the market to buy their own insurance, when those employees get sick, they go to the same hospital in the same town that is paid for with the health care premiums that are paid by the employers and employees of the two stores on both sides. The result is that the uninsured, then, shift the cost of their care onto the health care premiums paid by those businesses and individuals who do bear the burden in our society. It doesn't strike us as fair that those businesses that have made the commitment to health care should not only bear the burden for their own employees but literally the burden of the employees of others who have not made the same choice.

Yet at the same time, we are sensitive to the costs that confront some of those who have not. And one of the problems in this debate about small business is that many small business owners are looking at the insurance market as it currently exists. And they are saying "How on earth could I afford to go into this market and pay the average going rate for insurance that I know is what is being charged?"

We are talking about a reorganized, re-formed insurance market that businesses would be in. They would not only be part of a very large purchasing pool, which we know will bring down their costs, but for the small businesses and the low-wage employees, they would be given a discount, because we want all businesses to be fairly treated, which means all should contribute, but it also means we should cap the costs at the lower end for the small businesses. And we have run now some computer simulations, and we've had actually a number of businesses go into the Small Business Administration and sit down with their spread sheets and their balance sheets and they've run those figures themselves. And for many small businesses that currently ensure, they will see very large decreases. And for those that do not, the costs will be affordable as we have laid them out.

REP. ROSTENKOWSKI: The chair is going to make the observation that we're running a little behind schedule in hopes that members will shorten the question as opposed to making the statement. We will get back on track.

Ms. Kennelly.

REP. BARBARA B. KENNELLY (D-CN): Thank you, Mrs. Clinton, for coming.

Mrs. Clinton, under the president's plan, he specifically mentions reproductive health services. Currently under most insurance plans, they are silent concerning this. They leave those decisions up to the doctor, up to the patient. And under current law -- and I cite specifically the Public Health Service Act -- there is a conscience clause, and that, for example, would apply to a Catholic hospital. My question to you: Is it possible that this conscience clause could cover an entire health plan?

MRS. CLINTON: Yes, because in our conversations with the Catholic Hospital Association, which presented a plan very similar to the one that we are coming forward with, even again before the president was elected, we anticipate that their will be, for example, catholic health plans in many areas that will link hospitals and maybe even teaching hospitals and providers, and we do think that that would be possible and would be permitted.

REP. KENNELLY: Well, then, take it a step further. Could a conscience clause cover an entire alliance?

MRS. CLINTON: In a whole state?

REP. KENNELLY: Or a large alliance?

MRS. CLINTON: I don't believe so, because I think that what we are attempting to do is to provide the same kind of access to pregnancy-related services that is currently in force now. And, certainly, some states have constitutionally protected regulations that govern abortion, which would be abided by, but I don't think any state or any region of a state that's set up an alliance would, under current constitutional law, be able to prohibit that.

REP. KENNELLY: Thank you, Mrs. Clinton.

REP. ROSTENKOWSKI: Mr. Houghton.

REP. AMO HOUGHTON (R-NY): Thank you very much, Mr. Chairman.

Mrs. Clinton, when I was a little boy, I used to look up at the wall and see those wonderful Norman Rockwell paintings, "The Four Freedoms," and you're really instituting a fifth freedom, the freedom from care, the freedom from the ability to worry about health considerations. The thing that I would like to ask you is this. We have a very delicate system here, and it's called democracy. And why is it that the whole concept of managed competition has moved away from the original thought proposed by the Jackson Hole group towards mandates and federal controls and price controls, away from the federal government spelling out the basic outlines and then stepping back and letting private industry, private individuals, communities, have incentives and have tax credits and things like that to accomplish the same thing?

MRS. CLINTON: Mr. Houghton, we believe that we have taken what managed competition has developed theoretically and analyzed it and actually come up with a plan that rests on competitive and market forces, but recognizes that there are certain problems within our health care system that competition alone either could not handle or could not handle in a timely enough manner to deal with the extraordinary budget and economic pressures we are facing.

And one example is universal coverage, that the theorists of managed competition who have worked on this for a very long time will admit that it is not clear at what point we could reach universal coverage under a pure managed competition theory.

Yet, if we do not reach universal coverage, then we continue to have cost-shifting, and among the problems that would then be faced in any managed competition system is how to deal with the continuing health care costs of the uninsured and how to adjust risks for them. We believe, if we have everybody in the system, that will give us, for the first time, a truly competitive health care system, which we have never had up until now.

You know, many industries, like the ones that you're intimately familiar with, have had to become more efficient in the last decades because of external competition -- a threat from Europe, a threat from Asia. So they had to look hard at where their costs were and make some hard decisions. We don't have external competition in the health care industry in our country. We have to create it, and we believe that the plan the president's proposing takes the best of a competitive approach and puts that to work. And we do want the government to get out of the way, but we think everybody needs to be in the system as an example for the competitive forces to work most efficiently.

REP. ROSTENKOWSKI: Mr. Andrews.

REP. MICHAEL ANDREWS (D-TX): Thank you, Mr. Chairman.

And good morning, Mrs. Clinton. I'd like to follow up on what my friend from New York asked you about and just visit with you about a concern I have about your proposal. And that is that what I think may well be an inordinate amount of government regulation and ultimately micromanagement, which is exactly where we want to move away from. The idea of global budgets and premium caps, it seems to me, may well cause our providers not to compete to keep their costs down but to maybe game the system to get to the cap. And with a situation like global budgets, where different states give different amounts to Medicare recipients, some as widely as disparate as two to one, don't we run the risk, by these kinds of controls, undermining the very kind of competition we're trying to create in the marketplace?

MRS. CLINTON: Well, Congressman, you know, that is one of the sort of great theoretical debates we will have in the coming months, because I certainly appreciate your concerns. But it is very difficult to understand why this particular industry should essentially be without any kind of budgetary discipline, since every other industry has some kind of discipline built in, whether it's competition from the Japanese on how much a car costs or competition from the retailer down the street to see whether or not you get a good deal.

Now, in order for us to move from the kind of system we've had, which has basically been a blank-check system, without any kind of effort to rein in costs in any reasonable way over time to where you and I both want to get, which is high-quality providers competing on the basis of quality and price and not necessarily the kind of continuing micromanagement, overregulated approach that we have seen that does not control costs but continues to reward inefficiency, we believe that the premium cap provides a balance between the micromanagement and over-regulation we do want to eliminate from the system in order to simplify it, and the danger that in the absence of some kind of budget targets, we will continue to have a system that is out of control, that pushes on political levers instead of competitive ones.

But as you and I have talked in the past, we want to make sure that the way we structure this works the way we intend for it to structure, and to that end, we're continuing to have very fruitful discussions with many of the original theorists behind managed competition, with the American Hospital Association, the AMA, other groups that are very concerned as well.

But from our perspective, the country has been basically not facing up to what health care costs and not creating a system in which health care providers were encouraged to make cost-effective, quality-driven decisions. Therefore, we have a lot of practice styles out there among providers that are responsive to the continuing kind of flow of money from the public or private sector. In order to change that, we think we need some kind of budget discipline against which they will measure their decision-making.

REP. ROSTENKOWSKI: Mr. (Levin ?) will inquire.

REP. SANDER LEVIN (D-MI) (?): Thank you.

Mrs. Clinton, this is a special moment for the committee and, I think, a very special moment for women in this country, including my wife and two daughters.

Could I ask you: You've combined a deep commitment with a willingness to negotiate. Give us a further glimpse of your priorities. What, as you negotiate, do you hold most dear?

MRS. CLINTON: Well, Congressman, the way that I would say that is pretty much the way that the president has said now on several occasions in his public appearances.

We believe that we have to achieve universal coverage as soon as possible, as one example, in order to achieve security, but I think that as we work through the details on this, how soon we get there, what the level of benefits are, you know, we want to make sure that the pieces of the system that will get us to universal coverage can work.

Another example might be the whole issue of quality. We want to be sure that the information available to consumers so that they can make good choices is quality driven, and we want to do that in as straightforward and simple a way as possible so that we can sit down and every one of us can know how to choose a health plan that we think is better for us and our families.

But there are many ways of getting to that end point. We want this system to be as familiar as it can be to Americans. That's why we built it on the employer-employee system that already works for so many. But there are many details about the actual way it would function that we want to have a good conversation about, but we want to measure it against the goals that the president has laid out.

REP. LEVIN (?): Thank you.

REP. ROSTENKOWSKI: Mr. McCrery will inquire.

REP. JIM MCCRERY (R-LA): Thank you, Mr. Chairman.

Welcome, Mrs. Clinton. I look forward to future hearings when we have more time so that those of us who are lawyers on the committee can practice our art of develop a line of questioning which is designed to elicit responses to shed light on a particular area of the debate that we think the jury -- in this case, the public -- needs to know about. But in the two minutes that we have, just as a point of information, I hope that this debate revolves around facts.

There are problems in the system. And I hope we discuss the facts about those problems and the cost of solving those problems. Immunization, for example: in my state of Louisiana, a poor state by any standard, there's no excuse for someone not getting immunization. In our community health centers anybody can walk in and get their child immunized for \$5. And if they say they can't afford the \$5, it's waived.

So that's not a problem in Louisiana. If it's not a problem in Louisiana, as poor as we are, I submit it shouldn't be a problem in any state under the current funding.

One problem in the system, though, is the escalation of insurance premiums. That means a lot of people can't afford insurance, small businesses can't afford to provide it. What in your research through your task force have you found is a primary reason for those insurance premiums going up? Let me answer it: the cost of medical services going up. So what is the underlying cost drivers that you've found, if you could just name three or four, that get to those medical costs going up, driving those insurance premiums up?

MRS. CLINTON: Well, there are a number of costs, and I share your hope that we will continue to have this kind of a dialogue because I do want the facts to get out. I'm very confident that when the facts about what works and what doesn't work get out, the American people and the Congress will make a better decision. So that is something that I am committed to.

There are a number of issues. One is the kind of reimbursement system that we have. When you reimburse on the basis of procedures and tests as opposed to a per capita rate in which a plan or a provider is given a certain amount of money to provide all services, you have a difference in both motivation and incentive. If the way that you can be paid is by ordering more and more tests, then it's human nature to order more and more tests. And as Dr. Koop said the other day, he believes there is about \$200 billion in our system of unnecessary costs driven largely by what he views as unnecessary kinds of tests and procedures.

The second issue I alluded to earlier is what is called practice styles. Now, some of that I would argue is a result of different kinds of pressures in a region or different kinds of training. But if you take certain kinds of procedures and you try to determine why one is hospitalized in one community and not hospitalized in another for the same kind of illness or accident, you will find that practice styles of physicians determine often how much a community pays for medical care when in a neighboring community a practice style that, for example, wouldn't hospitalize somebody for the same disease will keep the costs lower. So those two are major reasons.

Thirdly, the way that we have created a system in which some people are paid for in certain ways and other people are not paid for or paid for less causes the whole system to be trying to figure out how to get the most return they possibly can from everybody who's got any money who walks in the door. So it's not just the issue of shifting costs from the uninsured to the insured, it is the issue of trying to figure out how many more patients you can get into a hospital or a clinic who are insured.

And then you're got the problem that we see in the insurance market and the related costs associated with that in the providers of health care, which is that once you don't insure everybody, you essentially, as they say, "cherry pick" among people. Then you've got all different kinds of policies with all different kinds of risk factors associated and costs, and then you raise costs within the insurance market in order to decide who is insured at what cost, and then you raise costs within the doctors' offices and the hospitals to try to figure out how to get under whatever policy words are written so that you can get reimbursed for the services you've provided.

You know, 15 years ago, give or take a few years, most physicians were not spending more than 20 to 25 percent of their income on filling out forms and paperwork. Today it is closer to 50 percent. Now, if you have to hire more clerical workers and bookkeepers, if you have to hire, as many doctors do, a person to sit on the phone to argue with insurance companies as to who will get paid how much for providing which service, you then charge more for the service you've provided because you have to pay for the bookkeeping costs.

So all of these things together have helped to create the kind of atmosphere in which we see costs continuing to go up.

REP. ROSTENKOWSKI: Mr. Cardin.

REP. BENJAMIN L. CARDIN (D-MD): Mrs. Clinton, thank you for your leadership in this area. First an observation on coverage, and then a question on state flexibility.

There are very reasons to be very pleased by the initiative as to the coverage. I am particularly pleased to see references to lead poisoning with our children both in the public health initiative as well as screening being part of the coverage package. Senator Bradley and I have come forward with a way to finance a program to try to prevent lead poisoning with our children, and I would request that we work with you and you designate someone on your staff that we can try to expand the lead poisoning initiative.

Question, though, on state flexibility. I'm very pleased about the state flexibility issues, and while we can be proud of some of the accomplishments in Medicare, some of that has been at the cost of shifting to the private sector. In your draft document, you mention exemptions or exceptions to the ERISA statute to allow states to have all-payer rate systems. My specific question is, will the initiative allow a state like Maryland to continue its all-payer rate system on hospital care? Maryland's looking at expanding that to physician care -- all payer rates. Would that be permitted? And would the authority be exercised either by the state or by the alliance?

MRS. CLINTON: Well, congressman, that would be permitted if that were an option that the state chose, and it would be up to the state to determine how that would be implemented within the state. And I think that's the kind of flexibility that we're talking about. But I'm very conscious of Chairman Stark's concern, because Maryland, to take Maryland as an example, is much further along in devBC-HWMC-H CLINTON 23THADD

x x x year?

How do you do that since he is not an employee so there is no cap on his premium of 20 percent? He has to pay the entire premium himself.

MRS. CLINTON: Well, Congressman, there will be a cap because he is -- we are treating the self-employed and the independent contractor as though they were small businesses. We think that is the fairest way to do this.

REP. MCDERMOTT: So the cap will be 80 percent or 20?

MRS. CLINTON: The cap will be applied to the independent contractor and the small business person who is self-employed. We will give them the 100 percent tax deductibility, but we will also treat them as though they were a small business with only one or two employees, because if the independent contractor uses his wife on some jobs, or his son on some jobs, that will be treated as a small business unit, so they will be entitled to the discounts and caps available to small businesses plus the 100 percent tax deductibility.

REP. MCDERMOTT: And if he can't pay it or doesn't pay it, or she can't or doesn't pay it, what are the enforcement mechanisms?

MRS. CLINTON: Well, we do not want to create some large bureaucracy to go chasing Americans who have not paid their health insurance premiums, which is one of the reasons why we favor the employer-employee system because then it will become automatic for most individuals.

For those individuals who are outside of any other employment relations and are self-employed or an independent contractor, we believe that the incentives and the opportunity to have affordable health care will be very difficult for people to turn away from. And if they show up for care and they cannot show their health security card, then there will be a process put into motion to collect what is due for the care that they have received, so they will be in a sense billed at the point of service, and it will be either deducted from their wages or obtained through tax deductions in some other

way.

REP. MCDERMOTT: Thank you.

REP. ROSTENKOWSKI: Mr. Shaw will inquire.

REP. SHAW: Thank you, Mr. Chairman. Mrs. Clinton, I'd too like to express my appreciation for you being here today.

Mr. Stark raised his mother's question a few moments ago and it seemed like we were going right along the line of everybody being concerned about their mother. I do want to return to that in that my mother is now one of my constituents in the 22nd Congressional District of Florida.

You -- in response to Mr. Stark's question, you made reference to the comparison between Milwaukee and Miami. Miami is one of my -- is part of my new district which stretches from the southern part of Miami Beach up the Atlantic Coast north of Palm Beach to Jupiter. This constitutes the most elderly population of any congressional district in the country. This makes me very concerned about the question of cuts in Medicare. Quite frankly, and to be very blunt, a \$200 billion cut in Medicare is totally unacceptable to the 22nd Congressional District of Florida. It may even be unacceptable to the Congress.

The hospital I was born in -- St. Francis Hospital in Miami Beach -- that was in business for over 70 years, a Catholic hospital, recently went broke, and it went broke because it was a high Medicare hospital. In other words, they had so many Medicare patients who weren't paying their full way now under the formulas set up by this Congress that they just did not have a universal population to spread this expense over.

There are many other hospitals in my district, non-tax-supported hospitals that are holding on by their fingernails. Quite frankly, a substantial cut in Medicare as it applies to the payment of hospitals will do these hospitals under and we will no longer have non-tax supported hospitals in the 22nd congressional district of Florida.

This is also true across much of the Sunbelt and many areas that have a high elderly population.

Assuming this is true and that we are unable to pass the cuts in Medicare that you have suggested in your plan, where would we go to make up the shortfall of \$200 billion and how is that shortfall projected in your formula as it would apply to hospitals versus physicians?

MRS. CLINTON: Well, Mr. Shaw, let me start by saying we project \$124 billion in cuts over seven years, not \$200 billion in Medicare. And of that \$124 billion, we intend to provide new benefits from not cuts but reductions in the rate of growth of Medicare. Because I think as we all know, we are not talking about taking the Medicare currently available and cutting below that amount. We are talking about beginning to reduce the rate of increase in Medicare of \$124 billion, which would bring us down from about 11 percent increase annually to about 6 or 7 percent increase annually.

Now, we believe that there are several advantages to your mother and your other constituents in the 22nd congressional district. The first is that with the reductions in the rate of increase, we will for the very first time be providing a prescription drug benefit for the elderly.

Much of the hospitalization costs and much of the large costs of Medicare are due in no small measure from people either being inadequately or wrongly dealt medication that they cannot afford and that they then end up self-medicating themselves. This is a particular problem among the elderly where you often have elderly patients on Medicare being discharged from the hospital with a prescription in hand which they cannot afford to fill, which means then they don't take the prescription, they end back up in the hospital which costs us more money and we're caught in a vicious circle. We think providing this prescription drugs will help both hospitals be more efficient and individuals be better taken care of.

Secondly, we want to provide a long-term care benefit for the elderly. Those two, prescription drugs and long-term care, are the single biggest issues to the elderly that we have encountered, whether it's individual anecdotes or from ARP and other groups that represent the interests of the elderly.

Specifically as to hospitals like the one that you are talking about, we want those to be considered essential community providers, and we have funds in this system to provide money for them because they do provide a service that would otherwise not be available if they were not there. So we intend to shore them up.

REP. ROSTENKOWSKI: The chair will make the observation that if the question is going to be a two-minute question he's going to suggest that the witness submit the answer in writing at a future time.

Mr. Kleczka will inquire.

REP. GERALD KLECZKA (D-WI): Thank you, Mr. Chairman.

Mrs. Clinton, I join my colleagues in congratulating your

leadership on this most important issue. And in reading the material that has been presented to us, there's so much that I agree with. However, the three areas which I'm having a problem with is the basic benefit package, which I think is more a Cadillac plan than basic. In fact, I'm told that the cost could be \$6,000 for a family plan in 1985 instead of your \$4,200. The National Health Care Board -- my fear there is that it's going to be a bureaucracy; where on the one hand we're trying to cut the paperwork in the private sector and for the providers and we're going to set up this National Health Care Board which is going to grow. And my question is, what is the size of that or what do you envision the size to be and what is the cost?

The last concern is the 80 percent federal pickup for early retirees. I think that's going to be a gigantic cost, which we're going to -- (inaudible word) -- cover, and I think it's probably an employer responsibility in the early retiree years, and it's going to be kind of unique when this early retiree turns 65 and he or she will have to pay 25 percent of the premiums, wherein for the last 10 years they're only paying 20.

MRS. CLINTON: Well, I can't possibly answer those questions in this time period, but let me just quickly say on the benefits package, we have priced that out very carefully, Congressman, and are willing to sit down and show you what the figures are. We have a total agreement among all of the actuaries inside the government who have pounded out these figures. It's the first time that the government actuaries have all sat in the same room and actually struggled over exactly what benefits would cost. And we think that the benefits package is a fair one, particularly because it emphasizes primary and preventive health care, which is not usually included in insurance policies but which we think will save us money over the long run. So I'd be glad to sit down and show you that in detail and also give you additional information about the national board and about the retirees.

REP. KLECZKA: Thank you very much.

REP. ROSTENKOWSKI: Mr. Lewis will inquire.

REP. JOHN LEWIS (D-GA): Thank you, Mr. Chairman.

Mrs. Clinton, I want to say to you what I've said before. As a nation and as a people, we're more than lucky, but we're very blessed to have you leading this effort for comprehensive and universal health care. I really believe when the historians pick up their pen and write about this period, they will say that you were largely responsible for health care reform in America.

Now, my question is very simple. In the inner cities, providers must face high crime and serious health problems. In rural areas, also as in the inner cities, resources are limited

So I'm deeply concerned about how the proposed plan will impact both inner city and rural citizens. How do we ensure, how do we guarantee that these people receive universal and quality health care?

MRS. CLINTON: Well, Mr. Lewis, that's one of the key issues facing this country because in our underserved urban and rural areas, we have literally millions of Americans who are basically denied health care because there are not providers there and they have no insurance to give them the resources to be able to pay for their care. We have a series of proposals, including once again reinstituting and strengthening the National Service Corps of health care providers so that doctors and nurses and others will have their loans paid back and will be encouraged to go into urban and rural areas where there are not health care professionals now.

We also want to see technology used to link areas where there are not enough providers with those where there are, to provide the kind of specialty care. But mostly, we think we will for the first time have a market in which everyone will bring with him or her adequate funding so that they will be able to therefore create a demand which will be met by health care providers.

We also believe, though, we must look at making sure that alliances and accountable health plans do not discriminate against any area geographically or any population, and we intend to put in protections against that.

REP. ROSTENKOWSKI: (Off mike.)

REP. RICK SANTORUM (R-PA): Thank you, Mr. Chairman.

Thank you, Mrs. Clinton. Two quick follow-up questions. You responded to one of the earlier questioners that your full plan would not be implemented for several years and that there would be certain reforms that could take place immediately, like insurance reform and others that we could act on. Would you be amenable, would the administration be amenable to actually doing that in two phases, doing something immediately, getting something up and going that we can implement right away, and then waiting down the road possibly for a longer debate, maybe later next year or the following year, to pass a more comprehensive reform of the program -- of the system?

MRS. CLINTON: No.

REP. SANTORUM: Okay. (Laughter.) See, I ask easy questions, Mrs. -- number two, you -- in follow-up to Mr. McDermott's question about the number of people who may, in fact, fall through the cracks in this system, have you folks done any analysis of what percentage of the people in America will still be uninsured under your proposal -- homeless people, people who have dropped out of the system? What percent are still going to end up at the emergency room without care, without an insurance card?

MRS. CLINTON: A very small percentage, Congressman, and we have done the best analysis we can on that, and we've also looked at Hawaii, which as you know, has an employer/employee mandate, and they cover all but about 2 or 3 percent of their population. And what we know will happen is there will be people who are homeless, who have perhaps mental health problems, who have not gotten into the system. But as they show up for care, they will be. And we have enough funding in the system, we believe, to be able to take care of their needs.

REP. SANTORUM: Under time, Mr. Chairman. (Laughter.)

REP. ROSTENKOWSKI: (Off mike) -- Payne.

REP. LEWIS PAYNE (D-VA): Thank you very much, Mr. Chairman.

And thank you very much, Mrs. Clinton, for taking up the task of reforming our nation's health care system. And I look forward to working with you and with the administration to ensure that implement this within this Congress.

I represent a very diverse congressional district. The University of Virginia's Medical Center is in my district, one of the finest in the country. I have 13 of 17 rural counties, though, that have been classified by HHS as medically-underserved areas. And I'm pleased that the plan does look at rural areas and the special needs that exist there.

I'm troubled, though, by one aspect of the president's plan, and that is the reliance on the tax of tobacco and tobacco products in order to finance health care reform, and I believe that there are some fundamental questions as to the fairness and equity of singling out one product grown in rural areas in one section of the country which will bear the burden of paying for and generating new revenues for the health care system. I have some 5,000 tobacco farmers in my district who rely on their product to support their families, and I would like this question: Can we continue to work together? Will the administration be open to discussing the source of financing for the health care system and open to discussing the amount of the increase on -- of tax on tobacco and tobacco products?

MRS. CLINTON: Mr. Payne, I want to assure you and the tobacco growers in your district that the president and the administration are sensitive to the economic burdens that they will confront when faced with additional taxation. That's one of the reasons, as you know, that the administration supported the domestic content legislation that was part of the budget reconciliation bill, to try to ensure that domestic tobacco growers were treated fairly by the big tobacco manufacturing concerns. And I hope that the growers in your district know your support of that and the fact that the president supported it, so that we can try to have at least a more level playing field against imported and foreign tobacco.

But it is the president's belief that, even though we want to be sensitive and we want to do things like domestic content to try to understand and support the growers, that tobacco is the only product that, if used as directed, can have such damaging health consequences.

And it's particularly damaging to young people. And we hope that price sensitivity about tobacco products will discourage young people from using them.

So we've tried very hard to balance our concerns about the tobacco growers -- whom I know and you know often are not big growers, but small growers with, you know, several dozen acres of tobacco -- against both the health consequences of tobacco use, the need to discourage use among young people, and the belief that tobacco taxes are a fair way to support health care. But as always, this president will have an open door and will be willing to talk, but there will be a tobacco tax as part of this legislation for the reasons I've just enumerated.

REP. ROSTENKOWSKI: Mr. Hoagland will inquire.

REP. HOAGLAND: Let me add my kudos, Mrs. Clinton, to the efforts of you and your staff on the health care task force that have placed health care reform on the national agenda where it belongs.

I have long felt that one of the major defects of the Medicare program is a lack of emphasis on preventive care. For instance, Medicare does not pay for annual preventive physical exams. It waits until our senior citizens are sick before providing physician services, and by then, of course, their condition is often advanced, it's more expensive to treat, and less likely to be cured.

I've introduced legislation for three years now to expand the Medicare program to include a physical exam. I'm particularly interested in the aspects of your program which encourage preventive care and lifestyle changes to make people healthier, and I wonder if you might elaborate on those.

MRS. CLINTON: Mr. Hoagland, we believe so strongly in primary and preventive health care. We think it is good for the individual, and we think it is good for the health care system, and it is both physically very good and also economically because we think we will save money, which is why in the benefits package that we are proposing to be guaranteed to every American, we emphasize primary and preventive health care. It is also why we are going to encourage medical schools to begin doing what they can to encourage more young people to go into primary care. We have examples around the country where that will make a difference. In fact, if you look at the Medicare admissions and if you look at admissions of the under-65 population, hospital admissions often correlate with the number of specialists that are in a particular area. And there is often no discernible difference in the kind of treatment that is given in one community and another community in terms of quality and outcome except that in one community there are more primary and preventive care physicians as opposed to specialists so that our balance has gotten wrong. We have 70 percent specialists, 30 percent primary care physicians. We need to move toward 50-50, and we believe we can do that without in any way undermining either quality or care and access for the entire population.

REP. ROSTENKOWSKI: Mr. Bunning will inquire.

REP. JIM BUNNING (R-KY): Thank you, Mr. Chairman. Mrs. Clinton, I do agree with you that something needs to be done. I just have serious doubt that the administration's plan, as we have discussed it, is the way to go. But I will wait for the plan in bill form to make any kind of decision on what's going on.

My concern is -- the humorist P.G. Rourke (sp) mentioned recently if you think health care is expensive, wait till you get it for free. The administration claims that it wants to tax -- and I'm following up on Mr. Payne -- smokers to make them pay for part of the new system, about \$105 billion over five years or the \$730 billion of the total cost.

If revenues from taxing cigarettes decline, do you think the administration would consider taking other like substances, like caffeine, cholesterol, salt, sugar, alcohol, and putting a tax on those like substances?

MRS. CLINTON: Well, Mr. Bunning, there is no free lunch in this health care plan. It is not going to be free; everybody is going to be paying something. Even people who are on Medicaid now will be paying something if they work, unlike today. And we think that is a big step forward for responsibility.

Secondly, we don't take just taxes on tobacco, we are also looking at assessing those corporations that are going to continue to be self-insured because there will be certain benefits in the health care system, such as the funding for academic health care centers that we believe they should be part of supporting. If there is a way that you can ever come up with to tax substances like the ones you've just named, we'll be glad to look at it.

I've not seen any that would be realistically implemented. But, again, I would repeat that tobacco, insofar as we are aware, is the only substance that if used correctly, as directed, has these health care benefits. Neither alcohol nor caffeine nor the others, if used in moderation or in small amounts, are proven to have the same kind of effects.

REP. ROSTENKOWSKI: Mr. McNulty.

REP. MICHAEL R. MCNULTY (D-NY): Thank you, Mr. Chairman.

Mrs. Clinton, I want to join with my colleagues in commending you for your outstanding work and also in saluting the president for having the guts to tackle this very complicated issue.

In our previous discussions, I have raised with you the issue of treatment for the disease of addiction to alcohol and other drugs, and I think that the evidence is very clear that lack of such treatment results in tremendously increased health care costs, loss of productivity on the job, lost wages, and, heaven forbid, if someone gets involved in the criminal justice system, tremendous costs there. I know I've mentioned to you before in New York state, in the new prison cells that we've been building in the past several years, it costs \$100,000 per cell for every new cell we're building, between \$25,000 and \$30,000 a year per inmate to keep them incarcerated. And it just seems to me that if we're catching people in the earlier stages of their addiction, that we could save a lot of these costs.

Now, I understand that there is some coverage provided in your proposal which will be expanded in later years. And I just wanted to ask for the record if you could briefly explain what that coverage would be.

MRS. CLINTON: Mr. McNulty, we agree with you 100 percent that if we do not provide for substance abuse treatment and we don't provide for mental health treatment, we are not dealing with health care problems. And for too long, they have been put out on the margins and viewed as not related to the overall health care issues confronting us.

And, in fact, it's not just the problems themselves; it's the impact they have on underlying health problems, you know, and I think that needs to be emphasized, that oftentimes hospital admissions and length of stay are determined not just by whatever the physical ailment is, but by the complications caused by underlying alcoholism or drug abuse. And so, we think we need to treat those in order to get health care costs down, as well as to treat the individual problems that they represent.

And in the comprehensive benefits package, we are proposing that there will be for the first time guaranteed coverage for mental health and substance abuse. We have worked very hard to make it a good beginning. It is not adequate to meet the demand that is out there, but it will at least provide a guaranteed base, and then I would imagine there would be a supplemental insurance market, as well as the public health system, that will be available to add on to that for individuals that have particular needs.

REP. MCNULTY: Thank you.

REP. ROSTENKOWSKI: Mr. Reynolds will inquire.

REP. MEL REYNOLDS (D-IL): Thank you, Mr. Chairman.

Mrs. Clinton, let me join my colleagues in saying that I think you've done an outstanding job, and the administration is to be really rewarded for its efforts in this area. For too long in this country, we haven't had this kind of a system.

I do have some concerns, however. I've listened to your testimony this morning, and I've heard a particular phrase in relating to Mr. Payne's question about tobacco. You said if used as directed, that cigarette smoking and tobacco has a severe impact on our health care system. If a Tech-9 semiautomatic weapon is used as directed, it will have a severe impact on our health care system. Last year, there was \$1.5 billion to \$4 billion in health care impact on our system. Has the administration, or is the administration considering including a tax on firearms?

And, if not -- to include in paying for the health care system? And, if not, can we work together to look at this further down the road?

MRS. CLINTON: Mr. Reynolds, we very much respect the proposal that you've come with and have really worked to develop. And we will continue to work and consult with you about it. We are not including it. I think the president's preference is to get semiautomatic weapons out of the hands of people who are killing themselves and each other with them and to take the kind of steps that we need as a nation to put an end to this senseless violence that is not only causing great human tragedy, but as you correctly point out, causing unnecessary health care costs. Violence is a public health problem, and in many respects, it ranks at the very top because the leading cause of death among young men of a certain age now is murder. And then we have all of those costs associated with the individuals who are not killed but who suffer grievous wounds and long-term injuries that we then pay for one way or the other.

So we are committed, as you are, to trying to eliminate the level of violence in this country, both as a moral matter but also as a health care imperative.

REP. REYNOLDS: Thank you, Mr. Chairman.

REP. ROSTENKOWSKI: Mr. Grandy will inquire.

REP. FRED GRANDY (R-IA): Thank you, Mr. Chairman.

Mrs. Clinton, as we move from the principles articulated by the president last week to the program that you designed with your staff that we will consider, I want to say that I am impressed not just with the awareness that you have created on this program, but with the understanding that has begun even at the grass root level of the details of this program. And that leads me to want to ask a responsibility question, taking the six principles.

There are two areas that were addressed this weekend at town meetings that I would like you to at least answer a little bit. One is the 10-year grace period for corporations and unions to extend very generous health benefit plans for a much longer period than a contract negotiation. And the second is the transfer of responsibility from corporations to the public sector to fund early retirees. And those are two tenets in your proposal.

Here's the question: What is the cost of those two attempts to transfer responsibility and, in some cases, forego revenue? And are these items negotiable in terms of perhaps scaling them down to pay for benefits or otherwise provide access earlier?

MRS. CLINTON: Mr. Grandy, yes, how we do these are certainly negotiable, because what we are attempting to do in the first instance with the grace period is to avoid imposing a tax on people who have basically foregone wage increases by having health benefits increase. And it's a very difficult problem that we confront. Because what we have seen in our economy over the last decade is that real wages have stayed largely flat and where the increase in compensation has come has come in increasing benefits which have had to increase faster than they should have because of the inflated cost of those benefits.

We don't want to tax the middle class, and it's not just negotiated bargaining contracts. It's many employers who have been willing as a competitive device to provide benefits that they would not otherwise have had to and which may, for some period of time, exceed the guaranteed benefits package. So we believe the fair thing to do is to give notice to these employers and employees that, at a date certain, they will no longer get tax preference for any benefits above the comprehensive benefits package. How soon we get there and how quickly we can implement that without the kind of tax increase that it would result in to many people is something we will show you our figures on and talk about, because we want to reach a fair and equitable resolution.

With respect to the retirees, we have costed that out at about \$4&1/2 billion. And there are several ways of looking at this issue. One is that, for many employers who have large retiree costs, they have been the most responsible businesses in our country. They have basically assumed a huge social cost, not only in direct dollars in terms of insuring their employees and their retirees, but in subsidizing many other sectors of the economy that refuse to or neglected to insure their employees because those employees were married to people who were taken care of by employers who bore more responsibility.

So, there's been a direct cost and an indirect cost. Huge sectors of our economy have been subsidized and able to provide either very low or no benefits because they have hired spouses of people who have been given big benefits. And we even have companies that have been giving cash bonuses to spouses not to go on their plan, but instead to let their employers, the spouse's employer, bear the full cost.

So, we think there's been a real showing of responsibility that has distorted the economy to the disadvantage of many of the businesses that have borne the larger costs. Now, how fast we do that, the number of retirees that are covered, the extent of the coverage, the sharing of the responsibility, all of that is something that we want to be sure works out and we'll be happy to talk to you about.

REP. GRANDY: Thank you.

REP. ROSTENKOWSKI: Mr. Coyne will inquire.

REP. WILLIAM J. COYNE (D-PA): Thank you, Mr. Chairman.

Welcome, Mrs. Clinton, and thank you for your testimony and your very comprehensive statement.

I see no reference in the preliminary reports of the plan to the National Institute of Health or biomedical research, and it has been suggested that possibly a \$5 surcharge on monthly policies, health insurance policies, might be a route to go to be able to provide for our medical research costs. And beyond that, what is our plan for the unemployed, the 20 million unemployed that we have in our economy today?

MRS. CLINTON: Well, Mr. Coyne, we believe in enhancing our research capacity and we do have funds earmarked for that. But I agree with you that if we can get a steady stream of funding into our research institutions, we are likely to save money again in the long run by finding cures and by making other decisions that will enhance health. And we'll be glad to look at the idea you just presented, as well as any others.

The unemployed will be federally subsidized because the unemployed will sometimes work part of the year, but not all of the year. When they work, they and their employer will make a proportionate payment into the health alliance. The time of the year when they are unemployed, they will have a federal subsidy. But we think a lot of the unemployed are seasonally unemployed. They are periodically unemployed. They come in and out of the labor market. So that there will be some money coming in from them and their employers to help match the federal money that will make sure that they are fully covered.

REP. COYNE: But, as you know and everyone knows, there's a lot of unemployed that have been unemployed for an awful long time, beyond even the 52 weeks of benefits that they get in compensation. And I think they need to be attended to.

MRS. CLINTON: They will be. They will be members of the alliance, and their share will be paid for by the federal government.

REP. ROSTENKOWSKI: Mr. Jefferson will inquire.

REP. WILLIAM J. JEFFERSON (D-LA): Thank you, Mr. Chairman.

Mrs. Clinton, I, like the rest of the committee members, want to thank you for your leadership in this area and for your personal investment, particularly coming to my district and the others around the country to inquire of our citizens.

Charlie Rangel and John Lewis have asked questions about the reform -- how reform affects the inner-city residents. I want to ask a question that has two aspects. One is, most of the primary health care that's being provided (in inner ?) cities is being provided by minority physicians, particularly through the Medicaid program. They have combined themselves as small cooperatives. They're concerned about how they'll be able to manage their affairs when it looks as if the small groups are going to be squeezed in this plan. The second is, there's a promise in the outline that I have seen of infrastructure support for public hospitals and clinics. Could you please tell me how the details of that might be developed and then comment on the earlier part about how the small physician groups might operate in the larger plan?

MRS. CLINTON: Mr. Jefferson, let me answer the first question orally and then the second in writing because I can't possibly meet the chairman's deadline trying to do both of those, if that would be all right.

With respect to minority providers, solo practitioners, others in both rural and urban areas, we anticipate several advantages in the proposal that we have. The first is that in every region of the country, there will be guaranteed in every alliance a network for all physicians to be members so that no physician will be shut out from being able to compete for the business of all of us who will put our health insurance premiums into these large pools. There will be a guaranteed network on a fee-for-service model, just as current medicine operates in most areas.

Secondly, there will be no permitted discrimination against any physicians from joining more than one plan, if that physicians chooses to do so, so that a physician could be both a member of the fee-for-service network, and a PPO, for example -- a preferred provider organization, and there would be no penalty or prohibition against that.

We also anticipate and have had conversations with the National Medical Association, with representatives of Hispanic physicians and others as to how -- when accountable health plans come in a bid for our business. They will find it in their interest to make alliances with and to have those physicians as part of their networks because in order to serve the populations that are already used to receiving care from certain physicians, they will want those physicians to be affiliated with them so that it is more likely when an individual comes to sign up for a plan, if they know the name of the doctor or the name of the clinic that they are familiar with, they are

more likely to sign up for that plan. So there will be, as I learned when I was in New Orleans and talking with representatives from some of the large hospitals and clinics there, an incentive that has never existed before to create partnership and relationships with inner city physicians and rural physicians to make them parts of these networks.

REP. ROSTENKOWSKI: Mr. Camp will inquire.

REP. DAVE CAMP (R-MI): Thank you, Mr. Chairman, and thank you, Mrs. Clinton. My question -- I have a two-part question involving primarily farm families. Specifically, how will seasonal and migrant workers be covered, and who will be responsible for their participation in a regional plan?

And secondly, many farm families fall under the self-employed category, and will the payroll tax be required even in unprofitable years, often not a result of anything they've done but because of weather or other conditions, so that they can continue to have, maybe, the small number of employees they have and continue in business?

MRS. CLINTON: Well, in our work on behalf of health care needs of farm families in particular, we believe that treating a farm family as a small business, giving them 100 percent tax deductibility for their health insurance costs, and capping the amount of money they have to contribute will make health care affordable for farm families in ways it has never been before.

In many of the instances where I've sat down and actually looked at the bills of farm families and sat and looked at their records, what I have been struck by is how they are among the most responsible people in our whole country. Oftentimes, they make enormous sacrifices to be insured. Often they send a member of the family off to work in a business where insurance is offered which then hurts the farm, but they at least are insured. And I think that what we're offering will be very beneficial.

Now with respect to seasonal and migrant workers, the health care benefits will be available to legal residents and citizens of this country, and that is a decision that we have made, looking at all the numbers. Certainly the public health facilities, the emergency rooms -- as they are now -- will be available to those who are not currently citizens.

Now seasonal employees -- just as now, when a farm family pays a seasonal employee who is a citizen, they make some kind of report or the responsibility shifts to the individual to make the report to the IRS about wages. If the individual is an individual contractor as opposed to an employee, then that individual will be responsible for his or her health

care. If it is an employee, then the farmer will be responsible for the proportion of time that the individual works for him, just as he would be with FICA or Social Security or any other payments that are now required, but the caps and the discounts would, of course, apply because of the wage of the worker.

REP. ROSTENKOWSKI: Mr. Deal will inquire.

REP. NATHAN DEAL (D-GA): Thank you, Mr. Chairman, and thank you, Mrs. Clinton. I think all would agree you've done a superb job this morning of answering the questions. I would guess in your next life that we ought to submit your name for Jeopardy. (Laughter.)

One of the perceptions we're going to have to overcome in this debate, those of us who are proponents of restructuring the health care system, is the suggestion in some quarters that we are going to be subtracting from the quality of health care for a percentage of our population.

In Massachusetts, we have many of the best hospitals in the world, and this is going to be part of the debate. But like Mr. Rostenkowski and Mr. Gephardt, Congressman McCrery and Speaker Foley, I have a Shriners' hospital in my hometown in Springfield. They don't accept any government money, no insurance payments. They're funded exclusively through charitable contributions. There is no other totally free hospital system in this country that I'm aware of. And the Shriners have petitioned me on behalf of that hospital that gives extraordinary care to anybody to raise the question of you whether or not they're going to be subjected to a host of new rules, regulations, or paperwork requirements that don't make sense for a hospital that doesn't charge its patients. And if you could speak to that question this morning, that would be much appreciated.

MRS. CLINTON: This is the first time I've ever been asked that, Mr. Neal, and my response --

REP. NEAL: I'm moved, I have to tell you. Thank you. (Laughter.)

MRS. CLINTON: But my response is I surely hope not. You know, that is one part of the system that's not broke, and we ought not to try to fix it. And if they are totally subsidizing the care that they provide without any government assistance of any sort, then we will certainly do what we can to make sure that continues.

REP. NEAL: And I hope I might extend an invitation to you to visit a Shriners' hospital, although I assume that the chairman will lobby hard for Chicago. (Laughter.) He might prevail over me.

MRS. CLINTON: I've actually visited the Shriners' hospital in Chicago. I share that hometown with the chairman, so -- .

REP. NEAL: Thank you very much, Mrs. Clinton.

REP. ROSTENKOWSKI: (Laughs.) Mr. Brewster will inquire.

REP. BILL BREWSTER (D-OK): Thank you, Mr. Chairman.

First, I would like to applaud your efforts in this monumental task. As a person who spent most of my life in health care, I know there's no issue more complicated than this one.

For many of us, the small business mandates will be a very difficult part. As a person who's been in small business, I know workers' comp is also a problem for small business. I would hope that you would look at the possibility of rolling the two together. I think it can be very workable.

But the small business subsidy in the plan I notice also is temporary. I don't see a timeframe listed. What is the timeframe you're considering on subsidizing small business, low-income-type business in this plan?

MRS. CLINTON: Mr. Brewster, we may very well have to extend that beyond what is normally thought of as temporary because we want to get the system on stable footing, as a friend of mine said, sort of stabilize the patient, and make sure that we get the kinds of savings and efficiencies that we know will come once we have a better organized health care system. But we certainly don't want to do anything that would impose unnecessary burdens on small business at any point in this process. The whole hope and what many people like Dr. Koop and others who have studied this really believe is that once we get better organized systems of care, then a lot of these costs will continue to decline even though we are in the short run -- and I think this is an important point to make -- we are in the short run going to be increasing health care expenditures.

You know, that is something that when people talk about the impact on small business is not a factor that is often looked at carefully. We are going to be putting billions of new dollars into this system largely from the employer-employee contribution, but also we're going to be very soon lowering the cost to other employers so that jobs will be created, new hires will be made, wages will be increased, and then at the same time if we are able to add the prescription drug benefit and the home health and long-term care benefit there will be more jobs opening up for people in health care.

So this is an issue in which there are many factors at work at one time. And we are very confident that small business will in the medium and long run and most small businesses in the short run be advantaged by what we are doing and other small businesses will be created by what we are doing.

So we intend to look very carefully at how we protect small businesses and give them the kind of fair, affordable health care they deserve to have.

And I can't help but add, Mr. Brewster, as a pharmacist, you know that one of our primary problems is getting affordable costs of prescription drugs available to everybody, whether they're small business, big business, individuals. And we want very much for this health care reform to make retail pharmacy, discount pharmacy, pharmaceuticals in general more available at more affordable costs. That, we think, will help bring down costs in the long run.

REP. BREWSTER: Thank you.

REP. ROSTENKOWSKI: Mr. Hancock will inquire.

REP. MEL HANCOCK (R-MO): Mr. Clinton, one of the greatest strengths of our society has been -- and our system of government -- is that it has historically stressed individual responsibility and initiative. Now, during the long period of development of the president's health care plan, was there any consideration given to the inclusion of a "Medisave" type account, which would be similar to a 401K or an individual IRA, but dedicated to pay to the individual's health care expenditures? Was this considered? And, if not, why not?

MRS. CLINTON: Yes, it was, Mr. Hancock. We looked, I believe, at every proposal for a "Medisave" or a medical IRA that we're aware of. And we do believe that it does promote individual responsibility, but we had several questions after analysis that we had that we could not adequately answer. One is that the medical IRA concept, in which individuals basically put aside money that they will then be able to keep so long as they do not use it, does nothing to encourage primary and preventive health care.

In fact, it is a continuation of one of the real weaknesses, we think, in our current system, which is that many people are insured only for catastrophic encounters and they, therefore, postpone seeking help as long as possible. We want people actually to get in and get good primary and preventive health care so that their diabetes, for example, doesn't end up with having to amputate a foot or whatever the other kinds of problems will come from not being taken care of.

And that was one of our problems with the medical IRA concept, is that it did not provide the kind of incentives that we think are necessary to reverse what has been one of the real problems in the health care system of emphasizing catastrophic and medical emergency over primary and preventive health care.

And the second issue is how we would ensure that all persons were covered. Many people will not be encouraged, unless required, to be responsible, so that the medical IRA might work for some members of the society who would either be encouraged to do so by their employer or would understand the tax benefits. But for millions and millions of other Americans, without some kind of mandatory system, either the kind of individual mandate that the Senate Republicans have talked about or the employer/employee contributions that is in our plan, we are afraid we will still continue to have millions of uninsured and underinsured Americans and the costs will continue to be shifted and will continue to go up. And those were our two primary problems.

REP. ROSTENKOWSKI: Mr. Kopetski will inquire.

REP. MIKE KOPETSKI (D-OR): Thank you, Mr. Chairman.

Welcome. I understand and appreciate the fact that under the president's plan, the mental health component of the benefit package will reach parity with the physical injury care by the year 2001. In spite of this, we need to provide a wide range of services to the mentally ill, and in most cases the least-restrictive treatment setting is the cheapest and, in many cases, the most effective. Given the need for a shift in focus from inpatient settings to outpatient settings, why are there 60 days of inpatient hospitalization coverage available in the mental health package but only 30 visits for outpatient psychotherapy?

MRS. CLINTON: The reason for that, Congressman, is that we are trying to start with emphasizing the care of the most severely mentally ill, those who do require the kind of inpatient intervention that often is linked to the most severe kinds of mental illness. We thought that would be our first responsibility, to provide that kind of system. And we intend to build on the 30 days of outpatient treatment as we go forward. We also believe that with a prescription drug benefit, the costs of medication will be more readily available for all different degrees of mental illness, and that the 30 days outpatient treatment combined with more affordable and accessible medication is an adequate benefit. It is not where we think we should end up as a country; that's why we have additional benefits that we would recommend be phased in as we realize savings. But we think it is a very good and strong beginning for mental health coverage.

REP. KOPETSKI: Thank you.

REP. ROSTENKOWSKI: Mr. Herger?

REP. WALLY HERGER (R-CA): Thank you, Mr. Chairman.

Mrs. Clinton, as you're well aware, we have a very major illegal immigration problem in our nation today, and regrettably, there isn't any state where this is more pronounced than my own home state of California. It's been estimated that between \$400 million and \$500 million a year is spent on Medicaid for illegal immigrants. Could you tell me, under the president's program, to what degree states would be mandated to continue this unfunded coverage?

MRS. CLINTON: Well, Congressman, you're right that this is a very serious problem, and in fact, one of the reasons why we have adopted the position we have, which is that only legal residents and citizens will be entitled to the comprehensive benefits and the health security card, is so that we do not do anything to encourage even more illegal immigration in return for trying to get those kinds of benefits. And that's why we have drawn the line as we have drawn it. But we are left, as you rightly point out, with a serious problem because we have a number of undocumented workers and illegal aliens in the country right now, and they do show up at our emergency rooms and they do use our public health facilities.

We are hoping to work out a more equitable sharing of that responsibility, and that is something that we will be looking at, and we would welcome your advice about how best to do that so that individual states don't bear the entire national burden for this cost.

REP. HERGER: So in other words, you're saying that where a state like our state is paying the bill themselves -- again, of almost a half billion dollars a year -- that you would be looking at a way to finance this? I've heard that perhaps there might be a pool. I don't know if you are familiar with that, if there's been any talk that's gone on on that extent or to what the cost you felt this might be.

MRS. CLINTON: Well, congressman, we are looking at a variety of alternatives, because we share your concern about this issue and the burden that it places on local hospitals as well as state budgets. And we don't have a final recommendation on that. But we do wish to work with you and others who represent the affected states to try to come up with a more equitable solution to those costs.

REP. HERGER: Thank you.

REP. ROSTENKOWSKI: Mrs. Clinton, it's very difficult here trying to keep the trains running on time. I know what your schedule is, and I want to make an observation.

I hope that your experience here has been as pleasant as I found you a pleasant witness. I'm tempted to applaud you, but then again, that would be only -- (applause) -- that would truly be only if you didn't perform as exceptionally as you did. And you were marvelous. You're a marvelous witness.

I've been here for a few years. And I've seen not exclusively this committee, but members of other committees wrestle with the health problem of this country. One of the reasons I ran for reelection was so that I could try in my little way to help solve this problem.

I think you and your husband are certain going to be the catalysts in this. We need leadership. We have on both sides of this aisle tried to solve this problem, but we needed somebody strong in the White House that was willing to bite the bullet. I think in the very near future the president will be known as your husband. Who's that fellow? That's Hillary's husband. (Laughter.) With the outstanding job that you've done here, my compliments to you, my compliments to the President of the United States for addressing this problem, and I hope that by the end of this Congress it will be on the president's desk, you standing at his side, for signature.

Thank you very much for joining us this morning.

MRS. CLINTON: Thank you, Mr. Chairman. (Applause.)

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FROM: Jeffrey L. Eller
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SUBJECT: HRC afternoon transcript from 9/28

THE REUTER TRANSCRIPT REPORT

HEARING OF THE HOUSE ENERGY AND COMMERCE COMMITTEE

SUBJECT: THE CLINTON HEALTH CARE PROPOSAL

CHAIR BY: REPRESENTATIVE JOHN DINGELL (D-MI)

WITNESS:

FIRST LADY HILLARY CLINTON

2123 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON DC

TUESDAY, SEPTEMBER 28, 1993

REP. DINGELL: (Sounds gavel.) The committee will come to order.
Today the committee is honored and happy to launch its hearings on the
president's health care reform proposal.

We welcome today most warmly the first lady, Mrs. Hillary Rodham
Clinton, as the lead-off witness in these hearings and as lead-off witness on
behalf of the administration.

Before we begin, the chair wishes to address a few housekeeping
matters. These were outlined in the memorandum which I sent to my colleagues
yesterday, but for the record, they will be repeated.

First, the chair will not be making an opening statement today,
and other opening statements today will be dispensed with so that the time
that the committee has can be used by Mrs. Clinton in the most efficient and
best fashion. Members may insert written statements for the record if they so
desire. And without objection, all members will be afforded rights at this
time to insert an appropriate opening statement in the record. Opportunity
will be later available for members to make oral opening statements at a
future hearing. The chair wishes to thank the members for their cooperation
on this point.

Second, in order to enable the broadest possible participation of
members today, it is the intention of the chair to observe the rules of the

committee strictly because Mrs. Clinton's time with us today is most limited. I know members will be fair to their colleagues who are waiting patiently for an opportunity to question Mrs. Clinton by limiting their dialogue with the witness to the allocated time.

Finally, and consistent with committee rule 4(c), members present at the time the hearing was called to order will be recognized in order of seniority, alternating, as is the custom, between the majority and the minority. In light of the fact that we have two subcommittees who will be

working on this legislation, the chair will treat the chairwoman and the ranking minority member of the commerce subcommittee, Mrs. Collins and Mr. Stearns, as having seniority immediately following that of Mr. Waxman and Mr. Bliley respectively. The rule also provides that members not present at the hearing when it was called to order will be recognized in order of their appearance, and staff will be making careful note of the arrival of members for this purpose.

The chair wants to thank the members of the committee for their cooperation.

The chair thanks you, Mrs. Clinton, for your patience and for your being present with us today. This is a rare occasion for both you and for the committee. You are only the third first lady in history to testify before the Congress, and this is the first time since 1986 that we have convened a full committee hearing, which we have done to hear you. We are honored to have you here today. I understand that you are appearing today without a formally prepared text, so you are invited to proceed in any manner that you seem appropriate.

MRS. CLINTON: Thank you very much, Mr. Chairman. I want to thank you and the members of this committee for giving me this opportunity. But more than that, I want to thank you for the time that you have spent with me over the last months as we have worked through a lot of the issues that will affect the future health care well-being of our country.

I would also particularly like to thank the chairman for the good counsel that he has given to me as I have pursued the issues related to health care reform. I think that is very appropriate for the chairman to have done because, as we all know, 50 years ago the chairman's father introduced the Dingell-Murray-Wagner Bill, the first national health insurance legislation ever put before the Congress. The chairman's father understood the importance of providing health security for all Americans. He fought vigorously to keep the idea alive in Congress for 15 years. And you, Mr. Chairman, have continued that fight by introducing similar legislation in every session since you succeeded your father in the House of Representatives. You both proved to be men ahead of your time.

Although parts of your father's bill have been incorporated into subsequent reform efforts, such as Medicare and Medicaid, we have yet to fulfill your father's dream and the dreams of many other Americans of providing comprehensive health care for all of our citizens.

Health care reform is not a new idea nor a revolutionary concept. But while most Americans favor reform, we have failed as a nation to make much progress when it comes to providing health security for every citizen. Sadly, health reform in this country is less a story of the typical American

“can do” attitude than a story of procrastination and parochialism and all too often greed, fraud, waste and abuse.

Thomas Jefferson was the first president to talk about the importance of individual health. Franklin Roosevelt hoped that health security would be the other half of the Social Security system. But political realities forced President Roosevelt to discard that dream, and the result, as we know, has been ongoing insecurity for millions of hardworking Americans.

When Harry Truman campaigned for a comprehensive health program in 1945, he told Congress, and I quote, “Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness.” But President Truman’s pleas for health security fell victim to the politics of the day and scares about socialized medicine.

Dwight Eisenhower came before the Congress in 1955 and said that health insurance could be improved by expanding the scope of the benefits provided. John F. Kennedy proposed expanding coverage to the elderly and the mentally ill. By the early 1960s, both Presidents Eisenhower and Kennedy could not say that their hopes of health security had gone forward but, instead, they saw once again the familiar sight of a dream of health security being stalled by outside interest groups and partisan bickering in the Congress.

Then came Presidents Lyndon Johnson, Richard Nixon and Jimmy Carter. There was progress made on Medicare and Medicaid. President Nixon came forward with a comprehensive health care reform proposal that built on the employer-employee system. President Carter proposed a number of advances, and particularly Mrs. Carter championed the cause of mental health benefits. They, too, envisioned reforms that would give Americans more health security and our nation more economic security. But like their predecessors, their efforts and their hopes were not realized.

So here we are in 1993, 50 years after the chairman’s father introduced the first legislation. We are still wrestling with many of the same issues and the same problems that previous generations have worked on. The difference is that today our system has many problems that have gotten increasingly expensive, and the difficulties of delivering health care in a cost-effective way is making a challenge to the fiscal integrity of the federal and state governments, to businesses, to individuals across the country. Now is our chance to beat the historical odds and give the American people the health security they need and deserve.

For the past 12 years, this committee has fought to extend health

are benefits to every American. For years, this committee has tried to root-out fraud and abuse in the health care system. For years, this committee has been ahead of its time.

Now I hope that all of our time has come. I hope that this committee, building on its rich tradition and many contributions, will help this president and this congress and this country pass health reform legislation so that we can control health care costs and provide every American with affordable, high quality medical care. I hope that during this session of Congress we will finally give Chairman Dingell's father the tribute he deserves; this committee will see the realization of the work it has done; but most importantly, as public stewards, the people you represent will know that their government has listened and heard and acted on their behalf.

Thank you very much, Mr. Chairman.

REP. DINGELL: Mrs. Clinton, the committee thanks you for a very fine statement, one which I take great pride and pleasure in, your mention of my old dad, who would have certainly been proud to have heard you say these things today. It was his hope and his dream and his prayer that we would one day provide a decent measure of health security in this country for all of our people. And I'm sure that he would have been very proud that you were taking the leadership on it, and he'd be very pleased that you would mention him today, as indeed am I.

I'm only going to say that I intend to do my best to help you push through the best possible form of health security legislation for all the people at the earliest time, and you have my pledge to that. And having said that, the chair is going to recognize my colleagues for questions in the order in which the rules proscribe.

The chair will recognize then, for five minutes exactly, first the gentleman from California, Mr. Waxman, chairman of the subcommittee.

REP. HENRY WAXMAN (D-CA): Thank you very much, Mr. Chairman.

Mrs. Clinton, I'm really delighted to see you here. My father just passed away, as did yours, and we started going through his papers. We found a letter he wrote around 50 years ago complaining about the fact that a doctor wouldn't come to my mother because they couldn't afford to pay the bill. She suffered for the rest of her life because of an illness that might have been controlled.

So I know it was my father's dream as well, and others around this country, that we finally have guaranteed access to care for all Americans. That's really what the core of the president's proposal is all about. And some of us who have worked in this area for a long time have felt that we needed a president who was willing to take the bold leadership to deal with

his difficult issue. I used to think that would be enough. Now I know that what we needed more was also a first lady like yourself to give us the expertise and guidance you have given us in preparing this plan before us.

The crux of the whole issue is that we have everybody get a comprehensive set of benefits. Your proposal would have us do that through the jobs side, through employer/employee contribution. Everybody's giving lip service to universal coverage, but some people are just simply saying employers ought to just offer it but without making a contribution. Some others are saying that what we ought to do is require each individual to go out and buy insurance and, again, no requirement that employers play any role.

How is it that you came to this conclusion that we needed to require employers, large and small, and all employees to participate in paying for health insurance?

MRS. CLINTON: Well, Mr. Waxman, I think that you've pointed out what is one of the critical features of the president's plan. And for all of the members of this committee who have struggled with the costs of health care and how we would achieve universal coverage, you know that there are really only three general ways to approach this, and we have looked at all three.

The first would be a large broad-based tax that would replace the existing private sector contributions. That would mean it would replace the existing employer/employee system and any individual contributions. For a number of reasons, the president rejected any kind of broad-based tax that would substitute for the system that we currently have.

A second possibility that you alluded to is to put the burden on individuals as some states currently do with respect to auto insurance; to essentially mandate that individuals would be responsible for their own health care insurance, and in order to make that affordable there would be some insurance market reforms and some kind of support through financial payments of some fashion to low-wage individuals who otherwise could not afford it.

We looked very closely at that and we are continuing to work with those who advocate that position, particularly the Senate Republicans who have advocated an individual mandate. But we have a number of questions about it. One is that we worry that it would undermine the existing employer/employee system in which on a voluntary basis, as a matter of either collective bargaining or employer choice for competitive purposes, employers have responded over the last decades in increasing numbers to provide health insurance. And that employer/employee system has served as the basis for insuring more than 90 percent of the people in this country who have private insurance. And we would worry that shifting the burden wholly

7.

over to the individual would result in many employers who currently insure ceasing to do so, or maybe only insuring their high-wage workers and not their low-wage workers. And we would worry that if we subsidized individuals below a certain income level that there would be pressure on employers to keep wages below the subsidy level so that they would continue to be paid for by the government. So we have a number of problems with the individual approach.

What we concluded is that what we want to do is preserve what's right about our system and fix what's wrong. We think one of the things which is right is the employer/employee system, which does work well for most Americans. Its biggest problems have been that the cost of insurance has made it more and more difficult for many businesses to be able to participate. If you build on the employer/employee system, you are already building on what is available and familiar to most Americans. And if you do as we propose to do, to provide discounts for small businesses and to subsidize low-wage workers, we think that is the fairest and most responsible way to get everybody into the system, and it's a system that is already working for most Americans, and that's among the reasons why we concluded it would be the best approach for us to take at this time.

REP. WAXMAN: Thank you very much.

REP. DINGELL: The time of the gentleman has expired.

The chair recognizes now the gentleman from Virginia, Mr. Bliley, the ranking minority member of the subcommittee, for purposes of questions.

REP. THOMAS J. BLILEY, JR. (R-VA): Thank you, Mr. Chairman.

Mr. Chairman, under the rules of the committee, I ask unanimous consent to be able to distribute to the members copies of two graphs that I intend to use during my question.

REP. DINGELL: Without objection, so ordered.

REP. BLILEY: Mrs. Clinton, first let me add my personal thanks for the job that you, the president and the task force have done in preparing your health care plan and beginning the national debate on the issue. I also want to thank you for the time that you and Ira Magaziner, though I wish he wouldn't meet at 7:00 in the morning, have spent with the House Republican Task Force during the past several months.

Mrs. Clinton, like many others, we are currently working with a draft of the president's health reform proposal. To enable members to more fully understand this very complicated plan, I would ask that you make

available to the committee the task force quantitative working papers concerning financing, premium caps, actuarial analysis of benefits, job impact, and the national health expenditure data.

Mrs. Clinton, the early evaluation of the president's plan by a wide range of experts, including economists and members of Congress, is that the plan will not cut costs nearly as much as forecast, and that the federal budget deficit will dramatically increase, as a result. That is because the success of the president's plan depends upon unprecedented cuts in the Medicare and Medicaid programs. The cuts generate \$285 billion in savings, which represent almost two-thirds of the plan's financing. A cap is also placed on both private health insurance premiums and the federal entitlements. When fully phased in, the cap is equal to CPI plus the annual percentage growth in population. And your own data projects the annual growth in population at less than 1 percent, or eight-tenths of 1 percent, to be precise.

Mrs. Clinton, this chart to your left shows an international comparison of the average annual growth rate of health expenditures adjusted for inflation for the years 1985-1991. For example, in this period, German health expenditures actually grew by 2.87 percent above the inflation rate. The Canadian single-payer system grew at 4.8 percent above the inflation rate annually. And the British nationalized system grew at 4.07 percent above inflation. All of these countries are showing significant real annual increases above inflation. In contrast to the experience of these nationalized systems, your cap on health expenditures allows real growth above inflation of less than 1 percent.

Mrs. Clinton, this data shows that nationalized single-payer systems such as Britain and Canada have not come even remotely close in limiting health expenditures to less than 1 percent above inflation. In fact, except for Germany, they have been growing at least at 4 percent per year above inflation, and even Germany has been growing at close to 3 percent annually.

In the case of Britain and Canada, we are talking about systems that explicitly ration care. Now, my question is, how is the president's plan going to accomplish these extraordinary reductions in health care expenditures when even systems that ration care have not remotely approached these growth limits?

MRS. CLINTON: Mr. Bliley, that's an excellent question. I really appreciate your asking that, because this is one of the crucial issues that we have confronted. And let me start -- and I hope the chairman may give us just a little bit of leeway on time, because it's such a critical inquiry.

Let me start by saying that we anticipate realizing some substantial one-time only savings over the next several years. For example,

We believe that insurance market reform, particularly in the non-group and small group market, will result in substantial savings. We believe that moving toward a single form system will result in substantial savings. We can outline in more detail and will gladly do so the kinds of changes that we anticipate beginning to bring down our base level of expenditures.

Secondly, we think that the crux of achieving the kinds of savings and then stabilizing those savings over time into the out years will result from changes in the way we organize and deliver health care. And there are many examples of that around the country that we can point to. And let me just quickly mention a few.

In the Medicare system we know that Medicare expenditures vary greatly between different localities in our country without any difference in quality outcomes for the patients, largely because of differences in the way health care is organized in a particular area and because of differences in practice styles and decisions of doctors. Currently there are no incentives in our fee for service reimbursement system that will move those decisions from being high-cost, inefficient ones toward being lower-cost, efficient ones. But we have substantial data to prove that if we change the way we provide incentives and reimbursement to providers, we will begin to reduce the costs that are currently continuing to escalate within our system.

In fact, the public-private model that we propose is, if anything, closer to Germany than closer to any of the single-payer national systems because it's a joint system of employer and government payments joined by individual contributions.

So to try to, with the red light flashing at me, Congressman, to say that we will give you a more complete answer in writing, we believe there are some first-time savings that would be realized that would begin to reduce the base on which we are growing. We believe that we can change the internal dynamics of this system to move it closer toward more cost-effective, quality-driven delivery of health care, and we believe further that we start with so much waste and unnecessary costs in the system -- Dr. Koop has estimated maybe \$200 billion worth -- that we can get this system stabilized and begin to reduce the increases in the rate of growth in a reasonable manner over time.

And we will be happy to share with you all of the data that you requested, all of our calculations, our economic models and the like. We have worked as hard on this particular question, Congressman, as any because, you're absolutely right, it is the key. And we believe we've got enough leeway that if we decide a GDP growth rate as low as we think can be accomplished should be phased in more gradually, we think we can do that; but we want to start with the firm conviction there is waste in this system,

there is better utilization that we can obtain in this system, there is better quality to be given to the citizens of this country if we reorganize the way we deliver health care more efficiently.

REP. BLILEY: Thank you.

Thank you, Mr. Chairman.

REP. DINGELL: The time of the gentleman has expired.

The chair recognizes now the gentlewoman from Illinois, the chairman of the subcommittee, Mrs. Collins.

REP. CARDISS COLLINS (D-IL): Thank you, Mr. Chairman.

I, too, want to extend my heartfelt thanks that you are here before our hearing, Mrs. Clinton. As always, you bring a certain perspective with you that we certainly learn from.

Let me say that one of the things that I'm concerned about right now in a number of issues is redlining, what I call medical redlining, at this point in time. As I look at what I perceive to be the kind of plan that we're looking at, if we are, it seeks to address redlining by health alliances by preventing states from drawing those health alliances in a manner that would discriminate against segments of the population on the basis of ethnicity or economic status. But I wonder how the plan would prevent individual health plans within the alliance from attempting to draw service areas that would, in fact, be redlining against those kinds of situations.

MRS. CLINTON: Well, Congresswoman, we have worried about that because we do not want to in any way permit discrimination against providers or against patients, and we think as part of the framework for determining what an accountable health plan is, there should be built-in protections against the kind of redlining and discrimination that you are talking about. It happens too frequently now in the insurance industry when people are eliminated from coverage because of who they are or whether they've been sick or where they live or who they work for. And we think that both by combining the changes in the insurance market that we intend to propose, plus protections built in so that accountable health plans will be offering their services in geographic areas and to everyone who's in that area, and there won't be discrimination against people who live in different areas, we will be able to protect against the dangers that you rightly have pointed out.

REP. COLLINS: There is a community health center in my district called the -- I can't think of the name of it right now, but it's a health center just outside of downtown Chicago, and it was closed for a long period of time and has been reopened. All the people in that health center -- in

that neighborhood use that health center for primary care for children and everything else. And so I wondered if that is the kind of center -- Martin Luther King Health Center -- the kind of center that would be sort of an essential provider center, and more about that would be helpful to me.

MRS. CLINTON: Yes, that is what we anticipate, that community health centers that serve underserved populations in both urban and rural areas will be considered essential providers, and they will become part of larger networks that will serve the entire population, but they will have relationships with hospitals and clinics and others so that the people who use the community health centers as the primary care givers will therefore be able to be referred on to a specialist or to a more complicated kind of care that they might need; whereas now, for too many people who use our community health centers, they may go to the community health center for primary care, but because they are uninsured or underinsured, they have no real recourse except the emergency room, which is their entry into the additional health services that they may need. So we do intend for those linkages to be developed.

REP. COLLINS: Thank you. I gave the wrong name. It's the (Miles Greer ?) Health Center. It doesn't make that much difference, but that is the name of the health center.

Finally, I have great concerns about the power that insurance companies can gain in the program -- in the plan that I've seen so far, and I believe that during his speech, the president noted that there were some 1,500 companies that are now providing health insurance in the United States today. But some of the reports that I have received suggest that a number of the insurers may eventually shrink to about 100. Now, if that happens, that puts an awful lot of power in the hands of just a few insurance companies.

I have had personal experience with insurance companies, Blue Cross/Blue Shield, for one, when I had to have cataract surgery. They decided that I couldn't have it done in the hospital even though my doctor wanted to do it in the hospital for various medical reasons. Some clerk in their office said no, they weren't going to allow that, and they overruled my doctor. I'm concerned about that kind of thing happening when you have so few. I'm wondering if there are going to be antitrust laws to keep these few from becoming, one, an oligopoly, and from, two, having too much power for the insurance providers.

MRS. CLINTON: Well, what you're describing is what's happening right now, that insurance companies are very often overriding doctors' opinions and making decisions based on insurance coverage instead of clinical judgment that the doctor would like to bring to bear. That is happening right

Now. We believe that moving toward the system that we've envisioned, there will be less of that, and in fact, doctors will, we hope, regain some of the autonomy and authority that they have had to give up. But the antitrust laws will still guard against monopolistic practices.

Now we do, though, want to make some changes in antitrust to permit doctors and hospitals to have the same kind of opportunity to organize

You know, we want to have alternatives to insurance company-governed plans. We want to have the Catholic Hospital Association or the Mayo Clinic or the local medical school to have the same kind of opportunity to join together with physicians to present services to the communities that will be covered, and we hope that we can strike the right balance in the laws to permit that.

REP. COLLINS: Thank you very much.

REP. DINGELL: The time of the gentlewoman has expired.

The chair recognizes now the gentleman from Florida, Mr. Stearns.

REP. CLIFF STEARNS (R-FL): Thank you, Mr. Chairman, and thank you for allowing me the courtesy of offering my questions as the ranking member on commerce-consumer protection and competitiveness.

Let me first of all say, Mrs. Clinton, I want to congratulate you. I've watched Federal Reserve Chairman Greenspan show up to tables like that with a whole list of people helping him, and I've seen cabinet officers from the Bush administration. So you're making a winning statement by showing up all by yourself on this table, and I want to compliment you on that.

My question goes a little bit further than my colleague from Virginia's question concerning the limit on insurance premiums to the CPI and to the population. And we move that when we start talking about insurance premiums in the commercial sector. You are, in effect, limiting the amount that doctors and hospitals can reimburse for hospital cares. And my concern is by this limit that you're doing, aren't you going to make the patients get less care, and in the end this will lead to higher cost sharing on the part of the patient?

MRS. CLINTON: Well, Mr. Stearns, we do not believe so, and let me give me just a couple of examples of the great mass of evidence that would support our belief.

First of all, there is such a wide disparity of costs of health care right now in this country. And there has been a great deal of research

to try to determine whether there are significant differences in quality or access between regions or communities that provide care at a higher price or a lower price. What we have found in looking at all of the available research is that there is no discernible difference in quality between a lot of the high-priced care and more moderately-priced care that is available in the country.

At a hearing earlier today, I held up a booklet as just one example of the countless kinds of evidence we will share with you as the course of this debate goes forward, which is a consumer's guide to coronary artery by-pass graft surgery that was put out by the Pennsylvania Health Care Cost Containment Council. Pennsylvania started before the president was even elected for a number of years to collect information to try to answer the question that you are posing and which is very important.

If you look at just this one simple booklet, which outlines how much it costs at every hospital in Pennsylvania to perform this surgery, you will find that the cost ranges from \$21,000 to \$84,000. Then if you look at quality indicators, including the number of patients who died and who were expected to die given the severity of their illness, you will find that there is no correlation between the high cost and better outcomes. In fact, the lowest cost of the operation in one hospital has some of the best results.

Now, what does this mean? It means that in just one state you have a range of costs for the same kind of operation from \$21,000 to \$84,000. Yet there is no incentive in our current system to move those hospitals and doctors that charge more toward a more reasonable cost because they don't get penalized, there's no budget that they have to in any way account for, they get all kinds of automatic pass-throughs, and if they aggregate all the different tests and procedures, they get more money than if they say here's the cost for a bypass in total.

What we believe is that if we could begin to reorganize our health care system so we brought down the cost, we would not in any way undermine quality; in fact, we would enhance it because we could afford in one state, and, therefore, across the country, to perform more operations like this for more people.

And there are countless examples of this, Congressman, all over the country where we are not delivering the kind of quality health care for

the price we are charging ourselves.

REP. STEARNS: But in all deference to you, wouldn't you think it would be easier and more appropriate to bring it down through competition than through the government itself pushing and mandating and limiting?

MRS. CLINTON: That's what we're doing. That's exactly what we believe will work. We believe that through competition and market forces, hospitals will begin to make these adjustments so that they will move toward lower costs and they will be motivated at the same time to take a hard look at what they are doing. What we believe is that there should be a federal framework that sets forth certain kinds of guidelines about how this system should operate, and then the government should get out of the way.

But we also believe that, given how much unnecessary costs, to be charitable, there is in the current system, to get from where we are to where we need to be, that if we have some kind of premium cap and if we have some kind of budget targets, there will be a real incentive for hospitals and doctors and others to make the changes that so many others have done within the marketplace. In the absence, though, of some kind of budgetary discipline to move some of our regions which are 300 percent more costly than other regions to anything like a national average, in the time we need in order to get this system under control with its costs, we think we've got to have those extra tools. But we'll be glad to talk about how they're defined and how they would be enforced.

REP. STEARNS: Thank you, Mr. Chairman.

REP. DINGELL: The time of the gentleman has expired.

The chair recognizes now the gentleman from Indiana, Mr. Sharp, and then the gentleman from California, Mr. Moorhead.

REP. PHILIP SHARP (D-IN): Thank you very much, Mr. Chairman.

Ms. Clinton, you and your task force are to be highly complimented for the extraordinary work in reaching out, learning, and the rigor and thoroughness with which you have put together these proposals in what everyone agrees is one of the most complicated and the most profoundly personal issues that we've ever had in the United States Congress. And as the president and the vice president and the Congress and others try to reinvent government, we all have your model to follow for quality work, which is what the American people want from the taxpayers and, I think, are unquestionably getting.

I must say, too, that I think that leadership has put us into a position that we can truly do something about this issue.

But I think the onus is now on us to follow that example, do the same kind of thorough, rigorous work, and, most importantly, consult with our people at home. And you and the president have again led in this in a critical way because the lesson we learned from catastrophic health insurance was, with a Republican president and a Democratic Congress committed to the same goal, we repealed the act one year later. And the reason we did that is because of the massive failure in this country to bring into the process the very people who would receive the services and have to pay the bill, and they were extremely confused and extremely upset as a result of that exclusion. So, to make this work, it is incumbent upon all of us to make a part of the process those people.

I certainly applaud and support the broad goals that you and the president have outlined.

We must provide health security for our people. All of us have had hundreds of conversations with people who thought they were in good financial straits only to find that their families were tortured and tormented by the absence of coverage or the loss of insurance. And I'll be submitting and talking with you and your task force about the circumstances of very specific individuals that we're hearing in our office, how they will be affected, how their businesses will be affected, because we have to examine it through their eyes as we judge this.

But there are broader systems questions that have been asked here, and we'll be asking about how the system will work, the incentive structure. And let me just put to you very quickly one of the questions that will come up that there's been a lot of quick criticism by people that -- I don't how they could have possibly analyzed the proposal, but quick criticism, and it's the question of bureaucratization, and that is whether or not with the plans, the health alliances, the national board we simply will be adding new layers of bureaucracy that might restrict individual choice or doctor choice or whatnot in the process when, clearly, one of your goals and the president's is simplification. Could you just comment on that?

MRS. CLINTON: Yes, congressman.

Well, of course, we think that this will simplify and de-bureaucratize, if that is such a word, the system because we are doing two things. We are eliminating a lot of the micromanagement and overregulation that comes from both the public and the private insurance systems right now.

The health alliances as we envision them are to be the conduits

For premiums that will be paid into them, and then health plans will bid for the business by putting out their services and each of us individually will choose, so that the way it would work is, under our plan most Americans, as they are now, would have their premiums paid from their employment. The employer's contribution and the employee's contribution would go into the health alliance. And then accountable health plans would come much as the federal employee health benefits plan works now with brochures and presentations so that each of us individually would then choose the plan that we thought was best for us.

We don't envision much bureaucracy attached to that. We believe that every qualified health plan should be permitted to compete for my premium dollar. And we don't envision the alliance eliminating any health plan so long as it is qualified.

The National Health Board is a feature that is found in both the Senate Republicans' approach as well as the president's because we believe there needs to be someplace where a lot of the decisions about benefits -- how they're actually defined in individual cases, when a treatment moves from being experimental to clinically provable -- those kinds of decisions need to be taken out of this body. They need to be taken out of politics. And that's one of the roles we see for the National Board, as does the Senate Republican version. And again, we don't anticipate a lot of extra bureaucracy or extra staff needed because there will be a lot of the staff already in place in HHS and elsewhere in the government that will be reporting to this board, and the board will be kind of acting like a board of directors, to be making decisions that will then be implemented by the rest of the government.

REP. SHARP: Thank you.

REP. DINGELL: The time of the gentleman has expired.

The chair recognizes now the gentleman from California, Mr. Moorhead. Five minutes.

REP. CARLOS J. MOORHEAD (R-CA): Well, thank you, Mr. Chairman.

Mrs. Clinton, you've certainly been generous of your time over the last few months in coming to the Congress. I don't know of any witness that's come to us and to as many different groups on the Hill as often as you have done. So some of these questions I'm sure that you've been asked before.

But the question that's coming up time and time again -- on the radio, on television, the press -- is the financing. And I know you've been asked similar questions before. But there was one broadcaster this morning -- Charles Osgood -- said that if you thought you could save -- if you'd spend

\$300 billion more in the next ten years and still be able to cut \$400 billion out of it, he has a car that will run only on water that he'll be happy to sell you. And that's the kind of a sale you have to be able to make, because the public is very, very concerned about that particular issue.

I was particularly struck by the comments recently made in a radio interview by a well-known liberal economist: Henry Aron (sp) of the Brookings Institute. He expressed concern over the impact of the stringent restrictions on health care spending and what they would mean in the real world, particularly at a time when new technologies are becoming more and more expensive and the number of very old Americans is dramatically rising. He drew what I thought was a very down-to-earth analogy between these spending limits and a family budget.

Dr. Aron (sp) said "If you and your spouse have ten children and your family budget's growing very rapidly because you're having more children and because the consumption of each child is rising, you're planning on having more children, but you're told that your budget cannot grow at all, what are you going to do?"

We know that your spending on the children's going to have to dramatically decline." In terms of the health care system, Henry Aron (sp) believes these budget limits mean fewer diagnostic services, fewer therapeutic services. He states that the real question is whether a sufficient quantity of services, physicians now provide for patients are just purely wasteful and unnecessary and can be done away with, with absolutely no loss in health benefits. Could you please comment on this?

MRS. CLINTON: Yes. I would be pleased to, Mr. Moorhead. I would just ask that the commentators and others look at examples in our country that are doing exactly what we think should be done on the national level. For example, if you look at Mayo Clinic, Mayo Clinic has one of the finest reputations in the world. It has kept its cost increases for last year below 4 percent. That's inflation plus a very little bit, at 3.8 or 3.9 percent. If you look at the very large California pension and retirement system, it has kept its increases the last two years even below that. If you look at Rochester, New York, which has a number of large employers and a dominant insurer in that community, they have kept their costs down. If you look at the state of Hawaii, which insures nearly everyone through an employer/employee system, they have kept their cost increases and the total amount that they spend on a per capita basis for health care far below the rest of the country. And I could go on and on, because there are many isolated examples.

If you look at the Medicare system, you can see that, in many communities that are relatively close together, like if you compare New

Haven, Connecticut, and Boston, Massachusetts, a Medicare recipient in New Haven costs the federal government about one-half of what a Medicare recipient in Boston costs with no discernible difference in the quality of care. There are so many examples in both our Medicare and Medicaid systems and in our private system which show, I think, conclusively that, if we better organize how we deliver health care, if we are smarter about making the decisions that should be made, if we eliminate the unnecessary tests and procedures that too often drive up the cost, if we root out the waste and the fraud and the abuse that is a very large amount of money that can be better allocated within the existing system.

And one of the things which has struck me repeatedly is the difference between the people who are commentators inside Washington and the people who run health care plans, hospitals, multi-speciality clinics, the Puget Sound Health Cooperative, and many others all around the country, they look at me and they say, "This can be done because we have been doing it without any kind of help, and what we would like is for the rest of the country to get in and help us get it done right."

So I am very confident that the kind of proposals we are putting forth are doable because I have literally visited and talked with people who have done exactly what we are proposing.

REP. MOORHEAD: Thank you.

REP. DINGELL: In accordance with the rules and the announcement of the chair as to how they will be administered, the chair recognizes now the gentleman from Oklahoma, Mr. Synar, for five minutes.

REP. MIKE SYNAR (D-OK): Thank you, Mr. Chairman.

Mrs. Clinton, building upon what's right in America's health care system and correcting what's wrong is a message that I think Oklahomans and Americans have embraced overwhelmingly. But there are unique problems in rural Oklahoma and rural America. There are three characteristics: one, they're older; secondly, they're poor; and finally, they have probably the least leverage of anyone in the health care system to negotiate with providers as well as insurers. They fear that we won't be able to reverse the trends of deterioration of health care in the future with this plan, and they also fear that they will be left behind and become second class citizens.

Describe for us the thinking of the task force with respect to rural health care and how it will better serve rural America.

MRS. CLINTON: Well, Congressman, I'd be happy to. And I don't

think the president and I could go home to Arkansas, which is next door to Oklahoma, if we had not paid a lot of close attention to rural health care, which is something that actually my husband has worked on ever since 1978 and '79, because everything you have said is absolutely right. In fact, a much higher proportion of rural residents are uninsured than urban residents. So we not only have the poverty but we have less of a capacity for rural residents being able to get care.

So we want to do a number of things which we think will improve access to care. And we have tried to strike the right balance between creating some kind of market in rural America, which is very difficult -- I mean that is one of the real challenges because there aren't that many providers who are willing to compete for the rural health care dollar -- and creating an environment through some government-assisted programs to create good health care facilities and providers in rural areas.

First of all, we think the fact that everyone would be insured will be a very big improvement in rural areas, because if we can begin to provide a stable funding base so it's not just the Medicare and Medicaid programs that are out there but it's also the uninsured who now have funding streams, that we will begin to create a marketplace. It won't be as big in -- you know -- some of the small towns in Oklahoma as it will be in Tulsa or Oklahoma City, but there will be incentives for providers now to offer care where before there weren't.

We also believe that by creating alliance areas that will cover both urban and rural populations that the health care providers who want to compete for the urban dollar will also then feel compelled to compete for the rural dollar and they will provide opportunities for rural providers and hospitals to become part of networks so that we will have connections between rural providers and urban providers we've never had before. And I've seen that already happening where some large hospitals in the state of Minnesota, for example, or some of the large providers there are now making linkages and providing contracts with rural providers.

Secondly, we want to encourage more physicians and nurses to practice in rural areas, and we want to do that through increasing the opportunities for them to pay back their loans and for having loan forgiveness if they will go into rural areas.

Thirdly, we want to improve the technology between rural areas and urban medical care, and I've seen some extraordinary examples of that, where we now have some programs in an experimental stage where you can be 400 miles from the medical school in a state like Texas, out in west Texas, and you literally can hold up an x-ray to a screen which then can be read in the medical school 400 miles away. So that the specialists can be right there on

he spot helping the rural hospital or the rural physician take care of that patient.

And finally, I would say that part of what we believe is necessary is identifying community hospitals and clinics, community health centers, as essential providers, because we know that during this transition, unless we protect the providers and hospitals that are already in rural areas, they may go out of business and there may not be anybody there to take their place. So we have some funds targeted to keep them going so that they can be there when the urban hospital and the network of providers wants to contract with somebody, so that we'll have that essential service available in rural areas.

And I just think it's so important because I've visited, as you have, in so many rural communities that are getting less and less medical care than they used to have. It used to be 10 or 15 or 20 years ago they'd maybe have a doctor or they maybe would have a hospital, and now they don't anymore. And what we want to do is to create the environment in which they will again.

REP. SYNAR: Thank you.

REP. DINGELL: The time of the gentleman has expired.

The chair recognizes now the gentleman from Texas, Mr. Barton.

REP. JOE L. BARTON (R-TX): Thank you, Mr. Chairman.

Mrs. Clinton, it's an honor and a delight to have you here before our committee. I come at this problem a little bit differently than most members. I'm a registered professional engineer, and I believe that one must identify the problem before one tries to develop a solution. I've also been very involved in providing health care in a limited way back in the past. In fact, the last time I saw you, in the late 1970s, I helped found and pay for a voluntary ambulance in Houston County, Texas, to deliver people that needed health care to the local community hospitals, and did so for three years. So I have not been involved as a professional physician like another member of the committee, but I have been involved in attempting in a limited fashion to provide health care.

I notice in the president's book that you use the number of 37 million Americans who do not have health insurance. Interestingly, nowhere else is that number as high as it is in the president's plan. The Census Bureau said that 32 million are uninsured at some point in time, and 16 million as of 1987 had no insurance for the entire year. The Agency for Health Care Policy said that 24.5 million had no insurance for an entire year, and 23.3 million were uninsured for part of the year. The Harvard School of Public Health in 1992 said that 21 million were without health

insurance for an entire year, and the Congressional Research Service says that 35.4 million lack insurance at a given point in time.

Could you explain or provide to this committee where the number that is used in the administration's official documents of 37 million comes from?

MRS. CLINTON: Yes, I'd be happy to give you that information specifically, but let me perhaps point out what some of the differences in timing and in analysis are that would lead to different figures at different points in time. If you're looking at the census figures for 1990, there is a difference in terms of where we were when those figures were collected and where we are today. And the growth that, for example, you would build on top of the Congressional Research figure that you just had would get us closer to the 37 million.

Others look at different points of time, and they take a -- what is called a kind of monthly or rolling average as to how many people are out of insurance at a particular time and for how long. It is our belief, based on all of those different kinds of estimates and how they're arrived at and the point of time at which they are taken and how they aggregate, that the 37 million is accurate figure, in large measure because it counts both those who are employed and uninsured, the family members of those who are employed and uninsured, and the unemployed and uninsured. And we think -- we will be glad to give you the very specific calculations that got us to the 37 million.

The most recent work that was just completed was done by Families USA looking at every one of the statistics that you have cited, plus trying to determine how to make it an understandable figure for people. They have pointed out that what we are now in the process of seeing because of increasing layoffs and people losing jobs and downsizing in the economy that accelerated in the last two-year period, and that may in part count for the difference between the 35 million and 37 million, is there are people who are losing their insurance now every month, who unlike in the past are not being reemployed and, therefore, regaining insurance. And their figure is that 2.25 million lose insurance every month. Some may get it back in a month; some may get it back in a year. But based on their projections, they believe that, by this year next -- by this time next year, in the absence of our doing anything, we will be closer to 40 million uninsured. And I'll be happy to lay all that out and give you all of the statistics and the cites behind that as to how we have calculated it.

REP. BARTON: Thank you. And as a subset of that, we'd like to have, of the numbers that don't have insurance how many of them don't have it because they don't want it, or, conversely, how many of them desperately want it and flat can't get it. Because the Heritage Foundation and some of those groups have indicated that the number of Americans that don't have health

insurance that do want it and just simply cannot get it for any reason is a much smaller number, somewhere between 10 million and 16 million.

MRS. CLINTON: Well, let me just add, Congressman -- we will certainly get that for you -- we have a difference in approach about defining the problem, to get back to your first point. We think that, for those who say they do not have it and do not want it, they put an unnecessary burden on the rest of us, because they are often young, they are often in their twenties. They are often people who don't believe they will ever be sick or be hurt. And too often, when something does happen to them, whether it's the unexpected automobile accident or the unpredicted illness, they, like every American, eventually get health care. And then, because they have been uninsured, the rest of us pay those costs.

So we don't think the distinction between those who want it and can't get it and those who don't want it is a good one, because the lack of insurance puts burdens on the whole system and burdens the private sector in ways that we don't think should be allowed to continue.

REP. BARTON: My time is expired. Thank you.

REP. DINGELL: The time of the gentlemen has expired. The chair recognizes now the gentleman from Oregon, Mr. Wyden.

REP. RON WYDEN (D-OR): Thank you, Mr. Chairman.

Mrs. Clinton, I'm especially pleased that you and the president are going after these drug company and insurance rip-offs. What we have seen in our hearings is that some of these drug companies think they've got a god-given right to charge whatever they can get and some of the insurance companies only want you if you're healthy and wealthy.

But what I'd like to ask you about is the matter of the insurance premium limits. Because I think, while the government proposal, your proposal, clearly rejects explicit rationing, as we've heard from our colleagues, I think some of the insurance companies, when premium limits start, some of the insurance companies may try to go back-door, sneaky, and do unaccountable rationing. The way it would work, say, on a middle-class person, and that's, of course, the bulk of the people, is they might say, well, you might normally get seven tests, but under this you'll only get three. Or if your appointment is going to be at the beginning of the month, they'll just put you off a few more weeks so that they could do this sneaky, back-door rationing.

Now, I know you're opposed to it and have heard you speak in favor of it, but I wonder if we could look at two other ideas in addition to the plan that could help us stop this kind of back-door approach. One of them

would be to say that when you have a closed panel, a health maintenance organization, that panel would also have to give people the right to go outside the panel and get what they want by paying a little bit more. That would be one proposal. And the second would be in the area of technology, where we know that new products are fueling the cost increases so dramatically, whether we could look at a way to give the companies an incentive to provide up front information that would show why their product is superior to what's actually out there.

And my question to you would be, I'd just like to pursue both of those because I think that would be the way to lock out these insurance companies who are trying back-door, sneaky, almost de facto efforts to undermine what it is you're trying to do in terms of protecting consumers.

MRS. CLINTON: Well, Congressman, I'm open to anything that stops sneaky, back-door attacks. (Laughter.) And I'll sure look at both of those ideas, and I think that the idea of having a referral out of a closed-panel HMO or any organized delivery system is one that we should look closely at because I think there's a real need on our part to be sure that referrals to specialists are as available as they need to be to all citizens. And I think you've got a good idea, and we'll follow up on both of those.

REP. WYDEN: Well, I very much appreciate that because I think the prism that you and the president are using is what does this mean for my family. And that's what people all across this country are asking, and I think that there are ways that we can balance cost containment and real freedom of choice, and I appreciate your willingness to pursue these and look forward to it.

Thank you, Mr. Chairman.

MRS. CLINTON: Thank you.

REP. DINGELL: The time of the gentleman has expired. The chair recognizes now the gentleman from North Carolina, Mr. McMillan.

REP. ALEX MCMILLAN (R-NC): Thank you, Mr. Chairman.

Mrs. Clinton, I want to add my welcome and express publicly what I've said to you in other meetings, my appreciation for the hard and effective work you've done in defining the problems and advancing effective solutions. I have been a part of a Republican task force, as you know, that's met with you on occasion and with Mr. Magaziner at 7:30 every Thursday morning for the better part of nine months, and I appreciate your willingness to listen. I'm not sure that you've heard everything that we've had to say, but I mean that constructively because I think that we all understand that the solution is probably going to require a broad bipartisan base of support.

And so, I'm hopeful that before we're through with this dialogue that we will be able to achieve that. And I mean that.

Some 20 years ago, I set up in a fairly substantial company comprehensive health care, over 7,000 employees in that company. And I had worked a lot with small business in doing likewise. So, I'm particularly concerned about how this impacts small and large business and how that interrelates with the very important issue of bringing the uninsured into universal coverage. And so, I want to ask you, if I may, a couple of questions on that.

Under the proposed financing scheme offered by the administration, corporations that choose to opt out of the regional health alliances and instead choose to operate under ERISA or Taft-Hartley alliances will be required to pay a 1 percent payroll charge over and above their health care costs into alliances of which they are not a part.

Furthermore, these ERISA and Taft-Hartley alliances do not have the protection which is afforded to smaller companies of only paying 7.9 percent of their gross payroll for health care costs. So presumably their cost base, in addition to the 1 percent extra charge, could go well above that, which creates an imbalance among large and small in that respect.

And with that in mind, I'm interested to learn your feelings on why any large corporation would (either barter ?) to create an ERISA or Taft-Hartley alliance. And in addition, for what purpose is the 1 percent payroll charge, and to whom will that money go or what part of the program will it go and for what purpose?

MRS. CLINTON: Congressman, the companies with whom we have spoken over the last months that would most likely want to continue to be self-insured believe that their costs either now are below the cap that you mentioned for employers or would be if they were in an insurance market with the kind of reforms we're talking about, and if they were able to control their own costs. Those are the economic decisions that they're making their conversations with us which lead them to believe that it is a better deal for them to continue to try to be self-insured.

We have pointed out, however, that there are certain system costs which they will be able to enjoy that would not be part of their premium base. And the one that we're most concerned about is our academic health centers, the medical schools of this country that train our physicians, that provide a lot of the tertiary care at the most specialized level for people, and which under our plan would have primary responsibility for serving as kind of quality guardians, if you will, for the entire health care system.

So the assessment that we would be asking the corporate alliances

to make would go primarily to fund these academic health centers, because if we do not have some support from them to do so, they would be able to enjoy the benefits of all the services that the health centers are going to be providing without bearing any of the costs.

Now, in our conversation -- and this is something that we will want to continue and that I'm sure this committee will want to engage in as well -- we have had a number of corporations tell us that even with the assessment that we would want them to pay into the alliance to help fund these purposes, they still believe they can deliver health care more cheaply. And so it will be a strictly an economic calculation that companies will make and we will work very hard with them to make sure that if there are any features of the plan that would unfairly disadvantage them that we will take a look at those. But up until now, we have not had a lot of opposition among those companies that are likely to have their own alliances.

REP. DINGELL: The time of the gentleman has expired. The chair recognizes the gentleman from Kansas, Mr. Slattery.

REP. JIM SLATTERY (D-KS): Thank you, Mr. Chairman.

Mrs. Clinton, I've been on this committee now for 10 years, and I must observe that I don't think I can recall another occasion when this many members on both sides of the political aisle have been so attentive for so long. (Laughter.) You have truly tested our attention span here, I suppose, today, and I think it's a real tribute to you and to the president that both sides of the political aisle are so engaged on this issue. And I think that it's a good sign for the months ahead as we really engage in this very, very important debate.

I have three very specific questions that I'd like to squeeze in in the five minutes that I have.

Number one, it is clear that you're attempting to give the states as much flexibility as possible in the implementation of this plan. I applaud that. I think that's a very good idea and extremely important for those of us who come from rural parts of the country where our Medicare reimbursement rates are lower than the national average.

I would like to know specifically, though, about Medicaid and what kind of specific flexibility you propose to give the states that will enable them to better utilize Medicaid dollars.

MRS. CLINTON: Well, Congressman, let me start by recognizing the extraordinary work that this committee, and particularly the subcommittee chaired by Mr. Waxman, has done over the years in trying to provide a medical

safety net for millions of Americans through the Medicaid program.

And you have done so against great odds, and I think you are to be commended for looking out for those least able to take care of themselves in our health care system. But we believe that we want to merge the Medicaid system into the universal health care coverage system, to end any kind of separate identification of Medicaid recipients and to essentially blend the funds that would follow the Medicaid recipient to those that would follow you or me into a local alliance, so that individuals would no longer be either discriminated against or identified as being a Medicaid recipient even though the state and federal government would continue to pay into the alliances the portion of the Medicaid cost that each Medicaid recipient would carry with them.

We think by eliminating the Medicaid program and integrating those recipients, we will end up giving better care to the recipients over the long run; we will, we hope, realize the kind of savings we think will come from having more Medicaid recipients in primary and preventive health care networks, the kind of reorganization that we anticipate; and we believe that we will eliminate a lot of the gross discrimination that currently exists against Medicaid recipients.

REP. SLATTERY: Okay, thank you.

The second question I have goes to the alliances and how they will be structured. I'm just curious. Do you envision anything that would prevent states from contracting with private entities to perform the function that you envision for the alliances to do?

MRS. CLINTON: No.

REP. SLATTERY: So theoretically, the states could contract with an insurance company, for example, to provide the kind of function that you envision that would be performed by the alliances.

MRS. CLINTON: Yes, but we would want the decision-making to be clearly the responsibility of either the non-profit organization that a state might set up or the state, because ultimately the state would have to bear the responsibility. So --

REP. SLATTERY: But they could have a private entity that would be established that would actually do the negotiating and do whatever administrative function that the state might designate that would be performed by the alliances.

MRS. CLINTON: But under the direction of the state. I mean, it could be an intermediary kind of fiscal and negotiating collection function

would be performed, but the ultimate responsibility would have to rest at the alliance level.

REP. SLATTERY: How much time is it going to take, do you think, for the president to present to the Congress the detailed programmatic changes in the Medicare program and Medicaid that will enable us to achieve the kind of savings that you envision? And let me, before you answer that, let me just observe that Congressman Synar and I share a deep concern about how these cuts are going to affect rural areas, and our hospitals out there -- I don't need to tell you this -- are extremely worried about the prospect of dealing with these kind of cuts of this magnitude. And I know that you're aware of that problem and you're committed to the rural health care needs, but could you answer my previous question about the time line we're looking at? And any hints that you might have as to what these programmatic changes will be would be appreciated, too.

MRS. CLINTON: Well, we anticipate coming forward with specific recommendations in areas where we can reduce the rate of growth in Medicare. We are not proposing a cap that does not make the hard decisions. We think that we ought to try to specify, both for purposes of clarity with the Congress but also for providers, where we think those reductions in the rate of growth can come. So we will come forward with specific programs that we think can be delivered more efficiently at less cost, and we will lay those out for you.

REP. SLATTERY: Do you know by when?

MRS. CLINTON: Within the next couple of weeks as we present the legislation.

REP. SLATTERY: Okay. Thank you.

REP. DINGELL: The time of the gentleman has expired.

The chair recognizes now the gentleman from Illinois, Mr. Hastert.

REP. DENNIS HASTERT (R-IL): Thank you, Mr. Chairman.

Mrs. Clinton, we appreciate you being here and certainly appreciate your openness and the work of Ira Magaziner and his staff over the last nine months and the ability that we've had to carry on a dialogue and really lay out our parameters and see some of your ideas, as well. I think that's been a very helpful situation and a good relationship.

There are some questions that we need to ask and to understand so that we can continue that work.

In my district I have the back and forth and the town meetings, and constantly I've had people in my district come up and say, "You know, I like the health plan" that they're currently in. "I like my Blue Cross/Blue Shield plan," or if they work for Caterpillar Tractor, which happens to be over 5,000 employees, they like that plan. And the question is, "Will I be able to keep the specific plan that I already have?"

MRS. CLINTON: We anticipate that in the vast majority of cases, the answer will be yes because those who are currently delivering health care in a region are more than likely to be those who will form the accountable health plans that will be presented in a region, so they will have the same doctors, the same hospitals, the same features that they currently see as consumers now.

REP. HASTERT: But it's conceivable there would be more than two or three health plans in a region, right?

MRS. CLINTON: Yes.

REP. HASTERT: And maybe more than that, possibly.

MRS. CLINTON: Yes.

REP. HASTERT: So if I have my pediatrician, who is joined up with one health care plan, and my internist, who signs up with another health plan, really I have to make a choice there; is that correct?

MRS. CLINTON: Not necessarily, Congressman, for the following reasons. Unlike what has happened up until now, where choice has been increasingly limited because doctors have been told who they can practice with if they expect to be reimbursed by this insurance company policy, we are going to end that kind of discrimination against doctors. Doctors will be able to join more than one plan, and every doctor in a region will be in what will be a fee-for-service network in addition to any other plan that the doctor is in. So there will be many more options for doctors as well as for consumers.

I'm not saying that in every single instance every doctor will choose to be in the plan that will correspond to the doctor that you also want for another specialty, but in most communities I think it will be more likely than not that a person like me or you or one of your constituents will be able to join a plan that will have all of the doctors you are accustomed to having. And where that doesn't happen it will be because of the doctor's choice as to which plan the doctor wishes to be in.

REP. HASTERT: So all the doctors will probably sign up for all the plans?

MRS. CLINTON: Well, either -- they will certainly all be in the fee-for-service network because we're going to require that every single community have one of those. Every alliance will have to have that. So every doctor will be in that. And then, in addition, it will be up to the doctor.

Now, some doctors may decide they don't want to practice in any other plans, but I would bet that doctors in addition to the fee-for-service network will sign up for at least one more plan, and maybe more than one. And it will be their option to do so.

REP. HASTERT: Many people in my district go to, for instance, the Mayo Clinic, which a lot of people do, and you use that in your reference, saying they have a very good ability to hold down cost. And, you know, a very unfortunate situation turned out -- turned out was fine. A young man in my district -- in my district? On my staff -- was diagnosed as having cancer. And he found a doctor at the University of Indiana -- another state -- that he was able to go to and was cured. Will those choices be -- if you sign up with a plan in Illinois, are those type of choices of people to be able to go to the Mayo Clinic or the University of Indiana's Health Care Center, can you still do those types of things?

MRS. CLINTON: Yes. And that ties into Representative Wyden's question. We want there to be what is called in the insurance trade a point of service option. In other words, even though you're in a plan, whether it's a closed panel HMO or a fee-for-service network in Illinois, you should have the opportunity to be able to pick a specialist outside of that plan.

Now, what we're looking at is how do we try to make sure that there really are true specialists? Nobody would argue with going to Mayo Clinic or going to the University of Indiana. Somebody would clearly have a choice to do that because they would both be considered, you know, centers of excellence. And so we do want there to be some perhaps qualification so it's not just picking anybody, but picking the Mayo Clinic, the university, the academic health centers, which goes back to Congressman McMillan's point: one of the reasons we need to be sure that everybody helps support these academic medical centers is so that they will be available for young men like the one you just mentioned so that that will be an option.

REP. HASTERT: One other point since you mention Mr. Wyden, and Mr. Wyden brought out, I think, something that is in the back of all our minds. He talked about sneaky companies that are going to try to ration through the back door. And one of our questions, what happens in Mr. Wyden's own state of Oregon and how they deal with Medicaid recipients?

Actually, Oregon has made an explicit decision to ration care using a rationing list. And Oregon has brought thousands more people into the Medicaid system -- a bigger pool. But they have done it by rationing care. Is there a likelihood or a fear out there among a lot of people that we talked to that health care in this country will be rationed in the future when our health care system will be growing by less than 1 percent?

MRS. CLINTON: Well, congressman, let me answer that in two ways.

I would argue that right now we have rationed care throughout this country. There are literally millions of Americans who don't have access to the same quality or quantity of health care as millions of others. I heard Dr. Koop say the other day that an uninsured person who enters a hospital with the same problem as an insured person is three times more likely to die than the insured person. Now, that's a shocking statistic. So right now, because of our non- system of health care, we are rationing care all the time, every single day.

We believe, by getting everybody into the system, making everybody in a sense carry their weight by having some funding that follows them, that there will, for the first time, be incentives to reorganize care so that it is delivered more efficiently at higher quality.

And I would go back to my example of the coronary bypass surgery in Pennsylvania. If a high-quality bypass surgery can be done in one hospital in Pennsylvania for \$21,000, then don't we need incentives in our system to convince those who are giving the same surgery at the cost of \$84,000 to figure out what they're doing that costs so much that doesn't add one bit to the improved health of the patient and to start bringing their costs down? And that's what we think will happen as we kind of get more market and competitive forces at work, but within a broad federal guideline so that we protect against exactly the kind of problem that you're talking about.

REP. HASTERT: Thank you very much.

REP. DINGELL: The time of the gentleman has expired. The chair recognizes now the gentleman from Georgia, Dr. Rowland.

REP. J. ROY ROWLAND (D-GA): Thank you, Mr. Chairman.

I want to commend you and the president for the time and energy that you have spent in trying to resolve some of the problems that we have in our health care delivery system in our country. It's long been a feeling of mine for over 20 years now that we really have a severe problem in the delivery of health care. I don't think that you will find very many people in

our country who will argue against the fact that we have the best quality care of any country in the world, but there is part of our system that is broken. As you have already pointed out, there are millions of people who do not have access to the care and are not able to pay for the care. That is the part of the system, it seems to me, that we need to look at in trying to fix.

Two federal programs that we now have in place for the general public -- Medicare and Medicaid program, both of which have cost far more than was ever anticipated at the time of their inception -- and this has been a particular concern of mine, because, since I have been in the Congress and before I came to the Congress, attempts have been made to hold down the cost of care under these programs. And in recent years, we have seen the Congress acting to try to reduce our budget deficit problem by focusing on Medicare to the extent now that we find the micromanaging of health care in our country to be something that those people who are providing the care find very difficult to deal with.

You're talking about having some savings under the Medicare program to help finance the new plan that you are going to put in place. In view of that, how would you explain that, if you're going to try to have additional savings, there will not be additional micromanaging of the delivery of health care to the detriment of those people that receive the care?

MRS. CLINTON: Well, Dr. Rowland, I think that what we see is what you have seen throughout your career, and what your colleagues have seen, and that is that all too often the decisions about how care is delivered and to whom and at what cost are made on factors other than what is best for the patient as to, for example, what will Medicare pay for this, this and this if I add them altogether instead of just trying to deal with the patient and get the patient well. And as we look around the country, we can see that Medicare for many patients in different parts of the country is delivered at less of a cost with no difference in quality than you will find in a neighboring state or community.

The difference, as you and your medical colleagues know, is that all too often the government has set prices for certain procedures which have not been in line necessarily with what a doctor's judgment would be, but determines often what the doctor does, because that's how he gets paid. Instead of being paid on a per capita or per citizen basis to take care of Medicare patients, he's paid on how many procedures he can run up, and it's just human nature. If that's how you're going to be paid, then that's how you're going to run your office and that's how much care is going to increase.

In very carefully comparing the cost of Medicare in areas that

have better organized how they deliver care to Medicare patients, and I would give, for example, the state of Minnesota, we believe that we can actually deliver better care to more Medicare patients by decreasing the rate of growth in the way we are currently funding Medicare, taking that money, paying for a prescription drug benefit for older Americans, and paying for the beginnings of long-term care for older Americans. And I say that, because, if you look at the hospital and physician costs, if they range from one to three times the cost from different parts of the country, we know there's a lot of difference that can be made in there.

And what we believe is, if we can provide some better incentives in our Medicare system, which has done a good job getting everybody covered but not in controlling the cost increases, we can move more people in high-cost areas to do what they do in Minnesota or in Rochester, New York, to provide lower-cost care for Medicare, and then with the prescription drug benefits, we think in the long run we will save money. Because too many older Americans leave the hospital with a prescription they cannot afford to fill or they fill it and then they self-medicate themselves. You tell them they're supposed to take four a day; they figure if they take one a day it'll last four times as long. They end up back in the hospital. That costs us more money instead of less.

So putting these pieces together is why we think we can deliver the kind of savings in the Medicare system with increased benefits that will be better for older Americans.

REP. ROWLAND: Thank you.

Thank you, Mr. Chairman.

REP. DINGELL: The time of the gentleman has expired. The chair recognizes now the gentleman from Connecticut, Mr. Franks.

REP. GARY FRANKS (R-CT): Thank you, Mr. Chairman.

Madam First Lady, I, too, would like to commend you for your efforts in putting forth this health care package. You have truly given us, as members of Congress, a major challenge.

I have just three questions. One, during these very difficult times, why not cut health care costs before adding new health care benefits? And my second question would be: What aspects of tort reform would you embrace? And my third question would have to do with the illegal aliens. Though I come from Connecticut, we do have a major problem in Connecticut -- in Danbury, Connecticut, in particular -- with illegal aliens. And my question to you would be: How will they be dealt with in your

proposal? They represent, obviously, an additional cost. They will have no insurance card, not being an American citizen obviously. And they also represent an additional burden to our overall system.

MRS. CLINTON: Congressman, let me try to answer those quickly within the time that we are allowed. The question about cutting costs before benefits is a kind of a "chicken and a egg" issue. And we have looked at this very carefully because, certainly if there were a way to capture all the savings from the public and private system and kind of sequester them and then take care of adding more people and adding benefits, you know, that does seem to have a certain logical appeal to it. The problem, as we look at it, is that the health care system is all intermingled parts which affect one and the other. And so, until we get everybody into the health care system, we cannot control costs and we certainly cannot control cost-shifting.

If we reduce the rate of increase in Medicare but we don't provide the kind of prescription drug benefits and long-term care, we will not be dealing with some of the continuing problems of the Medicare population that we think will help us save money in the long right. Because -- let me just give you a quick example.

You know, right now, Medicare will pay the hospitalization bills, by and large, of a hospitalized recipient.

If that person is very seriously ill, but does not any longer need hospital care, the family and the doctor are faced with a difficult problem. Do they keep them in the hospital at very high costs even though they may not need it, or do they discharge them to be either sent home or put into a nursing home where we don't provide any kind of help for most families to be able to deal with that cost.

So instead, often what we do, in your district and around the country, there are many people who are kept longer in hospitals under Medicare than even the doctors think they should because the doctors don't want to burden the families because there is no alternative. So this all is interrelated. As we provide alternatives to that, we will bring hospital costs down, we will get savings. And there are many examples of that. Furthermore, as we reduce the cost increases in Medicare and Medicaid, we cannot let the private sector simply add those costs to their insurance burden, or else businesses and individuals will find themselves paying even higher insurance premiums, so there has to be some reorganization within the private sector, which is why we think an employer-employee requirement, where everybody is in and where there are incentives, better organized care, will help us prevent that cost shifting. And there are many other examples of that which I would be happy to share with you.

Secondly, we believe in reforming the malpractice system, and we have recommended a number of steps that we would like to see the Congress take, including some kind of a required certificate of merit so that before a malpractice lawsuit were brought, there had to be an independent doctor or an independent board which certified to the merit of that lawsuit.

We would like to see the health plans have some kind of alternative dispute resolution so that problems could be worked out before they get to court and cost a lot of money and put a lot of people to the time and worry of a malpractice case. We also believe we should limit attorneys fees in malpractice cases.

And then finally as to illegal aliens, we agree with you that we do not think the comprehensive health care benefits should be extended to those who are undocumented workers and illegal aliens. We do not want to do anything to encourage more illegal immigration into this country. We know now that too many people come in for medical care as it is. We certainly don't want them having the same benefits that American citizens are entitled to have.

At the same time, when anyone in this country gets sick, they're going to come to our hospitals. If there is an outbreak of tuberculosis, we're going to treat all of those who might be involved in it, whether or not they are citizens. So there will continue to be costs in the system that will have to be addressed in order to deal with the emergency and public health needs of illegal aliens. But we want to draw the line as to who is entitled to have that health security card, and that should be only our citizens and legal residents.

REP. FRANKS: Thank you.

REP. DINGELL: The time of the gentleman has expired. The chair recognizes the gentleman from New York, Mr. Manton.

REP. THOMAS J. MANTON: Thank you, Mr. Chairman. Madam First Lady, at the outset, let me say we are honored to have you here today, and I think you and your president, our great president for bringing to fruition, hopefully very soon, the long-held ideal of universal health care. I had the pleasure this Sunday of spending several hours with the president in my hometown, in the borough and county of Queens in New York, where he had a sort of a mini-town hall in a diner. Somehow diners are important in our social life in Queens and also in our political lives. And we heard from people -- horror stories about the pre-existing condition limitation, about people who, because they are in a small pool in small businesses, pay extraordinarily high premiums. And one of my constituents who was there who was a college-educated woman who had had a kidney transplant had to

impoverish herself and not be employed so that she could qualify for medical care and not be above the so-called poverty line. We recognize that this is very, very irrational.

I am privileged to represent a district which has one of the highest numbers of senior citizens than of any of the 435 congressional districts. I wonder what we can say under this plan to our senior citizens who fear for their prescription medicine coverage and long-term health care, where the fear, again, of having to spend down or impoverishment is something that they find difficult to live with.

MRS. CLINTON: Congressman, I really appreciate your asking that, and also, reminding all of us about what we're really doing here, and that is trying to help the people that you and the president visited with in the diner, and people like those who've come to every one of the members of this committee over the last years.

In working with the senior community in our country, we have heard over and over again that although they are grateful for Medicare, they still face overwhelming medical challenges having to do with the cost of prescription drugs and the absence of adequate long-term care opportunities, particularly for home- and community-based care.

And in a community like the one you represent, where families like to try to stay together and help each other out, there is just no help. I mean, I have visited so many homes and hospitals and community centers that just ask me, why are we so penny wise and pound foolish? I was in a hospital, St. Agnes Hospital, in Philadelphia earlier this year and they tried to run an adult day care center so that the families in the neighborhood who wanted to stay in the neighborhood, but had older relatives, could send their family members to the hospital during the day while everybody was out working. But the cost was about \$35, \$40 a day. And many of the families, which themselves were uninsured, hard-working families, couldn't even afford that and could get no care or no compensation.

So, they had to do exactly what you're saying, which is to spend themselves or spend their -- have their adult parents spend themselves into poverty so they could qualify for a nursing home. They didn't want to be in a nursing home. They wanted to be at home, and they wanted to be able to spend the day at the local hospital where they could get good medical care. We didn't provide for that.

Under the president's proposal, prescription drugs and long-term care will for the first time become available to senior citizens, and we think that's a very important feature and one which will not only ease the anguish of a lot of older Americans, but save us money as we try to provide

these services in a more cost-effective way.

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REP. MANTON: Thank you.

I yield back the balance of my time, Mr. Chairman.

REP. DINGELL: The time of the gentleman has expired.

The chair recognizes now the gentlemen from Pennsylvania, Mr. Greenwood.

REP. JIM GREENWOOD (R-PA): (Off mike.)

Welcome, Mrs. Clinton, and let me make unanimous the bipartisan sense of respect and admiration that we've all expressed for the work that you and your task force have done. But, beyond that, I think that after the good feeling that's engendered by your presence passes and we move on to some of the hearings and the markups and the sharp differences of opinion that will emerge, I hope that when it comes time to report this bill from subcommittee that I, as a Republican, can vote yes. And I recognize that we have a lot to hammer out and compromise before we can get to that point.

And I think uppermost among them is the concern that is probably expressed by our side of the aisle a little bit more frequently, and that is the concern for the impact of this proposal on employment, particularly on small employers, and the ability of a small employer with relatively low wages, labor-intensive business with small profit margins -- restaurants talk about having margins of 1 or 2 percent -- even at the highest rate of subsidy, and therefore the lowest rate of contribution by the employer of 3.5 percent, there are employers who express to us that it isn't there, that there isn't 3.5 percent available to them, particularly in years when they're losing money, there are no profits whatsoever.

I'd like you to respond to your concerns about what happens to those businesses, how we deal with them. I know that there will be savings on the worker's comp side, maybe on the automobile side that might accrue to their benefit, even in their own personal health care premiums if they go down, but it seems inevitable that when you impose a mandate such as this on employment, you have to have a downward pressure on employment. There have to be hundreds of thousands of decisions about should I expand my workforce beyond 50 or not? Should I bring on a part-time employee, a temporary employee? All of those decisions have to be reweighed in consideration of the cost of providing health care, and I'd like your

omments on that.

MRS. CLINTON: Thank you, Congressman. And I want to assure the committee, and particularly the Republican members who have been so helpful in this process, that if we did not believe this was a net job increaser, we would not be here. We believe very strongly that removing the unnecessary and burdensome costs of health care from this economy will result in new and growing employment.

But having said that, I think I also want to stress how sensitive we are to the small business side of this. I mean, we come from a state of Arkansas where small business is the business economy in our state. And I come from a family where my father was a small businessman all of his life, and we never had health insurance, ever. And we were just very lucky that no one ever got seriously ill during those growing-up years because we never, ever had health insurance.

So, I'm very sensitive to what we are asking, and we have tried the best we know how to be as careful as we can. But, of course, we want your advice and suggestions about this as we move forward.

And let me just make a couple of points. First of all, we think that there will be a great benefit for those small businesses who have been providing some kind of health insurance, and they are the majority. It's not a big majority, but they are the majority. And we think that if you look at the fast-growing job sector in our economy of small businesses, they are the ones more likely to be offering extra benefits. And the Small Business Administration has been doing a survey of small businesses around the country to find out exactly who is offering insurance, how much it costs, so that we have some really good data, which we will share with you.

We also believe that as we lower the costs of health care to all-sized businesses, but particularly medium and large businesses, that will have a very positive impact on the economy.

I have spoken with the CEOs of major employers who have said that as we lower their burden they're going to be putting that money into new hires, into more wages, into more profits, into more contracts with small businesses.

I would also add that in addition to helping the fastest-growing small businesses and the small businesses that already provide insurance, we will be increasing health care jobs, a sector of the small business community that will just take off like a shot out of the night because there will be so much more money there for things like home health care.

Now, with respect to what will happen, if you look at Hawaii, which has during this entire time that it's had an employer mandate had an unemployment rate below the national average and has had some of the fastest-growing small business job creation, you know, we certainly can't look to Hawaii as supporting the concerns that a lot of small business advocates have presented. Also, if we look at the minimum wage increase over the past years under both Republican and Democratic presidents, it has never had the kind of depressing impact on small business development as some people have feared. And what we are talking about is much less than the usual increase in the minimum wage.

And finally, I would say that the 3&1/2 percent is a cap. Some small businesses will be paying 1 percent, 1&1/2 percent. And for many small businesses that are on the margins, as you're describing, we would like the opportunity to know more about their individual circumstances, because based on the scenarios that we have been running we think that this will be affordable given the worker's comp decreases that we would like to foresee, the auto insurance-health care decreases we would like to build in, the kind of cap that we would put on that would top out at 3&1/2 but be below that for a number of small businesses.

So in general we think there is no evidence on either a national level or a specific business sector level that would support the kind of dire concerns that some have voiced, but we want to be sensitive and work through that with you and others.

REP. GREENWOOD: Thank you.

Thank you, Mr. Chairman.

REP. DINGELL: The time of the gentleman has expired.

The chair recognizes now the gentlewoman from California, Ms. Schenk.

REP. LYNN SCHENK (D-CA): Thank you, Mr. Chairman, and Mrs. Clinton, I want to add my thanks to you for the fundamental and substantive work that you have done in this. I know that I speak for everyone when I say you have the admiration and the respect and the appreciation of the entire country. After all, you don't get paid to do this. And we couldn't pay you for this singular act of public service.

Before I ask my question, I'm going to take the liberty of giving you a message from my mother. She said I must do this when I talk to you.

And that is she wanted me to tell you that not since Eleanor Roosevelt has she so admired an American woman in public life. And this is from a woman whose admiration is not easily earned. So I can tell her I delivered the message. (Laughter.)

MRS. CLINTON: I hope my mother is watching! (Laughter.)

REP. SCHENK: Oh, she's very proud of you!

I would like to ask you about the section of the plan which deals with the regulation of prices of breakthrough drugs and new drugs. Most of these, as we all know, are developed not by the giant pharmaceutical companies but by the small biomed firms. And in the interest of full disclosure, I will tell you there are hundreds of them in my district.

Under the plan, as I understand it, these breakthrough drug prices are going to be regulated by the National Health Board through a breakthrough drug committee, and the committee would have the authority to, quote, "make public declarations regarding the reasonableness of the initial launch prices for these drugs." Some of the biomed executives have expressed concern to me that this kind of regulation, as proposed, would have a chilling effect on research and development in the industry. And, of course these types of drugs not only have the potential for enormous cost savings in the long run but, of course, have enormous potential benefit for humanity.

So could you clarify for me sort of the rationale relative to pricing the breakthrough drugs, and especially what consideration was given to motivating future research and development in the industry?

MRS. CLINTON: Well, Congresswoman Schenk, this is one of the really difficult areas because on the one hand we know that breakthroughs in medical research and pharmaceutical development can often be life-saving and certainly cost-reducing over the long run in terms of the medical costs. We also anticipate, as I have said previously, providing a prescription drug benefit that will greatly enhance the money going into our pharmaceuticals and drug manufacturers. We also want to enhance the federal government's research capacity that will be done both by government agencies and in partnership with companies like those that are found in your district.

But I don't think anyone can any longer doubt that we do have problems with the pricing of drugs in this country. And what we're trying to do is to strike the right balance between encouraging and motivating research but not permitting the public, either through government programs or through private insurance, to bear more than a fair share of the costs of any company recouping its research and development investment.

I don't know if any of you heard, as I did the other day, on

National Public Radio, the physician from Mayo Clinic who was talking in great detail about a drug that had been developed for deworming animals that was determined to have some beneficial use for colon cancer in human beings. And this physician at Mayo worked closely, hand in hand, with a drug manufacturer to make sure all of the testing was done so that it could be used for human beings. When it came on the market, the drug manufacturer started charging \$6 a pill when you had basically the same drug being charged at 6 cents a pill for use in animals. And this physician at Mayo said, you know, this has got to stop.

And yes, you could say maybe that was a breakthrough drug because it had a different use than it had because it was no longer just being used for animals but being used for humans. But at least according to this well respected doctor there was no justification whatsoever for that increase in cost.

What we've tried to do is to strike a balance in which more money is going into the pharmaceuticals through the prescription drug benefit, through additional research dollars. But somebody, somebody has to have some way of saying you cannot charge this much. And what the national board will do is not regulate prices but will publish information about what it considers to be a fair price for a drug based on its cost of development. And if we have any better ideas about how to sustain the good development of drugs, have the drug manufacturers and the biomed research companies get a fair return, but somehow put a brake on what are the unfair and in many respects totally unjustifiable costs that are still being asked in the pharmaceutical industry for us as the public and individuals to pay, we're open to that. But we believe strongly there has to be some method for trying to get a handle on these prices.

And we'll be glad to work with you further on it because we don't want to inhibit research, but we don't want to reward what are unnecessary prices and demands about pricing, either.

REP. SCHENK: I appreciate your willingness to work with me. Thank you.

REP. : Recognize the gentleman from Ohio, Mr. Brown.

REP. SHERROD BROWN (R-OH): Thank you, Mr. Chairman.

Mrs. Clinton, your work especially with preventive care has been particularly outstanding, and we want to thank you for that. Erskine Bowles, speaking during the day after you addressed all of us in the health university, talked about some losers that would come about in terms of the payroll payment, and he said those companies particularly that can lose would

be those that have a lot of young workers that have aggressively tried toatchet down, if you will, health care costs, and those companies, especially those that have real good wellness programs, aggressive anti-smoking campaigns, exercise on the premises, that sort of thing.

Putting aside how -- if you would, answer two questions. One, how do you sell this program to those companies and to those employees when, in fact, they probably, at least in the beginning, will pay more? And second, how do we as a government provide incentives to those companies to continue the kinds of wellness programs they do? You have talked about relying on employers for so much of this whole new health care program. How do we kind of merge that together and help to provide those incentives?

MRS. CLINTON: Well, Congressman, I think that one of the reasons that costs will go up for some Americans is because they have benefited from the kind of insurance practices that have eliminated other Americans from insurance or priced it so high that they could barely afford it. And by that, I mean that many of the people who choose not to be insured or who get good rates for insurance are young, predominantly single, healthy Americans, and they right now are either paying less than the rest of us because they are young and healthy, or are choosing not to be insured. They are among the category of Americans -- and we estimate this is about 10 to 12 percent of Americans -- who will pay more for about the same kind of benefits.

But the reason we think it's fair to ask them to do that is because if you look at the entire population, between 63 and 65 percent of Americans will pay the same or less for better benefits; about 20 or 22 percent will pay a little bit more for better benefits; and then we're left with this group that is young and they have benefited from what's called experience rating because they are young.

Now, we have several alternatives, and what we have chosen to do is to say to young people, yes, you will pay a little bit more now to get guaranteed, comprehensive benefits that will always be there for you, but as you age, which will happen, whether you believe it or not -- (laughter) -- you will have the benefits of that because you will not then pay more for those same benefits.

And I have told some of the young people who -- you know, we have a lot of young people around the White House, in case you haven't noticed, and some of them have come up to me and they've said, "Now, you mean I'm going to have to pay more?" And I've said, "Well, yes, because we have this old-fashioned idea that young people and old people and sick people and well people all ought to be insured because you all will get old and none of you know whether tomorrow you could be sick or lying in the emergency room because of a motorcycle accident." And so we think that the basic principles

of fairness mean that everybody has to be in the system and that some young people now who pay less will pay a little bit more, but that is an investment that will pay off for them as they get older and have children and do what the rest of us do.

So, we think if you look at all of the figures, we are being as fair as we can, but I want to be honest about it and say that there are some who will pay more for about the same benefits.

The other point you make, about prevention, there have been some employers who have really led the way and have had some benefits in their insurance rates because of the programs that they have implemented. We want to see those programs implemented across the whole society through health plans that encourage primary and preventive health care and encourage better opportunities for people who want to give up smoking or who want to change their diet. And we think no individual employer can have anything but, you know, the limited effect on his employees, but that if we take what we have learned from employers who have been successful with prevention and we move it to the national level and we move it to the accountable health plan level, we will have benefits that far outweigh what any individual employer could achieve for his or her employees.

REP. : The time of the gentleman has expired.

I noticed when I took the chair over from Chairman Dingell a note on the podium, and it says, "John" -- meaning John Dingell -- it says, "It's 50 years since your father introduced health reform legislation, and it is my 50th birthday today. Being here now is a great birthday present. May we meet with success for all Americans."

Happy birthday, Mike Kreidler. Recognize you for five minutes. And I might just note, on your time, it's attributed to Vernon Jordan that anyone who wakes up over 50, who wakes up in the morning without an ache or a pain, is dead. (Laughter.)

REP. MIKE KREIDLER (D-WA): Thank you, Mr. Chairman. It --

REP. : Mike. I mean mike.

REP. KREIDLER: Thank you, Mr. Chairman.

It is indeed a pleasure to be here and to be a part of this presentation today, Mrs. Clinton. I might point out that another group, a group that you mentioned earlier, Group Health Cooperative of the Puget Sound, is one of the exemplary examples of what can be done with managed competition and managed care.

This is an organization 21 years ago I began work with. And for 20 years, they give you this little utility knife with their logo on it, and I'm a recipient of that for 20 years of service with Group Health. And I have to agree with you; it is an exemplary organization. I went to work for them because I'd just completed a master's in public health and realized that when I started the master's I wanted to work in health administration, and I went to earn it because then-President Richard Nixon had proposed an employer mandate for health reform. And by the time I completed my degree, it was quite apparent that we weren't going to see the health reform that President Nixon was proposing at that time. So it's a pleasure to be here for that reason, too.

I have two questions -- or three questions here that are rather specific to the state of Washington. As you well know, it is the only state right now that has been as dramatic and bold in health care reform, closely paralleling that with that of the administration's. And it is also one that, as I say, has an employer mandate as a part of that program. It appears right now that the president's plan relies on major savings in Medicare, but it apparently does -- but does not try to change the basic fee-for-service structure of Medicare. Washington state has an enacted health plan, as I said, that parallels that proposal, but the state plan would include Medicare in its managed competition system. Do you think states should have the option to structure Medicare around competing managed care plans the way our state's plan would structure the system?

MRS. CLINTON: Yes, I do. I think that, by trying to encourage and move toward more organized care systems for Medicare patients, we would be doing a better job at a more efficient cost in preserving the quality health care. Too many Medicare patients now are being shut out of care because the existing fee-for-service networks will no longer take care of them at the price that Medicare will offer. And I think many Medicare recipients would be happier and have more security and be better taken care of if we could move them into more managed care settings. And I applaud the state of Washington for moving in that direction.

REP. KREIDLER: Great. Thank you. I was also encouraged to see how closely the -- in another respect that the president's plan parallels our state plan. But one difference is that our state plan does not require all health care coverage to be purchased through health alliances. Our plan has an exemption for large firms as the president's plan does, but it also allows smaller employers to buy coverage directly from plans without going through the alliance. Why do you feel that all but the largest purchasers should obtain coverage through alliances?

MRS. CLINTON: Because we want to get the maximum purchasing power, Congressman, and this is something that we have thought about a lot.

Many employers believe that they could strike a good bargain for themselves. The problem is that, if you don't have a large number of employers and employees in the purchasing pools, then you begin to have the kind of risk adjustment that works to the disadvantage of the whole system. And we're very concerned about that. If we could build in adequate protections against that, we would be glad to -- you know, to look at options like what Washington has done.

But on a national level, we are afraid that you would not have the kind of protection against what they call in the insurance trade cherry-picking, and you'd have, you know, younger, healthier people being hired by employers and, therefore, the employers being able to negotiate a better deal because there wouldn't be any protection against doing that. And we think that might cause even worse kinds of outcomes for people than we currently have. So it's an area that we're open to discussing, but it's one that gives us a lot of concern.

REP. KREIDLER: Thank you, Mr. Clinton.

Thank you, Mr. Chairman.

REP. : Mrs. Clinton, Mr. Dingell is on his way back from the vote, and he would like to close the meeting. We'd promised you you'd be out at 3:00. Could you take a few more questions until he arrives?

MRS. CLINTON: I'd be glad to. I'd be glad to.

REP. : Thank you very much.

I recognize the gentlewoman from Pennsylvania.

REP. MARJORIE MARGOLIES-MEZVINSKY (D-PA): I would like to add my voice to those who appreciate and respect what you've done. And welcome.

My question has to do with Pap smears and mammograms. How do you reconcile the Pap smear and mammogram regimen in the basic benefits package that falls short of the recommendations from the American Cancer Society and other women's health groups? In particular, I'm concerned that women should receive annual or biannual Pap smears and annual or biannual mammograms after 40, not 50.

MRS. CLINTON: Well, I'm so glad you asked that, because there has been so much misinformation and misunderstanding about this feature. And I am happy to have the opportunity, Congresswoman, to clarify that.

As you know, there are many insurance policies now that do not cover diagnostic services like Pap smears and mammograms, which means that the woman bears the entire cost if she should obtain such a service. What we have done is to absolutely include them in the comprehensive benefits package. Mammograms and Pap smears are covered services. That means that you can never be denied insurance coverage for those particular diagnostic tests.

What we have further done, and what we have done in line with a recommendation from the United States Preventive Services Task Force, which was created under the previous administration under the previous head of the National Institutes of Health, is to adopt their recommendation. Their recommendation was that women over 50 should have a mammogram every other year. So, what we have done is to say all women are covered.

Every woman for whom any doctor believes it is medically necessary or appropriate can start at whatever age is the age that that doctor thinks is the one that she should begin. But for women over 50, the service will be completely free. Now, what that means is that if I have -- belong to a health plan that has no co-payment requirement, then I can start getting my mammograms and Pap smears before I am 50 on a medically necessary or appropriate basis without any cost. If I belong to one where I have a \$10 co-pay, that's all I will pay, but I can start anytime before 50 and do it as many times as my doctor thinks is necessary.

But every single American woman, when she reaches 50, which is the age that was recommended by this very extensive task force that looked at all of the evidence, no matter what plan she is in, she will have that service absolutely free. So, the co-payment will not be necessary. It will not count in any kind of deductible. It will be absolutely free.

We think that is the right balance to strike. If, in the coming weeks and months, the Congress believes that we should try to extend that free coverage below the age of 50, we will look at the cost of doing that.

But I want to assure every woman -- you know, my mother-in-law has had a struggle with breast cancer over the last several years. I, like most women, have tried to do what I should do with respect to mammograms, and I've paid the full cost because they were not a covered service in the past. And so, I take this very personally. They will be covered. No woman will be turned away. They will be part of the guaranteed benefits package. And then, for women most at risk over 50, as a further inducement for women to come in and do it, they will be absolutely free as part of the preventive services we provide.

REP. MARGOLIES-MEZVINSKY: So, if there is family history involved or something like that, according to the doctor's wishes, they will be covered.

MRS. CLINTON: If it is medically necessary or appropriate, and that is a standard that would certainly cover women with a family history or any kind of suspicious growth, it would not be in any way prevented or eliminated from coverage. If a woman believes it is appropriate, she will be entitled to have that service, and it will be covered as an insured service.

REP. MARGOLIES-MEZVINSKY: I suspect this next answer may have something to do with a report card, but will there be a compliance element involved here also? I feel that it isn't enough for an insurer of any sort to just have this service available.

REP. DINGELL: The chair advises the time of the gentlewoman has expired. The chair recognizes --

MRS. CLINTON: Mr. Chairman, I don't mind answering that. If you would like me to, I don't mind answering it.

REP. DINGELL: If that's your wish, then please, Mrs. Clinton.

MRS. CLINTON: Because I think the congresswoman has asked a very important question about insuring quality and making sure that information is accessible to real people and not just, you know, folks who read medical journals.

We're going to do everything we can, and that's why I applaud your state so much, because this kind of consumer guide is exactly the kind of information we are going to need. And that will be part of the report card process. But I also believe that there will be a great interest in making sure that consumers get good information.

I would imagine that all kinds of consumer groups and maybe even a whole new industry will grow up to provide information so that every year when you and I make our choice about what health plan to join we will be looking at all kinds of information that will help us make the best choice. And I will look first, as I know you will, at what is the quality. You know, what kind of treatment do they get and what kind of outcomes do they have and how good a job are they doing? That's what my bottom line is, and I think that's what most Americans feel as well.

REP. MARGOLIES-MEZVINSKY: Thank you very much.

REP. DINGELL: The time of the gentlewoman has expired.

The chair recognizes now the gentlewoman from Arkansas, Ms.

ambert.

REP. BLANCHE LAMBERT (D-AR): Thank you, Mr. Chairman.

As you can see, we members are into preventive care. If we run back and forth enough -- (laughter) -- we'll get our exercise for the day.

I'd like to join my colleagues, certainly, in their applause to you and to the president, to the administration, and your task force in taking on such a well-needed and long-awaited-for task in reforming health care in this nation. I'm also pleased to have seen -- early in the spring I introduced H.R. 2336 -- to have seen that included in your package, which not only is a tremendous incentive to see health care but also to see people taking the responsibility of health care and offering them 100 percent deductibility for self-employed people. I share your goals in certainly looking for quality health care, affordable and available, but also lending itself to encourage responsibility in the American public and once again taking on the responsibility of their own health care.

I have about four questions and I'll be quick, and you can just choose whichever you'd like to speak about, first being malpractice reform. I see, really, basically in the proposal -- or at least my feeling is it hasn't gone far enough. It simply is an impediment, perhaps, not really the strengthening needs that we need in order to decrease defensive medicine that's being practiced in other areas, and we'd like to see if there are any other proposals or, certainly, additions that the administration would be amenable to as far as further malpractice reform.

The other, I hear a tremendous amount from my small rural hospitals, the disadvantage that they're put at because of the certain CLIA (sp) regulations and others. I'm hoping that there are certain CLIA (sp) regulation reforms that will certainly level the playing field hopefully, or at least put these hospitals in a position where they can be capable of competing with the larger urban hospitals.

And I guess that moves on to the next, which is the protection of the client base for the small rural hospital. Probably 15, 20 years ago we saw a move to try to eliminate rural hospitals and concentrate more of the tertiary care or, really, the care predominantly in urban areas where people felt like they could care for it more. And now today we're looking almost at a 180 from that movement, which is to try and preserve some of the rural health care because we do find that not only does it provide a better quality of life, but it's also more cost effective. I think many of my rural hospitals are frightened that they will lose that client base, that it will choose to go to the urban areas if they've got the choice, and that the urban areas are mandated to be able to provide it in the same way that the smaller hospitals are. So I'm hoping that there are some precautions there.

And also the state lines for the alliances. You, probably better

han anybody in this room, understand my district, and very often, for OBGYN coverage, for -- whether it's dialysis, or other things, many of my constituents have to cross either the Missouri line, the Tennessee, or the Mississippi line, and how will the alliances be able to work together in order to provide those people that care?

MRS. CLINTON: Well, Congresswoman, I do understand your district. I've spent many, many days and happy times in that district, and I -- often when I think about rural care, I think about your district because I know it so well.

Let me just quickly try to run down these points, and then we can give you additional information. We think we've struck a good balance with respect to malpractice reform between trying to limit unnecessary, frivolous lawsuits that do have a chilling effect and drive up the cost of defensive medicine against the legitimate needs of victims who have to have some kind of compensation in order for them to have their life needs met, but again, you know, we're putting this forward as our best effort at trying to deal with some very real problems.

Secondly, with respect to small rural hospitals and CLIA (sp), we look forward to working with this committee, which pioneered the kinds of protections that CLIA (sp) put into law to make sure that where adjustments and reforms might be called for, they can be made in a thoughtful way. And I know that the committee will welcome your specific suggestions based on the real-life experiences because I, like you, have heard that sometimes when we try to do the right thing we have unintended consequences have been particularly difficult in rural areas so that, for example, hospitals and clinics no longer feel free even to do a strep test for strep throat because they feel like they have to send it off and then it takes two days, and you could have beaten the strep infection if you had just been able to do it on site. So those are some of the practical considerations that I think this committee will be very sensitive to.

With respect to state lines for alliances, we anticipate health plans crossing lines, and so the health plans will be coordinating services across state lines, just as they do now, so that even though you might be insured by an insurer in Arkansas, you are free to use your dollars in Memphis or some other state, and we anticipate that that will become available, even though alliances will be confined within states as a way for states to be able to monitor their financial solvency and make sure that they are run correctly. We anticipate health plans bidding for business across state lines all over the country.

REP. LAMBERT: But if the alliances don't have the same programs, then there shouldn't be a problem?

MRS. CLINTON: No, there shouldn't be a problem because what will happen is that you will have providers joining together. In east Arkansas you will have, I would imagine, providers -- and in Arkansas and Tennessee networking together to bid on business in both Arkansas and Tennessee. Or you will have a Mississippi provider coming across the river to bid on business in southeast Arkansas. We anticipate that happening and think it will be very good for the kind of opportunities for enhanced care in rural areas like your district.

REP. LAMBERT: Thank you.

REP. DINGELL: The chair advises the time of the gentlewoman has expired.

Mrs. Clinton, we want to express our thanks to you for a superb presentation today. This is, I'd say, about the third or fourth time this month that I've had the privilege of listening to you and we -- I've learned a great deal each time. I want to tell you what a superb job I thought you did when you met with all the members informally in the learning session which we had earlier, and I reiterate to you my personal thanks for your kindness to us today, and I also reiterate to you the appreciation we have with regard to the superb job which you have done in explaining this.

I can assure you of my personal support and that of many others in connection with your efforts to move this program forward. I believe it's a good one, and I believe it's necessary, and I believe it's in the public interest.

The chair announces that the time that Mrs. Clinton had available to us expired 15 minutes ago, and so we express again to you our thanks for your kindness in that particular. Without objections, all members will be permitted to insert opening statements in the Record. The chair advises that our time here has expired and there will be no time for further questions at this time, but if members choose, Mrs. Clinton has indicated that she and her staff would respond to questions which we would not only make available to the members if they -- the response which we would not only make available to the members, but would insert in the Record.

So, Mrs. Clinton, we give you our sincere thanks for a sincere performance today. We thank you, and we wish you well, and we will do our best to be of help to you.

MRS. CLINTON: Thank you, Mr. Chairman.

REP. DINGELL: Committee stands adjourned to the call of the

Chair. (sounds gavel.)

END

EXECUTIVE OFFICE OF THE PRESIDENT

01-Oct-1993 12:42pm

TO: (See Below)

FROM: Jeffrey L. Eller
Office of Media Affairs

SUBJECT: HRC Transcript from Senate Finance 9/30

HEARING OF THE SENATE FINANCE CMTE:
HEALTH SECURITY ACT OF 1993
CHAired BY: SENATOR DANIEL PATRICK MOYNIHAN (D-NY)
WITNESS: HILLARY RODHAM CLINTON
THURSDAY, SEPTEMBER 30, 1993

SEN. MOYNIHAN: Mrs. Clinton, we welcome you. This is an auspicious occasion in every sense. It was in 1935 the Committee on Economic Security, which was headed by the -- by Francis Perkins as secretary of labor, which proposed to President Roosevelt, and he in turn to the Senate, what became the Social Security Act of 1935. They had contemplated including health security as part of Social Security. They chose in the end not to do so out of a sense that it would be more than Congress was ready for at the time, perhaps the people. In 1945, President Truman returned to the issue -- subject, as later did President Nixon. But those initiatives failed also.

But now, at last, it's clear that the time has come round for an extraordinary moment of national consensus which you have helped to shape in a most extraordinary way. So it's with a great sense of pleasure that I welcome you and turn to my colleague and friend, the former chairman, ranking member, Senator Packwood.

SEN. BOB PACKWOOD (R-OR): Mr. Chairman, thank you.

Mrs. Clinton, there are two subjects I want to mention in my opening statement. One is the bill in general, and the other, secondly, frankly, is abortion. On the bill itself, as you're well aware, I am somewhat pleased with the approach that you are taking. I like the universal coverage. I like the elimination of the preexisting illness as a disqualification. I like -- I call it an individual mandate, where the people are going to have to buy. The employer will share the cost, which is very similar to the German plan. And I like moving toward the community rating. All of those interestingly is what Hawaii has now, with no price controls in Hawaii. They have competition among their providers. But in essence, they have those four issues covered.

If I have any misgiving, and it is your fault or your husband's fault or your administration's fault, it is a misgiving based upon history, and that's the cost estimates of what we hope we can save and what we hope the new entitlements will not cost. And the only reason I say that is, over the last quarter of a century, we have all been wrong. You have done more to

attempt to quantify the cost as accurately as possible as I think can humanly be done, but I would still bet a dime to a dollar they're wrong, and maybe that's just 25 years of being burned.

So I would hope we don't jump too quickly into new spending entitlement programs, and you have three big ones in this, before we are sure that there are going to be some savings.

We must get our friends and neighbors and our loved ones to get their flu shot this year and every year. And it's a good time for older Americans to probably get their Pneumonia shot too, which is also paid for by

Medicare . Modern medicine has come such a long way from the plagues and the epidemics of the past. But now we really can reduce the impact of the flu, but only when we take responsibility for our own health and for the health of our loved ones and get vaccinated.

So, I'd like to thank everyone and I'm going to hold every press person accountable for making phone calls today, because we really need to get the word out.

DR. LEE: Doctor Phil Lee from the Public Health Service. I just want to stress several points that have been made by the Secretary; first, that not only should those aged 65 and older get their flu shots this year and get them earlier than we normally recommend -- the reason for the early recommendation -- it would be in October -- normally we recommend between the 15th of October and the 15th of November. The Centers for Disease Control and Prevention has already detected this higher risk strain -- A Beijing, it's called 3292H3N3 strain -- has already been detected.

So, we're recommending that in October everyone over 65 get the flu shots. In addition, there are individuals at risk under the age of 65 -- and I will mention some of those in a moment -- who also should receive their flu shots from their physicians. The reason that we're recommending this as an early shot -- one is the virus has already been detected; second, that this -- as the Secretary has indicated -- produces significantly higher morbidity and possibly much higher mortality in the elderly and groups at higher risk than the normal annual flu epidemics.

So, this is not an ordinary year. This is a year when it's of even greater importance than ever to have those flu shots. I would certainly include myself among those, as a 69 year-old individual. I've already had my pneumonia shot by my personal physician and intend early in the month to get my flu shot as well.

The others at risk, in addition to those 65 and older, include residents of nursing homes and other chronic care facilities housing persons of any age with chronic medical conditions, adults and children with chronic disorders -- cardiovascular or respiratory particularly -- and this would include children with asthma. Children are more likely to get the flu, they're not as likely to be severely affected as older adults -- but, in this case, children with asthma very definitely, or children with chronic respiratory problems, very definitely, adults who have required medical follow-up or who have been hospitalized during the past year because of Diabetes or other chronic metabolic disorders, kidney dysfunctions, blood disorders, who have immuno-suppression -- either through cancer chemotherapy, or perhaps individuals with HIV infection, or AIDS -- should also have those flu shots, and have them early.

So that it's a nationwide effort. It will involve physicians and other health personnel -- nurses, health departments, private practitioners -- throughout the country in order to achieve the goals that we're setting for this year.

Although the outbreaks, as I've noted, have occurred sporadically

In the past, I can't stress enough the seriousness of this potential epidemic, the urgency of getting the immunization, and getting them in October. And we're fortunate that that Centers for Disease Control and Prevention, which conducts constant surveillance on the viruses -- the influenzal viruses -- that are out there, has detected -- and they do this worldwide; they gather information; they're constantly looking for what viruses are upcoming. They have detected this A Beijing strain. Cases have been already reported in August in Louisiana. And that's the reason for this urgent recommendation. So, I would just strongly second the Secretary's recommendation.

And I just would make one final point. This effort is an indication of both the Secretary's commitment to prevention and the President's commitment, which he has stressed over and over again in his health care reform proposals. Thank you.

Bruce.

BRUCE VLADECK: Thank you, Phil.

Good morning. I'm Bruce Vladeck, Administrator of the Health Care Financing Administration, which is responsible for management of the Medicare and Medicaid programs. The Secretary and Dr. Lee have touched on most of the important issues for the purposes of this morning's announcement. But let me just emphasize a few points.

As the Secretary noted, the problems of influenza have been with us for hundreds of years, but this is the first flu season since the Medicare program began in 1966 that immunization against the flu is covered under Part B for all Medicare beneficiaries. And therefore, it's important to get the word out not only how important it is to the health of people 65 and older that they get their shots, but now, for the first time, the cost of those shots are covered. And, indeed, the Congress and we felt it so important to encourage people to get their shots that, unlike almost every other outpatient service in the Medicare program, for participating physicians, flu shots have no deductible and no out of pocket payment for beneficiaries at all. If their physicians take assignment or if they receive the services at a variety of institutional providers, clinics, and so forth, there is no cost to the beneficiary from getting the shot. It's important, as a matter of policy to encourage people to get preventive services of this sort.

That is a story that is repeated, unfortunately, many, many times all over this country, and it's a story among the many that we have heard that argue very strongly why this system of health care needs to be changed because of the impact it has on welfare dependency, on job lock and on other factors that are undermining the well-being of American families.

In the past few weeks, Mr. Chairman, you and other distinguished members of this committee have raised tough and important questions about how best we can finance health care reform. This is, as we all know, a subject of great complexity, one that has been studied exhaustively, but which is still subject to a great many questions. We have to, in the coming weeks and months ahead, work closely together to understand as fully as we are able the kinds

of issues that are raised by the reforms that are offered, not only by the president, but by the Republican senators represented here on this committee and others.

We have to be sure that we get the best value for the health care dollars we currently spend and that we do the best job we can to reform the system so that health care is delivered more efficiently at higher quality to all Americans. The simple fact is that Americans are spending nearly now \$1 trillion a year on health care, and we are not getting our money's worth. We have a health care system that stifles competition, breeds inefficiency, embraces bureaucracy and encourages waste.

You know as well as any the comparative figures on health care spending among the countries with whom we compete. Senator Packwood just mentioned Germany. They spend less than 9 percent of their gross domestic product on health care and they insure all Americans (sic) and guarantee better benefits to all of their citizens. We spend \$1 trillion every year, leaving millions of Americans lacking insurance and millions more on the verge of losing it because of the changes in the economy.

And too many Americans get the most expensive health care in the most expensive place, the emergency room. That care is not free even if they leave the hospital without themselves paying the bill. That care is paid by the rest of us.

And we know all too well how paperwork, administration and bureaucracy cost us at least 10 cents of every health care dollar. And for small businesses, administrative costs eat up one out of every three health care dollars. And finally, the Justice Department estimates that health care fraud, because of the kind of system we currently have, robs the American taxpayers and those who buy their own insurance of at least \$80 billion a year.

And we also have a system with the wrong kind of incentives, and there are many examples of that that I would be glad to go into later, but just let me give two. One is that we do not emphasize primary and preventive health care. We pay for care usually after a situation has developed where it is more expensive to care for it instead of taking care of it at an earlier and less expensive point in time.

And we also basically in this industry of health care have continued what most other industries gave up decades ago. We pay by piecework. We reimburse physicians and hospitals and other health care providers on a piecework basis, which, as human nature will tell us, results in more pieces being added to the pie to be divided than care being delivered in a cost-effective way.

There is no mystery, however, about how we pay for care. More than half of Americans' annual health care bill, and that includes both public and private funds, comes from employers and individuals, those who create the jobs, work hard, play by the rules and pay largely for our health care system. They pay for insurance premiums and they pay both through business and through individual payments. They pay through out-of-pocket

expenses, and they pay taxes to cover the public programs that include Medicare, Medicaid, the veterans program, CHAMPUS, and other federal outlays such as uncompensated care payments.

This committee and millions of Americans are asking the right question, who's going to pay the bill as we move beyond today's insecure system and guarantee health security to every American? The president has decided, first and foremost, that we should not raise a broad-based tax to fund health care reform. Instead, we should build on what works, but make it work for everyone. Our goal is to take the world's finest private health care system and make it work better.

There are three primary sources of funding for this health security plan. One is to ask all of the Americans, 30 million, who work and have no insurance and their employers to contribute something to their own health care. That will include asking those who are currently on Medicaid and Medicare who also work similarly to make a contribution.

Second, to limit the growth in the federal health care programs, not to cut them, but to reduce the rate of increase in the primary programs of Medicare and Medicaid. And, third, to tax tobacco. That is a tax that is not broad-based, but is health directed that we think could be used to fund certain of the health care expenditures necessary and to ask a contribution from large self-insured corporations that choose to continue to insure themselves.

Right now, nine of every ten Americans who have health insurance get it through their employer. Even with all the problems associated with health insurance today, high deductibles, co-payments, incomprehensible policies and insecurity, this way of getting and paying for health care works for most Americans, like those of us in this room. Under our health security plan, employers and individuals who pay premiums today will continue to do so.

And six of every ten Americans who currently has insurance will pay the same or less as they do today for coverage that is as good or better than what they get today.

And I want to repeat that, because this is a very important point. We estimate that approximately 63 percent of Americans who currently have health insurance will pay the same or less than they pay today for coverage that is as good or better than what they get now.

Here's what is different: We're going to make our employer-based health care system work for everyone. As Senator Packwood points out, the individual will be responsible for making a contribution, but the employer will also be supporting that contribution. Every individual will have to take responsibility and pay something, and that is where two-thirds of the financing for premiums will come from.

We believe this approach will provide the least disruption for people who have benefits who have fought hard for their health benefits and like how they get them now. And it is an idea that some would argue is a pretty old-fashioned one because it builds on the system we have. It was

advocated, as you pointed out, Mr. Chairman, by President Nixon, introduced by Senator Packwood, and it will provide a familiar way for Americans to know they will be secure.

We cannot reform the insurance market and just let it go at that. There will not be any way, by merely reforming the insurance market, to provide universal coverage without some system in which everyone contributes. If we reform the insurance market, though, and provide discounts to small businesses and low-income workers and the employed who do not work, then we believe we can cover the vast majority of Americans who now have no insurance.

There will be some who will fall through the cracks. For example, Mr. Chairman, as you rightly point out, those who are homeless, who are not connected to any kind of institution. But at least we will have a very limited number of people with whom to deal. Hawaii, which has had employer/employee system, still has trouble covering about 3 to 5 percent of the population, people who do fall in those cracks, and they are continuing to work on that. But they are at 95 percent of coverage at a cost less than what the rest of us pay, with very high consumer satisfaction.

Even with this approach, though, there will be people who have every right to ask, "Why do I have to pay anything?" They will say, for example, "I'm young and healthy and I will not get sick" or "I've fought hard for my health benefits; I already pay a lot, and I don't want to pay a penny for anything else" or, in the case of small business, "I don't think I can afford to pay anything." We believe the answer to these questions goes beyond responsibility and directly to the heart of what health reform and health security is all about.

Because the fact of the matter is that even young people who think they are immortal do get sick, do have accidents, do end up in our emergency rooms, and the rest of us pay. And people who have good health benefits today are just a pink slip away from having no benefits as countless thousands of workers who have been laid off from very well-established firms in the past years can attest to. And the small business owner who cannot in today's market afford health insurance is also taking a great risk, the risk that a family member will get sick and the business could very well be bankrupted as he or she faces a mountain of medical bills.

The second element in the financing plan is something Washington hears a lot about: trying to limit the growth of government spending. We all know, and you know better than most in this committee, that it is tough to stop, let alone try to control, government spending. But we do think we can slow the rate of increase down. And we intend to do so not with a cap that is not specified, but with specific, scorable, line-by-line savings proposals.

This president -- let me be clear -- has no intention of putting Medicaid or Medicare beneficiaries at risk. Indeed, under this proposal, Medicare recipients will see an increase in their benefits under the health security plan because, for the first time, we will be providing Medicare beneficiaries with prescription drug coverage that they need and new options

for long-term care that they deserve.

This president would not ask for these kinds of savings outside the context of overall health care reform. We know all too well that, if we simply pared back the growth of federal programs and did not address the private side of the health equation, the result would be more of the same: more cost-shifting, more pressing down on one side of the health balloon, only to find the other side expanding, more skyrocketing bills for people who have private health insurance and, unfortunately, more and more doctors refusing to treat Medicare patients or refusing to take Medicare as the only payment for the service.

By controlling the costs of health care increases on the private side, we will help stop cost-shifting and stop giving doctors any reason to do what they are doing now: dumping Medicare and Medicaid patients out of their offices and into emergency rooms. We will, in short, turn the incentives in today's system the right side up for the first time.

There are a number of serious health care reform proposals now on the table in Congress, including one supported by several Republican members here today under the leadership of Senator Dole and, particularly, Senator Chafee. They call for comparable Medicare savings. This committee, I know, will debate how fast those savings can be achieved and how big those savings can be. But I think we all agree there will have to be savings, and they will be the second major source of financing for health reform.

And finally, Mr. Chairman, we do ask the Congress to place a tax on tobacco and to require large corporations who continue to self-insure to do their part to pay for the health care infrastructure, particularly academic health centers and research that we all use and which we all benefit from. Other plans, as you know, have suggested a broad-based tax. Others have suggested capping the tax benefits on health benefits.

Both of these, make no mistake about it, are tax increase. If we were to try to substitute for the private sector investment now a broad-based tax, it would be an enormous, large -- I can't even think of all the superlatives you'd have to have -- of about \$500 billion in new taxes. We do not believe anyone can justify putting that kind of money into this existing inefficient system.

Likewise, to fund health care reform with tax caps would be a tax increase on at least 35 million American workers now who have given up wage increases in return for health care benefits. It would result in a substantial middle-class income tax increase that at this point in time, until reform has begun, we do not support. We do support changing the tax treatment on health care benefits once reform has occurred once comprehensive benefits have been secured and to draw a line to remove tax preference on any health care expenditure above that limit.

Mr. Chairman, the kind of questions that you will face and the debates that we will all have in the next months are very exciting questions finally to be facing as a country. I think that, if we enter into this debate with the spirit that we have had in the country in the last several weeks, we

are guaranteed that this Congress will produce a result that they will be proud of and that Americans will feel good about.

The president stands ready to work with all members on both sides of the aisle and in both houses so that all of us are able to, as public stewards, fulfill one of the great needs of our country both in human and economic terms. And it's a pleasure to be here to talk with you about that.

SEN. MOYNIHAN: Mrs. Clinton, we thank you for your superb opening remarks. We observe you no longer have a text, and you don't even use notes at this point. And this, of course, is not the first occasion we've met with you. From the beginning you have come and talked to us on a bipartisan basis, and I particularly would thank you for noting Senator Dole, Senator Chafee. Senator Durenberger has been very active as the ranking member of Senator Rockefeller's Subcommittee on Medicare and Long-Term Care. And Mr. Chafee is matched with Mr. Riegle on the Committee on Health for Families and the Uninsured, which is, of course, a particular concern of yours.

The Committee on Finance has the distinction of having among its members the majority leader of the Senate and the Republican leader of the Senate. And I'm sure the committee would defer to them in the opening questions.

And good morning, Mr. Leader.

SEN. GEORGE MITCHELL (D-ME) (Minority Leader): Mr. Chairman, thank you very much. I'd like, if I might, to use my time to make just a brief statement.

SEN. MOYNIHAN: Yes. And can we agree that, with the exception of our -- of the two leaders, that we will keep ourselves to five-minute questions?

SEN. MITCHELL: Well, I'll observe the five minutes as well so we can all be -- (laughter) --

SEN. MOYNIHAN: (Off mike) -- depends on it. He might as well know.

SEN. MITCHELL: Thank you, Mr. Chairman.

Mrs. Clinton, I join my colleagues in welcoming you here today. Your willingness to testify before five committees of Congress this week is evidence of your commitment to reform. I commend Chairman Moynihan for holding this hearing today. I look forward to working with him and other members of the committee, Republicans and Democrats, to enact comprehensive health care reform.

Members of this committee have traditionally worked on a bipartisan basis on health care issues. Over many years I've worked closely with several of the Republicans on this committee who are committed, as we all are, to providing access to quality health care for the poor, for the elderly, the disabled, and others who are without access to care and to provide peace of mind to those who now have insurance but fear losing it.

We face a legislative challenge that will take all of the knowledge, the experience, and the cooperation that members of this committee have developed over many years of work. The need for affordable health care

For all Americans is not a partisan issue. Health care is a fundamental human need and, I believe, a fundamental right of every citizen in a democratic society.

Our challenge is to provide access to affordable health care to every American. To achieve this goal, the attitudes, the habits, and the behavior of every health care consumer and provider must change. Rising health costs threaten the long-term fiscal health of the nation. They represent the single greatest contributor to the future growth of the federal budget deficit, a deficit which drains needed savings and investment from the private sector. Yet despite the truly enormous national resources devoted to health care in our society, we have a system which doesn't serve all of our people.

No American has security in the health care system today. A job loss, an unexpected illness or accident may result in the loss of health insurance even for those now covered. Any plan for reform must meet the threshold test of providing health coverage for every American and assure that health care costs are controlled.

I believe the president's plan meets that threshold test. It will assure access to health coverage for every American family. The plan also contains meaningful cost containment strategies to reduce the rate of increase in the costs of health care.

The president's plan is the culmination of many months of work by many persons expert in various disciplines. It builds on the work of many years by members of Congress, including several members of this committee, and many organizations dedicated to providing health care to every American.

It's not surprising that the president's determination to reform the system has found strong support in the American business sector. Those who pay the bills for health insurance know that they cannot continue to absorb these rising costs without seriously undermining their competitiveness in the free market.

Those who argue that health care reform will cost more are making the assumption that no one is paying those costs today. That's a wrong assumption. The costs of care are being paid today, but not always by the people who receive the care.

There will be much opposition to this proposal. There will be well-organized and well-financed efforts to defeat it. There will be claims that it will hurt business and cost jobs and produce no benefits, ignoring the fact that the current system hurts business, costs jobs, and leaves many without benefits.

I do not assume that every member here will agree with every part of this program. Indeed, I assume the contrary. Each of us has the right -- indeed, the obligation -- to work for those revisions we believe appropriate. I believe the plan undoubtedly can be and will be improved by constructive suggestions from many of the members of this committee.

I applaud the efforts of Senators Chafee and Dole and other members of the Republican health care task force. Their proposal contains

many provisions which are similar to those found in the president's plan. There is substantial common ground on which to build. I look forward to a vigorous and well-informed debate on the significant differences which exist in the two plans as well.

Whatever the outcome of the debate over those differences, it's important that on those areas where there is agreement, we recognize it and together build on it.

Americans will be best served by a process in which all significant points of view are debated fully, with reason and civility. We will have a better plan at the end, and we will have built the consensus necessary if all participants know that their voices have been heard, their ideas thoroughly debated. And I believe, Mr. Chairman and Mrs. Clinton, that the result will be one of the great events in recent American history when we next year enact comprehensive health care reform.

SEN. MOYNIHAN: Thank you, sir. And I take it that was a statement, but I would like to assume Mrs. Clinton will agree.

MRS. CLINTON: Yes, sir. (Laughter.)

SEN. MOYNIHAN: Nothing be added.

Senator Dole?

SEN. BOB DOLE (R-KS) (Minority Leader): Thank you, Mr. Chairman. And first I want to thank Senator Moynihan for convening this meeting. It's going to be the first of many, many, many hearings. It's a very difficult issue, probably the issue of this century if we approach it properly. And I also want to underscore what an extraordinary job you've done, Mrs. Clinton, not only in your testimony. To go before five committees is cruel and unusual punishment, except for this committee. (Laughter.) And also for your work in helping craft the proposal that you've been discussing.

I wanted to underscore many of the things that Senator Mitchell has said.

First of all, I don't think there's any doubt about anybody on either side of the aisle or anybody in Congress who's not prepared to try to reform our health care system. But I guess the question is how do we go about it and how do we do it, because as you've indicated, our health care system, notwithstanding its flaws, is the envy of the world. So we have to start off with that very positive premise that we're fortunate in America to have the health care delivery system we have today. And how do we change it to take care of the 30 million or 35 million?

And I think I can speak for every Republican -- I hope every Republican. We have our -- our intention is to be very positive. As I've said publicly -- I spoke with the AMA before I came over. I hope that doesn't prejudice my remarks. But we're going to start down the road together. Now, there may be a separation somewhere down the road, but we want to start down the road together. This is a very important issue. In my view, it ought to have broad bipartisan support, not just enough to make 51 or 52 or 53. Because, in my view, if it's broadly supported in the Congress by Democrats and Republicans, it'll be, I think, better received all across America.

And so, as far as I'm concerned, nothing's off the table. No preconditions. We hope that's the view of the administration, because as Senator Mitchell pointed out, even though the committee's -- we have a good record of being very bipartisan here. I can recall in the late '60s, early '70s we had the "3D approach" to health care. I think Durenberger, Dole and Danforth. And I think we had the fourth D; Domenici came in a little later. And we were trying to do many of the things that you're doing today, and we worked together with Democrats and Republicans.

And I hope -- and I don't think there has been any effort to label people who may have questions or maybe disagreements. Maybe they're doctors. Maybe they're hospital administrators. Maybe they're pharmacists. Maybe they're insurance companies. I hope we just don't write them off as some special interest group. And maybe we have to have a villain, but I hope that we treat their voices like the voices of all Americans who have real concerns about the program. They need to be heard, and we need to respect their thoughts.

So I also want to put in a plug for this committee. Obviously, we think it's about the best committee around. And we're very proud of its leadership, with Senator Moynihan and Senator Packwood. They've resolved some of the thickest -- you know, trickiest issues, most controversial issues, generally in a very bipartisan way and -- whether it's welfare reform or rewriting the tax code in 1986. And I believe with our help we can help achieve bipartisan consensus on health care. We know there are other committees that have other interests and certainly will have some jurisdiction.

There are some disagreements. I mean, I think it's fairly obvious there are some disagreements, mandates that bother us even though you suggest that that may not be such a big problem. I think we have to look at our states. In my state of Kansas, 99.4 percent of the employers have 250 employees or less. Many -- most of them are much, much less -- 25, 35 employees. We only have about 60 employers in my state with over 1,000 employees, and only two or three with over 5,000. So -- and there are a lot of states, as I look around here, that fit that same category, smaller, rural states.

We may have a little different view on some of these areas. We're concerned about purchasing monopolies, risk to quality and choice, and the creation of new entitlements. We certainly agree with the hope that we can achieve enough savings to have prescriptions and long-term care and take care of early retirees, but again I think we have to be very specific about the costs.

But I think finally I would say that whatever else happens, this issue is all about health care for American people. And I think we have to talk as honestly as we can to the American people -- no rosy scenarios, no smoke and mirrors, and no juggling of the books. That's true of us or anybody else, Republicans or the administration. Because there's no doubt about it, somebody has to sacrifice. And the thing that really interested me was

President Clinton's sixth point he made, his sixth principle -- responsibility. I mean, my view is if we're going to delay responsibility for 10 years for individuals in some cases, we may never have responsibility. And it seems to me if we want people to better use the system and save money in the system, there's got to be some individual responsibility. We think that's present in probably both packages, but I think it's very important.

And I'd just say finally, not to personalize anything, but I've had a lot of health care in my life and I know the importance of it, of good, affordable, accessible health care, and I've even experienced when you didn't have the money to pay for it, how important it is to know how it's going to be paid for. And I think many hundreds of thousands, maybe millions of Americans have had similar experiences.

So our goal should be to provide quality care for nearly all Americans. You said some will slip through the cracks. No question about it. We're not going to be able to reach everyone. So I think we ought to remember the Hippocratic principle that guides our health care providers -- do no harm. I think we may do a lot of good, but -- (inaudible) -- don't do any harm.

And we don't want to bury the American people under an avalanche of bureaucracy. When we're talking about reinventing government, we don't want to reinvent bureaucracy. And I think there is some concern when you have this very powerful, seven-member board, and when some of the states under the health alliance will be spending I don't know how many times more for the health portion than they spend for -- the state spends for all its other functions, the entire budget. So it's going to be a big, big responsibility to make certain that any new bureaucracy that's created is going to work without causing additional hardships. Because one thing that I find -- and I don't think I'm any exception -- it's not Republican or Democrat -- I don't care how good the package sounds; the American people are concerned about big government. And we're talking about one-seventh of our economy, 14, 15 percent. And you may promise everything, free this and free that and free that, but somehow when the government gets involved in it, people are very concerned, and I hope that we can somehow work together. We are prepared to do that, and we certainly appreciate your being here this morning.

Thank you, Mr. Chairman.

SEN. MOYNIHAN: Thank you, Senator Dole.

Mrs. Clinton would you like to -- ?

MRS. CLINTON: No, I just want to thank Senator Dole for the kind of leadership that you've shown on this issue and your willingness to work it through, just as you said. We do want to preserve what is best about the American health system and fix what is broken, and I think if we have in mind that that's the approach we want to take and we then really hold up to scrutiny anything we're going to do to see whether it advances that and advances, I think, the goals we all agree on of security and responsibility and quality and choice and simplicity and savings, I'm very confident that we're going to be able to come up with bipartisan support for a package that

we'll all be able to advocate for. We may not all like 100 percent of what's in it, but in the natural course of putting it together, we will have made the right decision for the American people.

SEN. MOYNIHAN: Let's start, then, in the spirit that Senator Mitchell and Senator Dole addressed, and which you and President Clinton have, on some of the issues that we as the Finance Committee have to ask ourselves.

The president on September 22nd had a group of us down to the White House. You were there, Mr. Mitchell was there and Mr. Dole was there, as were a number of us, Mr. Chafee. And the president said at that time that he wanted to build in to this legislation what he called a continuing reality check. He spoke of a system of -- what kind of monitoring system we build. If we might start that reality check right off, at least for me the first question is that the administration seems to contemplate a health care system in the nation which has zero growth.

One of the budget documents you've given us speaks of health -- it says, "Health premiums are allowed to grow at the inflation rate over time" -- that's a quote -- which means they don't grow at all in real terms. The basic table in the preliminary document which we've had for a couple of weeks shows the private sector by the end of this decade growing at CPI plus population, which is inflation plus population, which is no growth, and Medicare and Medicaid at CPI plus population plus four-tenths of one percent. And I make the point that Medicaid, for example, this year is growing at 16.5, so there's a change contemplated. The question is, how would that survive a reality check? Here are the numbers. Between 1960 and 1992, the cumulative increase in the CPI, the consumer price index, is 375 percent. The cumulative increase in medical prices is just about 875 percent. So we see prices behaving very differently, and prices do behave differently. In that period the prices of computers would have dropped 90 percent. But in the main, unless -- it's conceivable that innovation in medicine could turn out to be cost reducing and labor saving, but it has not been.

And what are we to say? Are we really thinking zero growth in cost?

MRS. CLINTON: Mr. Chairman, we are thinking zero growth as a budget target that this country should be moving toward, and let me, if I could, just expand on several points that you made.

We believe -- and I don't think you can find any health economist or student of the health care system who would disagree -- that there are considerable, substantial savings in the existing system that can be realized both on a one-time only basis and on a continuing basis. There are varying estimates as to what those savings are. Dr. Koop says, for example, that based on the work he has done with Dr. Jack Wynberg (sp) at Dartmouth and others who have been studying health care expenditures that there may be as much as \$200 billion of unnecessary costs within the health care system. And even if we take an estimate below that or above it, wherever it comes out, we know there are substantial one-time and continuing savings in the system.

We also know that the reorganization of health care into different kinds of ways of delivering it than we currently rely on are much more efficient, and there are many examples of that, whether one looks at the Mayo Clinic providing high quality health care at a cost this year of an increase of only 3.9 percent -- which is about the target and slightly below the target that we have aimed for -- or whether one looks at the giant California pension and retirement system that is now realizing savings because of the way it has used its purchasing power to achieve the kinds of health care reductions in the costs of insurance, or whether one looks at the city in your state -- Rochester -- which is a much better organized health care market than most of our cities, or whether one looks at Medicare expenditures.

You can look at different parts of our country where Medicare is delivered at a cost ranging between one and three times greater, so that, for example, if you are in Miami, Florida, you will pay three times for a Medicare patient what you would pay in the state of Wisconsin. To use one of Senator Durenberger's favorite examples, if you are in Duluth, Minnesota, you will take care of a Medicare patient at one-half the cost of what is the cost in Philadelphia. And there are many, many examples of that. And there is no demonstration of any less quality being given to the Medicare patient who is taken care of at less of a cost.

One of the things that you and I have had the opportunity to talk about in the past is what is the reality of health care cost increases around the world, which is that health care has, as a service which is labor intensive, increased when other goods and services have achieved productivity decreases. And your computer example is a perfect example. And one of the differences, though, in our health care sector than in those with whom we compete is that even though their increases have continued, we have grown at a much greater rate of increase without covering everybody in a universal system that would prevent cost shifting.

And I would argue that, you know, the economic theory of the cost disease, which you know so well, which points out the difference in service and labor-intensive services, often uses the example that a Mozart quartet being played in the 18th century and being played in the 20th century still requires four people. There's no productivity increase if you're going to play that quartet. The problem with the American health care system is if you can imagine that quartet has added people to hold the chairs, to hand the violins in, and has required the musicians to stop at the third or fourth page of the music to call somebody to make sure they can go on to the next bar.

And that is the kind of waste and inefficiency that permeates our health care system, and we believe very strongly that if we don't set the kind of very strong goals that we can achieve in both the public and the private sector, we will continue to reward this piecemeal, inefficient delivery system that does not guarantee quality at all. I think most of us on this committee would be more than pleased to get all of our health care from

a Mayo Clinic, and we would get it at much less of a cost than if we went to many of the hospitals within a few miles of this building.

SEN. MOYNIHAN: Mrs. Clinton, I have to say to you the only thing that you -- the one option you have not considered sufficiently in this whole plan is if we can just move every -- half the population to Minnesota, half to Hawaii, our problems would be solved. (Laughter.)

MRS. CLINTON: Well, you know, Mr. Chairman, we have laughed that if you look at cost differentials around this country, literally you could provide cheaper health care in our federal programs if you handed people round-trip, first class airfare tickets to fly to Rochester, New York, or Rochester, Minnesota or many of the other fine institutions that deliver high-quality health care at less of a cost.

SEN. MOYNIHAN: Well, Senator Durenberger does not say otherwise.

A vote has been called, Mrs. Clinton. And this is unfortunate, but we're at the end of a fiscal year. There are two votes. If we hold till 11:15, we could all be back.

(Off mike discussion.)

The committee will recess, stand in recess until 11:15.

(Recess.)

SEN. MOYNIHAN: The hour of 11:15 having come and somewhat passed, we welcome once again the first lady to this final hearing -- final hearing which she will address -- on the Health Care Act of 1993. I would note that we don't have a bill as yet, but of course, in due time, we will do.

And our next -- in our ordinary sequence, so we turn to the former chairman and ranking minority member, Senator Packwood.

SEN. PACKWOOD: Mr. Chairman, I understand we're going to hold pretty closely to our five-minute rule --

SEN. MOYNIHAN: We are going to stay to that rule, sir.

SEN. PACKWOOD: Okay. Very quickly on abortion, and then I'll move on to something else. Will the president's bill -- it includes pregnancy-related services -- will it include abortion?

MRS. CLINTON: It will include pregnancy-related services, and that will include abortion in plans as insurance policies currently do.

SEN. PACKWOOD: Good. Now, the new entitlements. And here's the problem with trying to estimate cost. All medical services seem to be driven more by volume than they do by price on occasion. You've got a provision where you're going to pick up 80 percent of the retirement costs for those between 55 and 64 that are now being paid for by the company. Do I have it right?

MRS. CLINTON: Yes.

SEN. PACKWOOD: Okay. Now, you're the company, and you've got a 30-year plan. Somebody age 55 can retire, and they get \$1,000 a month. And their health plan costs \$300 a month to carry them. And the company's having to shrink. It's getting more productive. So it says to this person, "Sally, Joe, listen, I'll make you a deal. I'll sweeten this offer and we'll give you \$1,100 a month to retire." And Joe or Sally says, "Well." "And no change

in your health plan." Sally or Joe says, "Great." The government picks up \$240 of the 300. How do you -- and, therefore, the company saves money. How do you estimate ahead of time what the volume of that is going to be?

MRS. CLINTON: Senator, we have tried with the assistance of the Treasury Department and the Office of Management and Budget and HCFA and all of the other government actuaries to make the very best calculations we can. And we've costed that out to be about a \$4-1/2 billion annual cost. And --

SEN. PACKWOOD: But how do you get there? How do you know?

MRS. CLINTON: Well, you know, as you pointed out rightly in your opening statement, there is a lot of estimating that goes on with health care, and there's no precision attached to it. But we have looked at both rates of retirement and rates of retirement when benefits were offered like early retirement bonus packages and have used those figures in terms of the percentage of the workforce willing to go into retirement. Now, the company will, as you point out, still bear some of that responsibility. A number of early retirees go to work somewhere else or start their own small business. So there will continue to be contributions coming in that regard.

We have done the best we can at estimating it, and I'll be happy to lay out all of the estimating that has gone on based on the figures that are available to us. But I don't know that anyone can tell you how precise that is to what percentage or decimal point. But we have satisfied ourselves that we have the best possible estimate, given this policy.

SEN. PACKWOOD: A second example related to the same situation. We're going to pick up the cost for prescription drugs for Medicare. Somebody on Medicare goes to the doctor, and the doctor says, "Well, go home and take two aspirin." And the person says, "Doc, can't you give me a prescription?" And the doctor says, "Well, sure." And it's paid for now. How do you avoid this? I mean, that is natural human nature. How do you estimate that?

MRS. CLINTON: Well, you're right that there has been that kind of situation, but we don't believe that it will be increased through this. In fact, what we think is that we will begin to get a better handle on controlling prescription costs and controlling the hospitalization and other related health care costs that are due to inadequate prescribing or the inability to pay for prescriptions. And let me just give you an example. Based on the information available to us, it is estimated that approximately 23 percent of Medicare recipients are admitted to the hospital because of problems having to do with prescriptions.

Some of it is cross-medication, where one doctor doesn't know what the other doctor is giving and there's no organized managed care system to keep track of that. So the patient goes and gets one thing for one and then something else, and those interact, and nobody even know that she was taking both. Some of it is due to what happens now very often when a prescription is given to an older citizen; they can't afford to do it in the way that the pills say. For example, take four times a day and then get refilled. So they self-medicate, and they take one a day because they think

it'll last four times as long and they end up back in the hospital.

So if you look at the costs we are currently incurring because of medication-related problems, we think we will actually be saving money. And there may be, as you point out rightly, the occasional example where somebody wants a prescription instead of taking aspirins. We think that is outweighed by the kind of benefits that better medication will provide in terms of better health care at more of a cost-effective delivery than the kind of hospitalization that results now from the inadequacies.

SEN. PACKWOOD: The last question on my first go-around. You very kindly -- the administration very kindly granted Oregon's Medicaid waiver when we could not get it from the previous administration. And Oregon has set up a prioritized list of medical services, and from number one to number 686 as I recall. And number one is the one that's most likely to make you well. And -- in fact, some at the bottom we're not going to do anything at all because there is known treatment. There's no point in spending money on something that no one thinks will work. But part of what's in there also is cost is part of the factor of consideration. And as you might expect, very high on the list are preventive services. It's cheap medicine, and it works very well and pays off bundles in the end. But it is a ranking of procedures below which we won't pay for some. Do you think the nation ought to be moving in that direction?

MRS. CLINTON: I think that the nation is implicitly moving in that direction every day in the fact that we ration care to many citizens who either cannot afford it or access it too late for it to do them any good.

Dr. Koop told me the other day that an uninsured patient who enters the hospital with the same ailment as an insured patient is three times more likely to die than the insured patient. That's the most dramatic example of the decisions that are currently going on in our health care system.

And I believe that as we change the incentives in our health care system to that we don't reward doing procedures for which there is no known clinical efficacy in the way that it is being performed or the cost far outweighs any kind of benefit any patient could derive, doctors will be making those decisions, and patients will be more understanding of them because they won't be made in a kind of arbitrary way but as a result of the better kind of decision-making we would like to see as a hallmark of the health care system.

SEN. PACKWOOD: Thank you, Mrs. Clinton.

Thank you, Mr. Chairman.

SEN. MOYNIHAN: Thank you, Senator Packwood.

Senator Baucus.

SEN. MAX BAUCUS (D-MT): Thanks very much, Mr. Chairman.

Mrs. Clinton, all of us commend and praise you and the president.

I think it's clear that our country's on the verge of making a truly historic step which will not only benefit the people individually but give them health care that they do not now have at lower cost, but even in a more fundamental

sense make American people feel even better about the country, ourselves as a people, because we will be joining the ranks of other nations where health care is essentially a right. It's something that all of us as citizens are entitled to. And you are trying to steer us in that direction, the president is trying to steer us in that direction, and we all are tremendously grateful and appreciative of the efforts you're taking. It's truly monumental, it's truly historic, and it's wonderful that we're doing this.

As we move in this direction, each of us has unique concerns because we do, after all, represent different states. One of the main concerns in our part of the country is rural health care, as you well know. And the problem, really, is -- it's cost and it's also access. It's both. In Montana, for example, over the last decade health care costs for the average Montana family rose 400 percent faster than wages. In addition, in Montana we spend about \$3,000 a year per family on health care, and our average income per family is about \$28,000: one of the lowest in the nation. And access, too, is a major problem.

I think half of the counties in the state of Montana have no doctors who will deliver babies, and there are many counties with no doctors whatsoever. And it's -- I think it's eight counties. We have 56 counties. But eight just have no physicians whatsoever.

I know there are many provisions in your plan which very directly address rural health care, and when you were visiting Montana in April -- to Billings, Montana and to Great Falls, Montana -- we were all very impressed with your understanding and sense of the nature of the rural communities in the West when you coined a phrase, frankly, that's become very popular when you said "Hey, this is not just ordinary rural America, this is hyper-rural," you said, "this is mega-rural." And it is true. The rural communities in the West are farther away than are rural communities, say, in the East. And could you just go over what you plan to do and what this plan contains that very directly addresses the concerns of many Americans who are isolated and who pay very high costs today because they're unable to enjoy the benefits of -- are unable to enjoy the benefits that people in the cities have?

MRS. CLINTON: Senator, I would happy to, and I am very grateful for the opportunity that I had to go with you to Montana. I care deeply about rural health care. The first thing I ever did when I found myself in 1979 being married to the governor of a state that was predominantly rural was to work on a task force to try to improve access to rural health care in Arkansas. But as I told you, there is rural health care, and then there is rural health care, and some of the difficulties that you face in Montana are even more dramatic than what we faced in Arkansas in trying to make sure access was real for our people.

We have given a lot of time and attention to this, and there are a number of ways that we believe it should be addressed.

The first is that there is a higher proportion of uninsured Americans in rural areas than there is in any other part of our country.

That, combined with a higher than average proportion of the elderly, places the primary burden on financing health care in many rural areas on the backs of Medicare and the uninsured. Through universal coverage, we will be providing more resources for reimbursement in the rural areas by ensuring that there are no uninsured and that there are contributions made that will be available for reimbursing for care.

Secondly, we believe there should be what we call essential providers in both underserved rural and underserved urban areas that are targeted for additional funding because of the difficulty of being able to support emergency facilities or hospital facilities in many rural areas, even though we might now have a better-insured population to take advantage of those.

The third is we want to provide more physicians and nurses and other allied health care professionals in rural areas. And we have targeted assistance to physicians and nurses, particularly advanced practice nurses to go into rural areas in return for having educational loans paid back or even forgiven. We also want to be sure that other states do what Montana has done, which is to make it possible to keep emergency rooms open even though a doctor may not be there, by permitting the laws to permit that kind of enterprise where emergency technicians, physician assistants, and advanced practice nurses are available in rural areas that are otherwise totally inaccessible.

We also believe technology can play a major role in bringing state-of-the-art medical care to rural areas, and we have seen some remarkable examples of that. There are now some good models being used where over hundreds of miles an x-ray can be read being held in a doctor's office in a rural area at an urban medical center. And it can be done over existing equipment that is not very expensive right now. We want to provide incentives for moving in that direction.

So, those are some of the things that we think will enhance rural care, but I would just add, as you well know, Senator, that it is very difficult to imagine how, in many of our rural areas, there will ever be a sufficient level of competition that will realize the kind of efficiencies that we expect to see in urban and suburban areas. And I think we have to continue to be very sensitive to the needs in the rural communities to make sure that there is a base level of delivery of high-quality care available for every American no matter where that American lives.

SEN. BAUCUS: Thank you very much, Mrs. Clinton.

I might say, Mr. Chairman, it's my belief, after studying the plan, that health care in rural America will be better than the status quo, significantly better than the status quo.

MRS. CLINTON: Thank you, Senator.

SEN. MOYNIHAN: Thank you, Senator Baucus.

Senator Roth.

SEN. WILLIAM V. ROTH, JR. (R-DE): It's a great pleasure to welcome you here, Mrs. Clinton.

One of the great concerns, of course, is coverage of the uninsured. And, as you know, I've been very much interested in the possibilities of using the federal employee health benefit program as a means of providing coverage to millions of uninsured who are working for small business.

I'd point out that this has been a very successful program. For example, this year, its cost is only increasing 3 percent, well below the average. In fact, 40 percent are getting a decrease. They are adding preventive measures to it. So, it's a program that I think can be said that is working very well.

It was my idea that we would open this up to small business so that they could provide insurance at the same low prices, I think roughly \$577 for the individual, \$1,000 -- a little over \$1,000 for a family. This has not been included as part of the plan. I would ask -- I would hope that you would take a second look at it, as it does seem to me a means of providing coverage. You've got a network that covers the rural areas as well as the urban. It would not require the creation of a new bureaucracy. And yet, we could give good coverage. So, I wonder if you would care to comment on that.

MRS. CLINTON: Senator, you're absolutely right that the kind of program that the federal employees health benefits program provides is the model for what we are attempting to do nationally. We have looked very closely at that. And as you know, the federal government pays a considerable portion of the share for the employee. And really, the idea of the alliance that underlies our program is again that all employers would, in effect, follow the model of the federal government and pool their resources to realize the same kind of gains that you point out this program has achieved.

We think that although it is a good model and one that we have learned a lot from, that in its current condition, it would not meet all of the needs we have to reach universal coverage. If you would like us to look further at whether given the same proportionate sharing, I think it's 70/30 now, that if all employers were willing to have a 70/30 split, how many employers could be covered and what the problems with access would be, we will give you a report on that. We have looked at that. I don't have all of that information with me.

But we do believe that using that as a model is what we have tried to do, and that many of the best features of that federal program will be in the national program that the president has proposed. But we'll be happy to provide you more specific information of the pluses and the minuses that we calculated after looking at it as the way that you had recommended being available for buy-ins on the same basis.

SEN. ROTH: One of the advantages, as I mentioned, of course, is you don't have to create a new bureaucracy. And my understanding is that you are keeping the postal employees in its current form. So, there is some precedent for keeping this kind of a program.

I'd like to turn for a moment to the question of -- really a two-

part question. I think we're all concerned about how we pay for it. And, certainly, a lot of the calls that I am getting from home are, what's going to happen to Medicare? There's a lot of -- a Mrs. Streets (sp), for example, is worried about what's going to happen to her proposal and so forth. I think that there are some serious questions in this area as to the savings. As I understand it, you expect to save something like 20 percent of the increased costs over the next five years. In the judgment of many people, that cannot be just made from eliminating waste, fraud and abuse, but would require very substantial cuts. What is the answer to this? Because Medicare obviously is of great importance to the senior citizen.

And this brings me to the second part of the question, because, as was said earlier, a lot of these estimates are really guesstimates. I mean, they're the best you can get, but there's no assurance of their accuracy. Would we be wise to try some demonstration programs before we move nationwide? We're talking about a seventh of the economy. We're talking about jobs, so that whatever we do will influence not only the quality and kind of health care, but the economy and growth of jobs.

Are we wise to put it in nationwide, or would it -- is there any merit to the idea of trying some of these proposals first on a demonstration basis?

MRS. CLINTON: Well, Senator, I think it's very important to be cautious and to be very careful, but I would respond by saying there are many examples around the country of high-quality care being given to Medicare recipients at much less of a cost than in other parts of the country. In effect, we have demonstration projects. We can point

to a number of states and a number of communities where Medicare recipients are taken care of very well at one-half or one-third the cost of Medicare recipients in the exactly same situation but in another part of our country. And what we fear is that if we don't build on what we know works, which is changing the incentives in our health care system, better organizing the way health care is delivered, and persuading people that they will get high-quality care if their physicians and their hospitals are making the decisions instead of insurance companies and government bureaucrats, that we will only fall further and further behind the cost curve.

So I believe -- and I will be, again, very happy to share this information with you -- there are a number of examples all over the country of what works, which is why we feel confident, as does Senator Chafee in his proposal, that we can reduce the rate of increase in Medicare without undermining quality for Medicare recipients. I don't think you would find the president, I know you wouldn't find any of the senators on this committee supporting that rate of reduction if they thought it would in any way hurt my mother or any of your family members. But we have too many examples now of how it can be done better at lower cost with the same or better quality, and that's what we're counting on the rest of the country being able to do as well.

SEN. ROTH: Well, I would only add we do have a number of

proposals. We have the Chafee, we have the Clinton plan. I guess my question is would it be wise to try those out first, because I don't think anything is exactly the same that's in operation at the current time.

MRS. CLINTON: I think both of them, Senator, recognize that until we get to universal coverage, we do not in any way control our health care destiny, because we have too many decisions that are still made for the wrong reasons. But I think both in the Senate Republican approach as well as the president's, it rests on very strong evidence that we can do this better and that we are not going to sacrifice quality or care for our citizens.

SEN. ROTH: Thank you, Mr. Chairman.

SEN. MOYNIHAN: Thank you, Senator Roth.

Senator Rockefeller, who is chairman of the Subcommittee on Medicare and Long-Term Care. Senator Rockefeller.

SEN. JOHN D. ROCKEFELLER IV (D-WV): Thank you, Mr. Chairman.

Mrs. Clinton, as you know, the president's plan includes a mandate on, in a sense, employers but also on individuals. Both have to have responsibility. The Republican plan has a mandate on individuals and not on employers. You touched on that in your statement, but I'd like to have you, if you would be willing to, to expand as to why it was that the administration chose that approach, question number one.

Question number two, the Republican proposal, which has a lot in it which is in common with the president's proposal, and I think there's not -- that cannot be said enough. Senator Dole has talked about starting down the road together. I think we're going to be travelling a long way together. But one of the things they have is a tax cap that limits the deductibility of health insurance to the average cost of one-third of the policies in the area, in whatever area that might be. I would like to get you, if you would, Mrs. Clinton, to expand upon your views about that.

MRS. CLINTON: Thank you, senator. And I also appreciate all of your help and guidance and the visit to West Virginia that we had that put faces on all of these problems for us.

The approach that the president has chosen, to build on the employer-employee system or, as Senator Packwood says, the individual mandate in terms of making sure everybody who is employed contributes to their insurance, was chosen for several reasons:

First because it is the way most people currently get insurance. Over 90 percent of those who are insured are insured through an employer-employee relationship.

Secondly, because it is the most familiar and the way that most Americans are used to getting their insurance. We think it will be the least disruptive to both people's understanding of insurance and their acceptance of individual responsibility because it is what others are doing or have been doing. Thirdly, the employer-employee system gives us an existing way to make sure that payments are made and can be collected. We anticipate very little additional paperwork or difficulty for employers or employees because they

would, as they currently do, whether it is FICA or Social Security, be looking at a table and then filling out their contribution which will be flowing to these alliances. For those who already are insured, they do the same, only they pay their insurance company. So we don't think that the difficulties that one would have in moving toward a system of universal coverage will be significant at all.

In contrast, although we very much applaud the Senate Republican approach of making sure we reach universal coverage and choosing an individual mandate as the route to get there, we have several worries that we will be working with the Senate Republicans on to make sure we fully understand their approach over the next several weeks.

Among those worries are that if we have a legislatively required individual mandate, we worry that the numbers of people who currently are insured through their employment will decrease, because there will no longer be any reason for many employers who have struggled to ensure their workers, particularly those whose incomes are not significant, to feel that responsibility, because by failing to insure, the individuals will be mandated to have insurance, and individuals below a certain level of income will become the government's responsibility. They will fall into the subsidy pool.

It's very to predict how many or at what rate that would possibly increase the number of uninsured, but we worry that that would be one of the unintended consequences.

Secondly, unlike the existing employer-employee system, we have great concerns about how the administrative structure to track the individual contribution, to collect it, and to then connect it with health insurance would be set up.

In our efforts to try to work with Treasury, and OMB and others to create that individual subsidy system, it struck us as extremely complicated and bureaucratic, and also maybe more intrusive, because instead of the employer-employee transaction, with the money coming in, individuals would have to perhaps show their income tax returns, they'd have to have their income tracked because they would either be up or below the subsidy level at certain periods or certain years. So we believe it would be much more difficult to administer the individual mandate system.

And finally, we worry that there would be some incentive to keep wages lower so that individuals would remain in the subsidy pool as opposed to being covered by their employer, with whatever contribution might be available, which would result in, perhaps, a further splitting of the kind of care that's available between those who can afford and have some kind of employer contribution and those who do not.

So those are some of the reasons that we have preferred the employer-employee system, and we think with the addition of discounts for small business, with a subsidy system that works through that relationship which would be, we believe much easier to administer, we have taken care of the biggest problems that an employer-employee approach have.

And I know my time is up, but let me just try to briefly answer your second question--

SEN. MOYNIHAN: Mrs. Clinton, may I say Senator Rockefeller's time is up. Your time is never up. (Laughter.)

MRS. CLINTON: Thank you, Mr. Chairman.

Well then, on my time, Senator, I will answer your question, the second one you posed.

We also looked very hard at the proposal that is common in managed competition approaches to controlling health care costs, of imposing a tax cap and limiting deductibility. And we believe that eventually that should be a feature in our system. But we have a lot of difficulty with starting it at the beginning of reform because currently there are millions, and our estimate is at least 35 million working Americans plus their dependents, who currently have health care benefits that would be taxed if either the approach of taxing at the average cost of one-third the policies in the area, or the approach that some of the managed competition advocates propose, which is taxing at the lowest cost plan in the area, were to go into effect.

We would then be in a position in the administration and the Congress of telling millions of Americans, a very, very big percentage, that health care reform means for you right now a big tax increase. I don't think that's the initial message that any of us want to deliver, when we know there's already more money being spent in this system than we need to spend, and when we know that millions of those same Americans have seen their wages held flat, have not realized any kind of increase in their wages comparable with what their productivity or wage increases in other sectors should have brought them, because their compensation has been in effect made up of health care benefits.

So what we believe instead is that we should wait until we have our health care reform in place, the comprehensive benefits package is secure, and then we say with fair notice to these Americans, at a certain date, you will be taxed for any expenditure above that.

And in addition to the problem of the tax issue, is trying to administer a tax cap that is based on either lowest cost plan in a region, or the average cost of the lower one-third of the plans, is extremely complicated.

When we went to the Treasury people to talk to them, how they would do that, they were just beside themselves, because you would have to track that cost, plus you would have to track the individual's payment, plus you would have to have some kind of tax proof as to what that was, and the complexity and administrative bureaucracy necessary to administer that is substantial.

So for those two reasons, we decided we would wait until the system was up and going, give everybody fair notice, and then tax at a level that was more uniform around the country.

SEN. ROCKEFELLER: Thank you, Mr. Chairman.

SEN. MOYNIHAN: Thank you, Senator Rockefeller.

Could I just express appreciation for the sensitivity you have

shown to the question of complexity of administration. That is the continuous concern of this committee with the Treasury Department, what the form looks like. And also, to say that it would be just about 50 years ago that Robert K. Murton (sp), at Columbia University, who is still thriving, wrote his essay on the unanticipated consequences of social action, and I was pleased to see you use that phrase, and we will be thinking about unanticipated consequences all through this, which is a necessary way to go about it. Because you think about it doesn't mean you can't come up with some answers.

Senator Danforth.

SEN. DANFORTH: Mrs. Clinton, I want to ask you a general question of philosophy, and then if I have time, follow up on whether or not this can be accomplished in fact. My question is whether you would agree with me that somehow there should be some way of telling people that they cannot have the medical care that they might want for themselves or their family, and we'll give you some examples.

The so-called Baby K case that's been publicized recently, a baby born with a condition called anencephaly (ph), the brain is missing, the baby can't think, the baby can't feel, the baby has been kept alive, I think for 11 months, well over \$1,000 a day because the mother says I want the baby kept alive; the siamese twin case in I think Pennsylvania, one baby died, the other has a one percent chance of survival. The more prevalent case, the low birth weight baby, the baby under one pound, the likelihood is only 15 percent of these babies will be functional, enormous cost of keeping them alive, average of \$150,000 each.

On the other edge of life, a case I heard of yesterday, a 92 year-old man who received a pacemaker, and then everything in between. The case of somebody who's dying who wants to be kept alive for another three months, six months at a very high cost.

Philosophically, before we get to the mechanism question, should somebody at some level be in a position to say no?

MRS. CLINTON: Senator, I think there should be a discussion in this country about what is appropriate care and that a lot of these very hard decisions that you have just outlined should be made with more thought and more concern about both the human and the economic cost. So I would agree that for both moral and ethical reasons, as well as economic ones, there has to be the kind of very difficult conversation that you are suggesting.

I have thought a lot about this and I have had a lot of time to think about it both on a personal level, when I was in the hospital with my father, and spending literally all day every day talking to doctors and nurses about the very kinds of cases that you are outlining. And I have had a lot of time to think about it in this position that I am in.

And I think that there is more of a likelihood that we can actually have that conversation once we establish health security and a more rational system of making decisions about providing care to people. And I would just give you an example that struck me recently.

The hospital administrator of a very large hospital came to me as

a part of a group visiting, as a delegation brought in by the member of Congress, and he said that he had recently asked one of his cardiac surgeons why the cardiac surgeon had admitted a 92-year-old man for a quadruple bypass. And the cardiac surgeon had said, "Well, because he was referred to me by the cardiologist who refers me all of my cases, and I didn't want to say no because he might send his cases to another cardiac surgeon." And the hospital administrator said, "Well, do you think it was medically appropriate for you to accept this surgery?" And he said, "No, it wasn't appropriate or necessary, but that's the way the system works."

SEN. DANFORTH: I think that there's maybe a harder question, and that is the question of the person or the person's family who simply wants the treatment no matter what the cost. And there is a treatment that's available, for example, to keep this baby going who can't think. And -- I mean, I guess the threshold question is: Under any circumstances, should there be somebody out there or something somewhere at some level that says, "No, I mean, it's possible to do this; it's possible to perform whatever this procedure is, but even though you want it, the answer to you is, no, you can't have it"?

MRS. CLINTON: I think that, if we do this health care reform right and we create the kind of security we're talking about so that people will know that they're not being denied treatment for any reason other than it is not appropriate, it will not enhance or save the quality of life, we will have a much better chance of having that kind of conversation, and physicians will, once again, have much more latitude and discretion in advising families in an honest manner about what the real costs are. So I think we will get to that point, but I think, in order to get to there and to bring the country along with us, we have to make some of these other changes first to establish the kind of climate in which those conversations can take place.

SEN. MOYNIHAN: Thank you, Senator Danforth.
Senator Breaux?

SEN. JOHN BREAUX (D-LA): Thank you very much, Mr. Chairman.

Thank you, Mrs. Clinton, and welcome to the committee. I think that what you and the president have done on this health care debate is truly remarkable in at least two significant ways. I certainly hope that what you all have accomplished becomes a pattern or a blueprint perhaps for future legislative action on major and controversial legislative proposals. I think it's remarkable, first, in outlining very clearly the goals of this very complicated effort -- universal access to health care; comprehensive, standardized package; and quality health care for everybody. I think you all have done a real remarkable job in spelling that out -- what we want and what the goal is.

The second area I think that is truly remarkable is the way this process has been put together. We can learn a lot from that. You have had -- and the president has had private meetings with Republican senators, private meetings with Democratic senators, and private meetings with both of us

together in the same room.

You have done the same thing, I think, also on the House side. So I think it's truly remarkable as to what has been accomplished so far.

I think that as we move towards reaching those goals, however, we have to decide which path we're going to take. I think there are two options. One is the path of improving the marketplace, changing the rules so that competition can work better than it does right now because right now doesn't work very well. The second path we can take is more government regulation, more government bureaucracy, either at a state level or a local level or at the federal level. And I think that it's difficult if we try and mix the two. I think that when you try and add some regulatory rules and regulations to a system that's saying we're going to improve the competition system, it gets very difficult to make sure how much we add without messing up competition. And that's my concern as we move down this path.

I had introduced, and we've discussed this a number of times, in the last Congress the bill that was called managed competition, with a number of co-sponsors, which was, I think, a more pure competition without the regulatory regimes. I want to work very closely with this administration on marrying these concepts, and hopefully, we'll be able to do that.

My question this morning is I'm concerned that by adding some regulatory requirements to the proposal, and by adding what I think are disincentives to changing the way people buy health care, that we make it difficult to reach the goals and make competition less possible.

The point I have in the short time I have is, as I understand the proposal, is that after the law is enacted for 24 months, two years, we are hoping to make some rather dramatic reductions in the cost of health care in this country. If we do not, the premium caps kick in. I am concerned that 24 months is not nearly enough time to allow the competition to really work, particularly in areas that don't have any competition now, and I'm concerned that there are disincentives that have been added that really make it even more difficult. And the disincentives are the complete employer deduction regardless of the price of the plan. I think that's a real disincentive to purchasing the least costly plan. Not taxing the employee benefits if they are in excess of that plan for either 10 years or to the year 2000 I think is a disincentive. Quite frankly, I think the prescription drugs being made available without requiring Medicare recipients to change their habits by joining an alliance is a particular problem area. I think all these are areas that we can work on to try and reach some compromise, and I guess my question would be: Is there any possibility or any thought about trying to delay or spread out the time in which the premium caps would kick in in order to give the competition the time to be put into place and actually start showing some results? I mean, I think it's 1996, or what about the year 2000, or is there some type of phase-in that can be considered?

MRS. CLINTON: Senator, we would certainly work with you to consider exactly those issues. We are trying to do two things simultaneously, and I certainly understand how trying to do two things simultaneously sometimes creates perhaps some question as to how you can get both done. But we are trying to create incentives through the market and through enhanced

competition to reorganize our health care system so that services are delivered more efficiently at high quality. At the same time, we have to recognize we start from very different stages of development in different parts of the country with incredibly different practice styles used by physicians that have increased costs dramatically in those regions.

So, what we are looking for -- and we will work very closely with you because I share your concern -- we want the competitive market forces to work, but when you create a new system in which the costs in some areas of our country are three times what they are in others, and where, if there isn't any feeling on the part of the providers that there is some budgetary discipline waiting out there for them, I worry that you will not create the kind of incentives for the changes in practice styles to occur that will create exactly what you and I want, which is a much more competitive, market-driven, high-quality health care system.

Now, whether we can get to where we need in two years or over a longer period of time, we are very open to talking with you about that. But to go back to the example I talked with Senator Danforth about, this hospital administrator told me this story about this inappropriate care in the context of saying to me that he appreciated having some kind of premium cap out there as a backstop because, he said, otherwise it will be very difficult for me as a hospital administrator to go to this cardiac surgeon or for his colleagues to go to him and say, "Remember we got together last year and we made these decisions about what we were going to be doing this year and how we were going to be providing care, and this is why we need to do it because we've got this budget backstop up there that might possibly reduce our income if we don't do it right?"

And so, on psychological as well as economic grounds, some form of discipline in a marketplace that, frankly, has had none, in which blank checks have been written by both the government and private insurers until very recently, seems to us a feature that needs to be there as a backup. But how we get there, when it's triggered, under what circumstances, we're very open to that. We want to get to the same place, and we very much want to work with you on that.

SEN. MOYNIHAN: Thank you, Senator Breaux.
Senator Chafee?

SEN. JOHN H. CHAFEE (R-RI): Thank you, Mr. Chairman.

Mrs. Clinton, I want to join in welcoming you here and pay tribute to your tireless efforts in this area. I'm absolutely certain that health care would not have the prominence it has now but for your personal involvement, and I think we're all grateful to you. You've been wonderful.

I just would like to point out one thing in connection with your conversation with Senator Rockefeller and the points he raised.

Your plan does have an individual mandate to the extent of the 20 percent.

MRS. CLINTON: Yes, sir.

SEN. CHAFEE: In other words, the individual is responsible for

paying a portion of his or her -- the employee -- insurance . Whereas ours makes the individual 100 percent, yours makes him 20 percent. So it's a difference of degree --

MRS. CLINTON: That's right.

SEN. CHAFEE: -- more than the total difference.

The other point is, sort of referring back to what you were talking with Senator Breaux about, regarding the taxation of benefits over a certain level. In our plan we go into that; your plan you defer that, but as I understand it, it is your intention that down the road that would occur.

MRS. CLINTON: Yes.

SEN. CHAFEE: There would be a level -- call it the reasonable level of benefits. Anything above that would be taxable to the employee and non-deductible by the employer.

MRS. CLINTON: That's absolutely right, senator.

SEN. CHAFEE: The thrust of the various bills, as I see it, is to provide coverage for those who are not covered now. And this is costly, but it's worth it, we believe. However, in one instance it seems to me that the administration has embarked on providing coverage by the government for those who are already covered. And this I have great difficulty with, and I'm referring to page 13 of the plan summary, in dealing with retirees. And I'll briefly read it: "Americans who retire before 65 and were employed for at least the amount of time used as a standard to qualify for Social Security purchase health coverage through their regional alliance and pay only the employee share of the premium for their health plan. The federal government pays the 80 percent of the employer's share."

And it seems to me that this is a very, very expensive undertaking. What you're doing is saying that an employee who is retired whose employer currently is providing all or a substantial portion of his or her insurance will no longer have to do that -- employer: the government will do it. And I see that being very costly. And furthermore, we get into this point you've made with Senator Moynihan, our chairman, unanticipated consequences of social action. Many more employers, I believe, will choose to have their employees go this route. I mean, what a bonanza. The government is going to step in and pay this 80 percent. Could you explain why you chose that?

MRS. CLINTON: Yes, senator, and I want to start, though, by thanking you for your leadership on this issue and your incredible willingness to educate and to talk with us about the approaches that you've taken and that you have worked on for many years. I'm very personally grateful to you.

This is a policy decision that is certainly one that we will be debating and discussing. And it comes out of several sources of concern.

The first is, there is a growing tendency for businesses that have contractual obligations to retirees for them to abrogate or limit those health benefits in some fashion, whether it's an outright abrogation of the contract or some attempt to negotiate below whatever the level of promised

benefits were, so that in fact there are more and more people in this time period before they're eligible for Medicare who are finding themselves without health coverage and who are not employed because they had taken early retirement or reached the requisite retirement age. This is becoming a problem for the general society that we believe we're going to have to deal with.

Secondly, those companies that are continuing to provide retiree benefits are doing so at an extraordinary cost that we think should be more broadly shared by the general public because their commitment to retiree health care is taking out of investment, wages, wage increases, profits, money that should rightly go there instead of taking care of the work force that is no longer working.

We think that, for example, those industries -- largely the older manufacturing industries -- that assumed these responsibilities are beginning to make a comeback.

They are increasing their productivity, they are competing with the Japanese, and the Europeans and others, but they are doing so still with one hand tied behind their back because of the extraordinary health care cost which they have borne, which in many instances they have borne not just for their own employees and retirees, but indirectly for other businesses that have shifted the cost onto them, because they were willing to pick up those costs. And we consider that that kind of benefit, which -- (inaudible) -- to the entire population in indirect ways, ought to be borne by that entire population.

And finally, we have costed this out as I expressed to Senator Packwood, it is about four-and-a-half billion dollars, but we think that it is an investment in our competitiveness and our manufacturing base, as well as picking up the cost of people who are falling into the uninsured that is worth making. But obviously, we are more than open to talking with you and to exploring SEN. CONRAD: Thank you, Mr. Chairman, and again I want to thank you for holding this hearing and bringing us together around this issue because obviously this is the focus for the rest of the year and much of next as well. And I want to thank you, Mrs. Clinton, for the leadership that you have shown. I think your competence just shines out and I think that has made a difference in the way people are approaching this issue, and I think that's a real contribution to the country.

Let me ask this. One of the underlying assumptions is that we can save money by changing the incentives in the system, as I understand it. The current incentives in the system run toward doing more procedures, doing more tests, not only because you make more money if you're a provider that way, but also because you protect yourself from malpractice, and so we all understand the incentives run toward increasing costs in the system. <

As I understand it, one of the goals of this plan is to change those incentives so that we begin to control costs. Obviously when you change incentives in this system, that then creates a potential vulnerability of providing too little care, doing too few tests, doing too few procedures.

What is your reaction to those who say I'm very concerned that we're going to wind up with a system in which the incentives run toward doing too little rather than too much?

MRS. CLINTON: Senator, I would ask them honestly to look at the system we have today, where because of the wrong incentives, we do too much at too high a cost, for too few people. And what we need to be doing is figuring out how to deliver high quality health care to everybody. And there are several examples I would just like to share with you.

I have pulled this out at every hearing and I keep it with me because I think it's the best example of what I am talking about.

If you take a look at this Consumer Guide to Coronary Artery Bypass Graft Surgery that is put out by the Pennsylvania Health Care Cost Containment Council, it makes the point that I would like to answer those who worry about this.

This document has all of the costs of providing coronary bypass surgery in all of the hospitals in Pennsylvania that perform the surgery. The cost runs from \$21,000 to \$84,000. The information has tracked the quality indicators as to what happens to the patients who receive this surgery, including how many die from this surgery, and they have done so by comparing population and demographic statistics of the patients, so that we compare apples and apples.

If you look at this, the hospital that is doing coronary bypass surgeries at \$21,000 has better quality than many of the hospitals performing surgeries at much, much higher costs. Now, if more hospitals in Pennsylvania learned how the hospital is doing it for \$21,000, you would actually have more coronary bypass surgeries able to be done in Pennsylvania at less cost than is now happening, and that is repeated all over the country.

The second example I would just like briefly to mention was explained in a speech that I heard when I was in Minnesota with Senator Durenberger. A physician there who was the chief of quality and the head of one of the very large health networks in Minnesota talked about how one of the health care providers in Minnesota has created a new test to determine whether a lump in a woman's breast is or is not cancerous, without having to have a surgical biopsy. And this physician said that this procedure is much cheaper, less invasive and can be done more quickly than often a woman having to wait and having sleepless nights until she has her surgery. Why is it not being done? Because it would require, in this doctor's words, "surgeons giving up up to \$40,000 in income to radiologists." So there's no incentive in the current system to move toward a procedure that has here to make these different choices, but there is no question that these different choices would preserve and even enhance quality if we could structure our health care system so those choices were made instead of other ones.

SEN. CONRAD: All right. I think I'm right at the end of my time, Mr. Chairman, and in the interest of allowing others their full time, I'll deed back what I have.

SEN. MOYNIHAN: You're very generous, Senator Conrad. Thank you.

And Senator Durenberger?

SEN. DAVE DURENBERGER (R-MN): Mr. Chairman, thank you. I thank my colleague from North Dakota.

And thank you very much, Mrs. Clinton, for sharing your time, your talent and your commitment with us. Thank you also for mentioning Minnesota with some frequency, which leads me to a point that you and I talked about yesterday in another committee, and that is that everything that's going on in Minnesota is because people want it to go on, not the government insisted on it. Not a thing that you've heard from Mrs. Clinton today, nor that you've heard from me over the years, is because Minnesota state government said it ought to happen. It's because people who are providers of care, consumers of care, insurance plans, creative doctors, creative multi-speciality groups have decided that the relationship between the consumer and the provider of care is critical to improving quality and lowering costs.

This committee is a very awesome place because we have \$903 billion in medical spending this year, 14 percent of the GNP. Forty-two percent of it comes from government, most of that the federal government, and practically all of it is generated by the policies made by our -- us and our predecessors. And that's an incredibly awesome responsibility. Economic policy, tax policy, Medicare, Medicaid -- go on up and down the line -- most of the driving forces in the income security system originate in this committee. So I think that's why your time spent here is incredibly valuable. <

Two observations that I'd like to make about the so-called tax cap and your response to that and the FEHBP.

Health care reform means -- has to mean that the taxpayers of this country can't have the government subsidize extravagant buying. And that's your husband's sixth principle: responsibility. We can't just have responsibilities for the docs and the hospitals. We have to have responsibility for everybody, and people have to start taking that responsibility.

The FEHBP. If we're going to cop out to the Postal Service plan or any existing plan to not take on the driving force in this community that causes the health care costs in this community to be higher than anywhere in the country -- Medicare in this District of Columbia is at the top in the country -- 33 percent -- not because people are more ill. Take that out of it. Just because of the way Medicare -- the way health care is practiced here in the District of Columbia. Thirty-three percent higher here, above the national average. Hawaii is 43 percent below the national average. And so is -- and Oregon is down there, and Wyoming and Utah and a bunch of other states.

Those of us who are buying in the private sector here probably pay 60 percent, 100 percent, 200 percent above the national average, what you'd pay anywhere else, in this community. So, unless we take that responsibility principle seriously and we deal with the big health alliance or whatever you want to call it around here that might change the way

medicine's practiced, the FEHBP, and do that right up front where everybody can see it, everybody can take responsibility, I don't think we're going to make it.

Secondly, to get at the point we talked about yesterday and sort of illustrated by Bob Packwood's description of take two aspirin and something, the answer to the question is, if the doctor knew the doctor knew the doctor was responsible for the quality of your care and gave you what you actually needed, and you and the doctor were rewarded at the end by something other than one of these prescriptive benefit plans, you wouldn't worry.

That's the answer to the problem.

So, I need -- perhaps, I need you to share with us why we can't do Medicare reform right now, why you can't come to us, and the president can't come to us with a plan to provide -- since we've had (tougher risk ?) contracts going since 1986, and we know what's happening out there. The people who are doing efficient health care in our communities through (tougher risk ?) contracts are being penalized.

I'll give you an example -- New York. In 1994, here's what HCVA just decided. This proves that there are savings in the market, but it also proves how dumb government is, i.e., HCVA. (Laughter.) In 1994, the (tougher risk ?) contractors in New York who currently charge Medicare \$569 to get into one of these plans will go up 15 percent. In Minneapolis and St. Paul, where the charge for the very same service for the very same kind of people is only \$351, they're going down. And that's for the benefit of everybody here, who is making, you know, the current policy. Now why, if we have all these demonstrations around the country, why, if they're that successful, why don't we just go to changing Medicare right now? Give the elderly the same kind of comprehensive benefit that we're promising everybody else, put it through one of these accountable health plans. We have the model of the (tougher risk ?) contracts operating in many of our communities. Why not just do it?

MRS. CLINTON: Well, Senator, you make a very compelling argument about what is currently going on in Medicare, and we ought to be able to figure out incentives so that more people will use those systems that are better organized, and we'd be happy to work with you on that.

You know, as you know in this committee better than most, dealing with Medicare and explaining it and making sure the public understands what you're trying to do is a big task. But if we could come up with a bipartisan approach that would explain how we are actually making Medicare better, then I think we ought to take a hard look at trying to do that. I have no problem with doing that at all, because you're absolutely right, there is no explanation other than the way care is delivered and organized to explain these differences in cost.

And yet, we have a system that rewards inefficiency and penalizes efficiency. Minnesota will get less money because it's done better. New York and many others, not to pick on New York, will get more money because they are not as efficient. And that is not the right kind of incentives that we

want to have in the system. So, we'd be happy to work with you to try to figure out how to reverse those incentives within the existing Medicare system.

SEN. MOYNIHAN: Thank you, Senator Durenberger.

Mrs. Clinton, may I say this being the United States Senate, it's all right to pick on New York. (Laughter.)

MRS. CLINTON: I love New York, Mr. Chairman. It's New York, New York, as far as I'm concerned.

SEN. MOYNIHAN: Senator Bradley.

SEN. BILL BRADLEY (D-NJ): Thank you very much, Mr. Chairman.

Let me say, first of all, Mrs. Clinton, I think you're providing an enormous public service to the country. I'm personally grateful, and I think there are millions of people who are very pleased that you're doing what you're doing and you're where you are.

One of the most, I thought, poignant moments in the president's speech the other night on health care was when he leveled with the American people about their own self-destructive behavior and the fact that it's going to be pretty difficult to get health care costs under control in the long run if every American doesn't recognize that they have a part in this process. He mentioned tobacco and he mentioned violence.

Now, on tobacco, as you know, as anyone knows who looked at this, the Office of Technology Assessment says that costs are \$68 billion a year, \$2.59 per pack. It seems to me that in talking about a tobacco tax that, A, it should be very high, and, B, it should be talked about in terms of health, not only in terms of revenue.

On violence, one of the most startling numbers that I've come across in recent years is that if you want to be a gun dealer in America, it costs you between \$30 and \$75 to get a license. There are 276,000 gun dealers in America. There are more gun dealers in America than there are gas stations. And that, to me, is a remarkable number.

And I think it's directly related to the accessibility that guns have in the country today. And if we simply put a 25 percent sales tax on the sale of the gun and raise the dealers' fees from 30 to 75 to \$2,500, we'd raise \$600 million. That would be a tax directly on the purveyors of violence in terms of the sales of the means of violence.

Now, what is your opinion on the tobacco tax, how high do you think it'll be, and what is the increase in the dealers' fee -- how do you react to that, and how do you react to a 25 percent sales tax on handguns and on automatic weapons?

MRS. CLINTON: Well, senator, with respect to the tobacco tax, we agree with you that tobacco should be taxed as part of this package, and largely for health reasons, and particularly to try to deter smoking among young people. And we're, you know, still trying to make sure that we know exactly how much revenue we will need, but the tax will be between 75 cents and a dollar additional to what is already the federal tax.

Speaking personally -- and that's all I can do with respect to

your second proposal -- I'm all for that. I just don't know what else we're going to do to try to figure out how to get some handle on this violence. And one of my best friends, a woman I've gone to school with since grade school who is a full-time homemaker, has three children in a suburb of Chicago, is just outraged because a gun dealer opened a store in a strip mall across the street from the local high school. And the parents -- mothers like her -- have picketed, they have tried to talk with this person, they've even tried to find alternative places for him to go that he could still be in business, and he's just absolutely pleased as he can be to be in a gunshop across the street from the high school. He thinks it will increase his trade remarkably.

And I share my friend's outrage, you know. She's somebody who is not political and doesn't march or picket, but there's just something wrong when it's that easy to sell guns to high school students after school. And this is a suburb, and we know what happens now in every part of our country with that kind of availability of weapons in the hands of teenagers. And I know Senator Chafee has been concerned about this issue for a long time, and it has to be addressed. And we will look at your proposal and be happy to talk with you about it. I'm speaking personally, but I feel very strongly about that.

SEN. BRADLEY: Well, let me say that there is no more important personal endorsement in the country today, and I thank you very much. (Laughter.)

SEN. MOYNIHAN: Thank you, Senator Bradley.

May I just interject the thought, Mrs. Clinton, that the epidemiologists have begun to think in terms of personal violence, handgun violence and the consequences and trying to think, as epidemiologists will, in terms of vectors and so forth. And the point can be made that guns don't kill people, bullets kill people.

We have a two-century supply of handguns in this country. There have been 50 million sold since Jim Brady was shot. We only have about < a four-year supply of ammunition. And the federal government through the Bureau of Alcohol, Tobacco, and Firearms -- which doesn't seem to know this, but it is the fact -- has the right to tax the sale and manufacture of bullets, of ammunition. That's right there in the statute. And I think they do issue -- for \$30 you can manufacture 300 million rounds of 9 millimeter ammunition and you don't have to report back. I suggest --

SEN. PACKWOOD: Could I give you an addendum to that?

SEN. MOYNIHAN: Sure.

SEN. PACKWOOD: I quoted your figure when I was in Oregon last week in some hearing, and I said "Whether or not gun registration works I'm not sure, but there's a relatively short supply of ammunition which could be easily run out." I said "There is not a century's supply of ammunition in this country." The witness says "There is in my basement." (Laughter.)

SEN. MOYNIHAN: (I heard ?) the sometime gunnery officer of the United States Ship Quirinus (sp) say "If it's in his basement, it won't be worth a damn in about ten years' time." (Laughter.) Powder, the secretary of the Navy will assure, powder degenerates very fast, .45 caliber pistols do not. And that's -- I'll stop right there. But you took that note down, did

you not?

MRS. CLINTON: Yes, I did. (Laughter.)

SEN. MOYNIHAN: Senator Riegle.

SEN. DONALD W. RIEGLE JR. (D-MI): Thank you very much, Mr. Chairman, and let me just say to our very distinguished guest, you're just giving terrific leadership to this country, and you raise a level of hope for people across the nation that something good can happen by giving it this intense personal leadership as you have. And I've had a chance to watch that at close range, as we all have. It's just really been extraordinary, and I thank you for everybody in Michigan, everybody across the country.

I want to just make two points. One is that on this committee now, there are four of us who have announced we will not be seeking reelection in 1994, so Senator Wallop and Senator Danforth and Senator Durenberger and I are in that group, and so we all not only are relieved of the time and the effort that it takes to be engaged in a campaign, but it gives us the chance to work across the partisan aisle, which we really must do to succeed in this effort. And you've been so diligent in your efforts to talk with members on both sides, and we've talked privately and we talked down at the White House the other day with the president, when all of us were there, about this is the only way we can get this done. The only conceivable way that we can enact health care over the next year is by working on a bipartisan basis.

And I want to just say again to Senator Chafee, the ranking member on the Subcommittee on the Uninsured, that I am chairman of, and to the colleagues on that side, I intend to do this in a fully bipartisan way, and I have also said that to our colleagues over on the Labor and Human Resources Committee. And Bill Roth and I came here together 27 years ago in the same party. So it's easy for us to work together despite an occasional difference here or there.

So you've got a pledge from me that for my part we're going to work across this party aisle and try to get this done. And Senator Dole has said as much, and I have complimented him for doing that.

Let me just talk about the comprehensiveness of the program and how quickly we are able to phase it in. We have talked before about the fact that we have this very important model for us in Hawaii, where we've had now comprehensive health care for about 20 years. And the cost of health care as a percent of the Hawaiian economy is about eight percent, the rest of the country it's 14 percent. So we know that after that 20 year experience, that we are getting this huge financial dividend, plus the health outcomes are much better.

But when you go over that 20 year history, it takes the first 10 years before those cost lines really break apart and you really start to get the big financial benefits and savings of good primary care and good preventive care.

Now our problem here is going to be how quickly do we phase this

in? And the problem is going to be, we're going to try to measure the results, essentially over a five year budget time frame, and we're basically going to be measuring public costs, because that's what we deal with, so we're going to have to do something special to factor in the private savings and the impacts out there, and then we've got to think about what the time frame is over which we really measure the returns of this program.

If we try to just take and finance it based on the returns over five years, when you look at Hawaii, that's not going to be a long enough time period in which to really understand how these savings will accrue as we avoid a lot of diseases, we avoid a lot of problems of people with high cost care and so forth.

So I am wondering what your thought is as to how we sort of reconcile that, in terms of how we think through this question of how we cost this out so that we don't fool ourselves, in a sense undershoot on the front end, when we've got to make, in a sense, the investment in good health in order to save the huge dollars later on down the line?

MRS. CLINTON: Oh, Senator, that is such a good question and it is made so complicated by the way the federal budget is structured and operates, because it is very hard to achieve savings based on investments in prevention, or savings based on competition in the private sector as part of the budget analysis and projections.

It has been one of the issues that I have really struggled over as I have tried to understand it, and I just hope that this committee, which certainly has so much credibility on these issues, will continue to stress that even though something may not be scorable in Washington, D.C., budget talk doesn't mean it's not real. You know, we know that prevention will work if we can get prevention in place. It is absolutely one of the clearest commitments we can make to getting costs under control. But we also know that some people will claim, well, utilization will go up a little. If everybody is going to get prevention, utilization will go up.

Well, utilization should go up, we want it to go up. The average citizen of Hawaii has more doctor visits than the average citizen of the other 49 states. But because they are doctor visits for primary and preventive care, as more likely to occur there than here, their overall costs are less. So yes, we will have some increased costs in the beginning to get this system set up, and what we're going to have to figure out how to do, is within the constraints that this budget imposes on your deliberations and on your ability to deal with your colleagues, we have to explain that.

And we have the other problem, which we believe, competition will increase savings as practices styles change, as administrative loads go down, and all the things you know so well, but we can't get those scored either because they're not considered within the budget world that exists here, to be savings that can be actually laid out for people to see and realize.

So we have to be willing to make a strong stand for investment and stick to it because we know it will pay off if we do.

SEN. RIEGLE: I thank you, and I'll just say, Mr. Chairman -- I

know my time is up -- maybe one of the things we can do is when we lay out the cost numbers, do it with the five-year projections, the ten, the fifteen, and maybe even the twenty, recognizing that that's what experience has taught us so that we don't fool ourselves on how we really get this job done and save the money at the same time.

SEN. MOYNIHAN: Good -- that's a good proposal, and let's, indeed, undertake to do. Senator -- thank you, Senator Riegle.

Senator Daschle.

SEN. GRASSLEY (?): Mr. Chairman, will I get a chance to --

SEN. MOYNIHAN: Yes, sir, you're after Senator Daschle.

SEN. DASCHLE: Thank you, Mr. Chairman. Mrs. Clinton, I -- Senator Grassley and I may be the last two questioners you get this week, and I want to commend you for the quality of your answers. The clarity and the command of the facts that you've demonstrated all week is admirable, and I appreciate very much your contribution to the debate this entire week. Somebody recommended today that maybe somebody offer you a sweatshirt that says, "I survived." I think it ought to be "I flourished," because all week long you certainly have done that.

You've answered in characteristic fashion my concerns about some of the aspects of the plan in rural America, but I was home this last weekend, and three concerns are raised that perhaps you might be able to address: the first, from insurance holders who have been told by some that this is going to radically change the way they buy insurance; the second, by state officials who express concern that we may be dealing with yet another unfunded mandate as we change the structure in the relationship between the federal government and the states in addressing governmental responsibility, and the third has to do with those who benefit from alternative health care -- home health care and other forms of care, especially evident in rural America. But if you could address those three concerns, I would appreciate it.

MRS. CLINTON: Thank you very much, Senator, and thank you for all of your help on getting this project underway and particularly for the health care university work that you did. With respect to insurance holders, we are trying to design this so that those who are currently insured will see very little change. Every year they will be given the opportunity to choose what health plan they wish to sign up with. They will then have a cost that is assigned to that health plan based on how the health plan has costed out its services. Under our system then, the employer and the employee will be making a contribution to the alliance, and the individual will see very little difference in terms of making payments into the alliance as opposed to making payments into the insurance company. The most important feature will actually be enhanced, and that is the individual insured will have the choice as to what plan to use his insurance dollars for. That decision will not be made by his employer if he has insurance through an employer. So we really are trying to keep this system as much like what most Americans know right now, and we believe that we can do that.

With respect to the unfunded mandate for states, that is an issue we've spent a lot of time talking with the states about, particularly the governors with whom we have worked closely. We certainly do not intend for this to be in any way an unfunded mandate.

The states feel very strongly, and with good cause. They've had more than their share of unfunded mandates. And the most difficult to deal with has been health care, particularly in the Medicaid program, where now, for the first time, states are spending more on Medicaid than they are spending on higher education. So, we understand that that is a legitimate fear on the parts of states and we intend to give states flexibility and responsibilities that they have largely asked us to give them, but not the kind of costs that come from unfunded mandates.

And then, finally, with respect to alternative health care, particularly home health care, this is one of these difficulties that we have where, on the one hand, I think there are legitimate questions raised about should we start a new program like long-term care? You know, this is a new investment that we would fund through the reductions in the rate of growth of Medicare. On the other hand, if we do not provide some support for long-term care, particularly for home health care, we will spend more money than we will if we make the investment in long-term care now, it is our belief.

So, we want to be providing a better array of alternatives to citizens, particularly in the long-term care area, through home-based care and community-based care. And we think that investing in that now will reap dividends down the road, both in terms of human and family concerns, as well as economic. So, that's how we would like to begin to address what are rightfully seen as alternative, but cost-effective, ways of taking care of people.

SEN. DASCHLE: Thank you, Mrs. Clinton.

Thank you, Mr. Chairman.

SEN. MOYNIHAN: Thank you, Senator Daschle.

Senator Grassley.

SEN. CHARLES E. GRASSLEY (R-IA): Mrs. Clinton, Senator Durenberger asked you about Medicare being included. I want to hit it from a little different angle. Your plan calls for states having the option of taking over Medicare. My governor, former Governor Ray (sp) as well, are -- he's president of the Blue Cross/Blue Shield, and then our hospital association, lots of others as well believe that you're never really going to have health care reform unless Medicare is put into it. So, maybe in my state, we might opt for that. So, I have some questions about how this might work. And they're kind of based on the fear that, you know, we've got 65, 70 percent of our people in our hospitals are Medicare recipients, and so we don't get reimbursed on the cost or on the charges for that.

First, could you tell us how the amount of Medicare money coming to a state from the federal level would be calculated? Would it be on a per capita amount based on historical reimbursement patterns? Or would it be on some sort of new reimbursement methodology? And if it would be a new

methodology, how would it work in general?

Now, I ask this question, as you probably know, because Iowa has one of the lowest cost and charge structures for health care in the country. And people in our state believe now and have believed for years that Medicare doesn't pay its fair share of the costs, not of the charges, of treating Medicare beneficiaries. Our providers believe that Medicare doesn't pay more than 70 or 80 percent of what it costs to treat a patient. And I've already mentioned that these costs are at the bottom of -- for my state of all the states. So, a reimbursement pattern that freezes in what is now an inadequate reimbursement level wouldn't be fair for my state.

One additional point, and then I'll let you answer. If the state were to take this over and under your plan was slowing down Medicare, would the slowdowns that are at the federal level also apply on the same basis to what the states might have, if they assume that cost?

MRS. CLINTON: Senator, those are really important questions. And the way that I would have to answer them is it will depend upon how we finally decide to deal with Medicare in this legislation. The way the plan is currently proposed, we would be starting from the historical levels that currently exist. And I share your concern. I come from Arkansas. I think Arkansas' rate is even below Iowa's rate. And it is something that has been a particular burden on rural states like ours because you start with a differential where Medicare pays less than the private sector and then you add burdens by making it very difficult for a lot of states and localities to even reach what is a fair differential because we don't get reimbursed at the same rate as others. So, I'm very conscious of this.

And what we have struggled with and what I would very much appreciate being able to work with you and your staff on is if we don't start from the historical rates and then move toward a fair allocation, we don't know at what level we could start. Because we've got built-in costs in many of these systems that we're going to have to get out before we can reach a fairer level of reimbursement across the country.

It concerns me because already now you've got situations where Medicare patients are being taken care of extremely well in Iowa or Arkansas or Minnesota at one-half or one-third the cost of what is being paid for Medicare patients elsewhere.

We want to bring the costs in those other states down. That is the whole theory behind what we are doing. But we worry that, if we started by saying just off the bat, "Okay, State X, you've been reimbursed at two or three times what Iowa has gotten; you're not going to get that anymore," that would cause too much of a disruption in the existing system. So we want to try to bring it down gradually. We also want to try to figure out how to do what Senator Durenberger is saying, which is, through the states -- is our proposal -- you would begin to move people into more cost-effective settings. You would begin to provide more care to more Medicare recipients for a better value for the dollar.

So we have looked at it on a state-by-state basis as opposed to a

national reform. But we're open to looking at both your questions and Senator Durenberger's questions, because the bottom line is we know that Medicare recipients in Iowa are being well taken of and they're being given care at less cost than other states, and we need to reward Iowa for doing a good job instead of penalizing Iowa, which is what we currently do. And so we had thought the best way to proceed was to give more authority to the states, which is what the states have asked us -- like, you know, I know both Governor Ray and your current governor -- because think, frankly, they can do a better job than the federal government. But we need to look at both a state approach, which is what we favor, and the national approach that Senator Durenberger has alluded to. And we'll be glad to do that.

SEN. MOYNIHAN: Thank you, Senator Grassley.

I would note that the house of 1:00 is approaching, and there's only so much we could ask of our witness.

Senator Mitchell has been patiently waiting to ask some questions.

SEN. MITCHELL: Thank you, Mr. Chairman.

Mrs. Clinton, my question builds upon that of Senator Grassley and your response to it and relates to some of the criticism that's been made of the president's plan. Following the president's address last week, in the official response to that address, it was criticized as, quote, "a one-size-fits-all federal health care system," unquote. We each represent different states. I and others on this committee represent states which are called rural, with relatively sparse populations living primarily in small towns spread over large areas of land. And the people of Maine want some assurance that this will not be a one-size-fits-all federal health care system, that while there will be a basic package of benefits which will provide health care security to all Americans and will travel with that American wherever he or she goes, that the method of delivering health care will be substantially left to the states, provided they meet the threshold requirement of security for all Americans.

Is this criticism accurate? Will there be a one-size-fits-all federal health care system. Will Maine have to do what New York does and California have to do what West Virginia does? Or will the states have flexibility in the delivery of health care?

MRS. CLINTON: Senator, we are trying very hard to design it so that states do have flexibility within a federal framework. This will be, I think, one of the difficult challenges you will face in the Congress. There are states that are very anxious to take on the challenge of health care reform, that they've already passed legislation they want to see implemented, that they have a track record of doing something successful -- like a Hawaii, for example -- and they are just chomping at the bit for you to give them the kind of framework in which they can proceed. There are other states that don't want anything to do with health care reform whatsoever. They don't see it as their responsibility. They want the federal government to dictate the terms, and they want to be told what they're supposed to do and how they're

supposed to get it done with as little interference as they can put up with, but just basically fulfill a federal program.

We believe that there ought to be a federal framework with state flexibility and that states ought to be given the opportunity to design their delivery systems to meet the population needs of their states. The Congress will have to decide how to make sure every state meets its basic obligation, so that if any state is unwilling to make decision about health care, then the federal government will have to be sure that the people in that state are protected. But other than that, we want there to be state flexibility to the extent we possibly can design it.

SEN. MITCHELL: What assurance can you provide now to the people of Maine who live in rural areas and small towns that the delivery and quality of care to them and to other Americans in rural settings will not be diminished, but rather will be enhanced under the president's program?

MRS. CLINTON: Senator I think there are a number of features that, in Senator Baucus' words earlier, will be greatly beneficial, enhance the delivery of health care in rural areas. I've driven through Western Maine. I know that people are sparsely populated in those beautiful forests. And we want to be sure that we have a system of delivering health care in rural areas that is firmly grounded in a solid financing mechanism, which is why we want everybody in the system and everybody making a contribution which identifies providers in those small communities as essential so that they are given a additional support to be there when the people need them, where we have the kind of incentives for physicians and nurses to practice in rural areas by forgiving loans and by extending loan paybacks and where we use technology better than we have to get health care services into remote and rural areas.

Those are some of the features that I feel very comfortable telling the people of Maine that they can count on, because it will enhance what they have now and give them health security, which they do not have now.

SEN. MITCHELL: Mrs. Clinton, finally, on the question of the reform is financed, I have here a chart which appears in the materials prepared by the administration covering the period 1994 through 2000, a seven-year period. Some of the critics of the president's plan have used this chart to suggest that there will be \$700 billion in, quote, "new government spending" or \$600 billion in, quote, "new government spending."

I'm going to ask, Mr. Chairman, that the chart be placed in the record at an appropriate point.

But as I read this chart, I interpret it that there will be approximately \$350 billion over seven years for such new benefits, the remaining \$350 billion will be merely transference of current Medicare and Medicaid recipients into the alliances and for deficit reduction. Is that your understanding as well?

MRS. CLINTON: Yes. I mean, the bulk of this money, Senator, will come from employer/employee contributions that are not now being made, from

reducing the rate of increase in Medicare and Medicaid, from reallocating existing federal funding sources, such as disproportionate share, which will no longer be needed because we will be decreasing uninsured care, and from the tobacco tax and the contributions from corporations that choose to stay out of the system. And that's a very brief overview of where we're getting the money from, which we will, obviously, be going into great detail with this committee in the weeks ahead.

SEN. MITCHELL: All right. Mr. Chairman, if I might just note for the record -- I know my time is up -- that the areas in which the funds will be used, according to this chart, are long-term care benefits for the elderly, Medicare drug benefit, a prescription drug benefit which does not now exist, public health and administration, a large of part of which I understand will go to improving the delivery and quality of care in rural areas, and finally, the largest amount will be subsidies for low-income firms and workers. That, I understand, is what you talked about earlier in the discount for small business and in the effort to help small businesses. Am I correct in that?

MRS. CLINTON: Yes, sir.

SEN. MITCHELL: I thank --

SEN. MOYNIHAN: We will place that in the record. Be happy to do it. There's a deficit reduction of \$91 billion in alliance coverage. And we'll probably get revised numbers before we --

MRS. CLINTON: Yes, sir.

SEN. MOYNIHAN: -- the final legislation, which is --

MRS. CLINTON: Well, in fact, we're taking in all of the advice and suggestions that all the members are giving us and revising the plan as we speak, so -- but these are the broad outlines.

SEN. MOYNIHAN: Thank you, and thank you, Senator Mitchell. And now, the one Senator who has not been heard, has waited very patiently, Senator Boren.

SEN. BOREN: Thank you very much Mr. Chairman and Mrs. Clinton. I'll try to be brief, we appreciate the amount of time you have shared with us, and appreciate also the hard work and personal commitment that you have brought to this issue, and also the decision of the president to tackle this head on. I think we all realize we have a lot of problems in this country because administrations of both parties, and members of both parties in the Congress have wanted to shy away from tough issues -- would be very difficult to resolve. And I think the president deserves a lot of credit for being willing to take this one on head on and face up to it.

I suppose my biggest concern, because I share all of the goals that have been announced in terms of the president's program, is to make sure that we are adequately paying for it. I don't think there has been anything that has caused Americans to become more cynical about government, than the fact that we have overpromised sometimes, and underdelivered, and that we certainly, nearly always missed our estimates, so that the deficits have been higher than anticipated. That's happened to us in budget, after budget, after

budget.

I think it's understandable that some Americans have skepticism as to whether or not we're promising too much and providing too little revenue to sustain it.

One of the criticisms that has been raised has been of the \$51 billion projected figure that would come from anticipated new revenues due to increased wages and profits. I wonder if in making that estimate, if it was considered that some companies, rather than paying either higher wages or disbursing profits, might choose to reinvest their money in tax exempt ways, ways for example that would allow them tax deductible depreciation or other ways that might reduce the revenues. And I wonder, more broadly, that if indeed we find that we have underestimated the costs and overestimated our anticipated revenues, that we do get a gap between the money available and the outflow, is there some mechanism anticipated in the plan for dealing with that?

Small businesses tell me, for example, well, we're due to get this subsidy, but what if the plan costs more than anticipated, or what if the revenues don't come in to pay for it as we anticipate? Will we see that subsidy cut back?

I guess the basic question is if the estimates end up not being accurate, will we solve that gap by cutting back on the amount of the benefits, scaling them back to what we can afford, or will we solve that by putting additional costs on the businesses and others that will be paying for the service?

MRS. CLINTON: Well Senator, let me answer your question in several ways. Let me start with the revenue gains to be anticipated from freeing up funds for increased taxable transactions, such as increased wages, profits, or whatever.

This is a figure that has undergone intense scrutiny. It has been run through the Treasury models. They have put into those assumptions matters such as you raised, what would be the trade-off if X percent went into non-taxable transactions or investment? And I am sure that the Treasury people will be able to explain that in much more detail than I can.

But it is the kind of change in policy that we think is not uncommon to this committee, because for example, if you were to make a policy change to shift funds from non-taxable compensation to taxable income or to deal with pension income in a different way, you would run the same kind of modelling in the treasury that we have done to come up with this figure.

And so I think that the Finance Committee particularly will understand how we arrived at that.

Now, clearly, there has to be an understanding that that is an approximate figure, because who knows precisely how new revenues will be used. But those kinds of assumptions have been taken into account.

With respect to a gap that might develop between the costs of the program and the amount of money available to pay for it in both the private and the public sector, let me answer that in several ways.

First, in all of the cost projections that we have given you and that we have worked internally, we have tried to be conservative. We have not, for example, included any of the savings that we think will accrue because of competition and because of changes that physicians and hospitals will engage in on their own that will result, as I said earlier, in more coronary by-pass surgeries being done closer to 21,000 instead of 84,000. None of those figures are in these cost estimates. We believe -- and we believe we have very strong support for this -- that this proposal will realize a very significant amount of savings. So we think that helps to cushion whatever gap there is.

In addition to that, we have included padding, if you will. We have tried to be as conservative as possible. For example, in looking at how much the benefits package would cost, we have tried to run through all kinds of scenarios -- what will happen if there's an earthquake in California followed by a plague -- and we've tried to make sure that we have sufficient dollars allocated for that so that there is the opportunity for this gap to be filled. We do not anticipate that with the combination of the revenue that we have already laid out, with the savings that to some degree or other everyone is confident will come if we pursue this plan, and with the kind of additional funding we have put in to cushion any eventuality that we can at least foresee at this point that there should be grounds for concern about any individual or business having to step up and fill the gap.

Now, we know that even though we intend to get savings out of this system to make it more competitive that the history of health care costs is that they at some point will continue to rise because something will happen that will cause more care to be given at certain periods of time or whatever.

It is difficult at this point to know what that continued growth rate might be, but we think if we bring the base down, if we squeeze out the savings and the cost to be obtained from it, we will be a lot better off than we are on the current course, where the gap between any of us who are insured and uninsured is growing bigger, and the gap between what we pay and will have to pay is growing larger. So that's the kind of analysis we have undergone to get to the point where we are, and we're going to be sharing obviously much more of the details of that with you as we continue with this.

SEN. BOREN: Thank you very much.

SEN. MOYNIHAN: Thank you, Senator Boren.

Now, Mrs. Clinton, are there any questions you would like to ask us? (Laughter.)

MRS. CLINTON: Do you all ever take a lunch break? (Laughter.)

SEN. MOYNIHAN: I think on that practical note, I'd like to express the great gratitude of the committee, I think we all -- what do you say we give a little hand here. (Applause.)

Thank you very much, and the committee stands adjourned.

END

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