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TO: (See Below)

FROM: Jeffrey L. Eller
Office of Media Affairs

SUBJECT: HRC transcript from a.m. 9/29

HEARING OF THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE
SUBJECT: THE CLINTON HEALTH CARE PLAN
CHAIRED BY: SENATOR EDWARD M. KENNEDY(D-MA)
WITNESS: FIRST LADY HILLARY RODHAM CLINTON
RUSSELL SENATE OFFICE BUILDING, ROOM 325, WASHINGTON DC
WEDNESDAY, SEPTEMBER 29, 1993

Internal Transcript -- Not for external distribution

SEN. KENNEDY: (Sounds gavel.) We'll come to order.

We're now beginning the most significant domestic policy debate since Medicare was enacted almost 30 years ago, and it's appropriate that as the Senate begins its action on this issue we're meeting in this caucus room that has witnessed so many historic hearings going back to the earliest years of this century. Congress enacted Medicare in 1965 because the nation had reached a consensus that action was essential to end the health care crisis affecting senior citizens. Today a comparable crisis faces every American family, and action is just as urgent.

The key to success in this undertaking is bipartisanship. Going back over many years, no major reform has been enacted without bipartisan support.

This committee has had a tradition of bipartisanship, a tradition which I'm confident will be extended to consideration of the Health Security Act. All of us intend to work closely together and with the administration. The final bill that Congress approves needs and deserves the support of both Democrats and Republicans, and the country expects that kind of participation and consideration. No individual has contributed more to the development of the president's plan than our witness this morning, the First Lady, Hillary Rodham Clinton. And she's worked tirelessly with great skill to shape this plan. In doing so she has reached out to a large number of citizens, to experts on all sides of the debate, and to all of us in Congress. Her leadership has been extraordinary, and we're honored by her presence here this morning.

I am looking forward to working with all the members of this committee, the Finance Committee, and the other committees in the Senate with

jurisdiction over the many complex aspects of our health care system. Today, Mrs. Clinton testifies here before the Labor and Human Resource Committee. Tomorrow she'll testify before the Finance Committee. I know that under the guidance of Majority Leader George Mitchell and Republican Leader Bob Dole we'll work as closely as possible together to pass a bipartisan bill that meets the goals the president has set and that the American people deserve.

Nancy.

SEN. NANCY LANDON KASSEBAUM (R-KS): Mr. Chairman, I certainly agree with you that Mrs. Clinton has provided extraordinary leadership, and

.'s a pleasure to welcome you here this morning in our first formal hearing.

The task before us is numbing in its complexity, which you know all too well. It's also, I think, rich in opportunities for political conflict.

For some of us the challenge will be to make sure our concerns about the specifics of reform do not overwhelm the commitment to making it happen. For others the challenge will be to reverse, to temper eagerness in moving the bill with recognition that lasting reform cannot occur without careful deliberation and sincere compromise.

But Mr. Chairman, I agree.

I think that obviously we cannot achieve this overnight, but I have great confidence that bipartisan compromise will ultimately be achieved. And welcome.

I would like to ask my full statement be made a part of the record, Mr. Chairman.

SEN. KENNEDY: Mrs. Clinton, we'll be glad to hear from you, and we'll have a five-minute time limitation for the members.

Thank you very much.

MRS. CLINTON: Thank you, Mr. Chairman. Thank you, Senator Kassebaum.

I want to begin by thanking the members of this committee for the consultation and advice that you have given me over the last months. I have met not only with this committee several times but with many of the members individually numerous times, and I'm very grateful for the assistance that you have given me.

It is an historic opportunity as we come together in this Senate caucus room. This is a place where much of America's history has been played out. It is a place where years ago President Kennedy announced his campaign for the presidency. Eight years later, Senator Robert Kennedy announced his own presidential candidacy here. Your family, Mr. Chairman, and your commitment to health care reform bears special notice. It is a commitment that goes back 25 years. And you have added your own stamp to our history in this room, and your name has been attached to every piece of health legislation that has passed through Congress. So I'm especially grateful that we would have this opportunity to begin this discussion about the future of health care reform before this committee in this room.

I am also grateful because this committee has shown a welcome and courageous spirit of bipartisanship when addressing difficult social problems. For the good of the nation on many occasions, you have put aside partisan and ideological differences. That tradition of open- mindedness and courage will be beneficial to all of us as we work toward lasting, substantive health care reform in the months ahead.

Like you, I have had the opportunity to travel around the country and listen to thousands and thousands of ordinary Americans talk about health care . I have listened to the employed, the self-employed, the unemployed,

those who labor in our factories, on our farms and our offices, those who never have had to worry about health care because of their financial affluence. I have read letters from, I think, every state represented here that came in amongst the more than 700,000 pieces of mail received at the White House from citizens pouring their hearts out, sharing their stories and offering their suggestions.

Nothing is more important to our nation than ensuring that every American has comprehensive health care benefits that can never be taken away. When the president laid out his goals for health care reform, he was committed to building on what is right in our current system and fixing what is wrong. That principle will guide us throughout this debate.

We want to preserve and strengthen the high quality of medical care that is a trademark of our nation -- our unrivaled doctors, nurses, hospitals and sophisticated technology.

We also want to honor every family's desire to choose a doctor and other health care providers. At the same time, we have to be equally committed to fixing what is clearly broken. Each month, more than 2 million people lose their health insurance for some period of time. Every day, thousands discover that, despite years of working hard and providing for their families, they are no longer covered. And every hour, hundreds who need care wind up in our emergency rooms because they have no health care insurance.

These are not isolated and individual tragedies, because every person who loses health benefits who is denied health insurance is part of a growing national problem, and that is a problem that you know so well is not only causing human tragedies, but undermining our social fabric, reducing our nation's productivity, draining our federal and state budgets, as well as denying hard-working Americans the kind of wage increases that they deserve to have because their compensation is so heavily weighted now toward benefits instead of wages. You have, as I have, heard the stories about those insurers, 40 percent of whom, refuse coverage to people with so-called preexisting conditions. Up to 30 percent of employees report they are afraid to switch jobs for fear they will lose their health insurance . And hundreds of thousands of people are locked into our unproductive welfare system because to leave welfare would mean giving up Medicaid benefits.

The harmful effects of the rising health care costs on our workforce and our nation cannot be overestimated. I think all of us, as we move through this debate, have to put ourselves into the lives and into the stories that we hear about to really know what it feels like to be the most qualified applicant for a job but be told you can't be hired because your child has an illness that will drive up the company's health care premiums; to be told that, if you leave the job you have to take a better opportunity, which is the American dream -- to move to another city, to move up the ladder of success -- you will lose your health coverage. And imagine the disillusionment of those people who have worked so hard all their lives who now, because of economic changes, lose that job, are laid off and find

hemselves without health care coverage.

Today, the average worker pays $7,423 for health care each year. If we don't change our system now, that amount will rise to $12,386 by the year 2000. And as the average worker's bill for health care goes up, his or her real wages will decrease by about $655 a year by the end of the decade. Today, the trade we are offering American workers is to give up any wage increases that they deserve and that they have earned in return for less health care coverage and less health security.

When I was with you in Massachusetts last spring, Mr. Chairman, we met a number of small business owners and had a conversation with them. One man particularly stays in my mind. He owned a small family bowling alley. He also manufactured great ice cream, homemade, right there at the alley. He had one long-time employee. That is the only person he employed. And that man's son became seriously ill. As a result of the boy's illness, the cost of that very small business' health insurance premiums went up. As I'm sure you remember, Mr. Chairman, that bowling alley owner told us with tears in his eyes how confounded and confused he was by being left with the choice of either firing his long-time employee, denying the man coverage for his family when he needed it most, or continuing to pay the rising cost of health premiums, knowing that that increase in cost could undermine the success of his family business.

In our current system, stories like these have become too common. That is why we must finally ensure that every American citizen has comprehensive health benefits that can never be taken away, not when you lose a job, not when you change jobs, not when you move, and not when someone in your family gets sick.

We have all learned probably more about the technicalities and details of health care and the way it is delivered in this country in the last months than any of us ever knew before. But what I know most and what I care about most is what I have learned from personal experience, because when you strip all the technical details away, what really matters is what is there for you when you need it. And those of us who are well-insured, those of us who do not have to worry about getting the best care that can be offered anywhere in the world,
I hope will always keep in mind the mothers and the fathers and the sisters and the brothers and the children of this country who do not share that sense of security.

We want to emphasize primary and preventive health care as well because we think that will save us money and provide more security for all Americans.

We want to extend prescription drug benefits to all Americans, but particularly older Americans, because we have heard more about the costs of prescription drug increases than probably any other issue from older Americans.

We want to be sure that we begin to provide long-term care for older Americans. The choices we now pose to families are just unconscionable in many instances: spend yourself into poverty in order to find a safe, secure nursing home for your family; you can't get care for taking care of that family member in your home; you can't get reimbursed for a much cheaper form of care in your community; all that is available is a nursing home, and they are not available in enough numbers for enough older Americans.

We also want to be sure that everyone's health care needs are taken care of, and I want to say a particular word about women's health care needs.

For too long, women have been relegated to the fringes of medical research and medical care. The leading cause of death among women in our country is coronary disease, but until recently women were routinely excluded from major coronary clinical trials. And I want to thank this committee for its leadership in including women where they rightfully belong, at the forefront of being taking care of in our health care system. But we still have a ways to go. We need to focus on other diseases, such as osteoporosis. We need to provide diagnostic tests like mammography and Pap smears. We need to be sure that women who are the primary caretakers of our families are taken care of.

By ensuring comprehensive benefits to all Americans, by emphasizing primary and preventive health care that saves money and keeps people healthy, and by devoting more attention to the special health problems of women, we can control costs and build a healthier nation and make our economy and our workforce more productive.

I want to thank you for the assistance you've already given to us and thank you ahead of time for what I know will be a very productive and fruitful working relationship as we move forward to solve this problem. SEN. KENNEDY: Thank you very much, Mrs. Clinton. I think, as we examine the proposal, there is obviously a long list of detailed questions that come to mind, a number of which we'll examine today. But I think it's important that we don't lose sight of the real importance of this program, how it'll affect families all over the country.

And I was wondering if you could really elaborate for just a moment about what this program will mean to most American families. I don't like to use the word "average" because no one's average, but how would you describe for most working families what this program really means to them in terms of themselves and in terms of their future?

MRS. CLINTON: Well, Mr. Chairman, I think that's exactly the right question to ask because we have to look at what we want to do to try to increase security for Americans, and particularly American families. And I would describe the impact on most families in terms of security and break it down into several different kinds of security. I would start by the obvious: that we will be able to look every American in the eye and say that they are guaranteed health security.

You know, the health security card that the president held up during his speech is a symbol of what we mean when we will be able to say that. Every American who is entitled to that card will have one, and standing behind it will be a guaranteed set of benefits.

I think we will also be able to tell American families that they will be more economically secure. Right now what has happened over the past decades is that most American families have seen their standard of living either stagnate or begin to diminish because wage increases have not been able to keep up with inflation at the rate that they did in the decades previous to the 1970s and '80s.

Many American families feel immense economic insecurity, and what they may not realize is how our rising health care costs, the burdens that have been imposed on both government and particularly business, is directly related to the kind of economic insecurity that too many Americans feel. We believe that we will be able to stabilize the amount of money that we will spend on health care, and because of that we will be able to bring costs down for many businesses, and we hope we will begin to see wages react to that and economic security once again become a cornerstone of American working life.

And I guess I would finally say, Mr. Chairman, that I think we will provide a lot of psychological security.

You know, one of the issues that worries me a great deal is how alienated and how insecure many of our people seem to be. Clearly, in material ways they are not less well off than my parents and grandparents were during the Depression. But in psychological ways they feel that the future is closing in on them, that they aren't taken care of, that they can't count on their children having the same kind of opportunities as they did. And I don't think there's anything more important to establish than the fact that they will not have to worry about health problems that come up and that might undermine their sense of security.

So in those very important respects, I think we will find through health care reform not only what we will be talking about in terms of benefits and cost containment and the like, but we will find a shift in attitude among our people that will render them more secure and, I therefore believe, more productive, more willing to face the future with the kind of confidence that we need in America.

SEN. KENNEDY: Well, that's certainly an enormously important change in attitude among the American people, going back to sort of a community of caring, which I think is a central challenge to society. And I think as the president has pointed out in his speech -- and you have -- that you can be for this program because it gets a handle on costs on the federal deficit, you can be concerned about it because of the bureaucracy that providers have, you can be concerned about the issue because of the increasing profits that are taken away from American businesses.

But I think for many that are concerned about it, it is because of their out of pocket costs to doctors and to providers -- hospitals. And I

think many people will want to know whether this really is going to do something about those factors, which I think is of enormous concern to most Americans, perhaps those that have it -- health care -- and those that don't. And what kind of impact do you think this program will have on those working Americans and others who have seen the extraordinary increase in out of pocket costs?

MRS. CLINTON: Our estimate is, Mr. Chairman, that for Americans who are currently insured, about 65 percent will have the same or better benefits at less cost or the same cost. And that includes out of pockets, it includes deductibles. And individual consumers will be able to make choices that will drive those costs down even lower because we will, we believe, through this reform enhance the number of choices available to citizens. If they want to choose an organized network of doctors or a health maintenance organization that has very low or no co-pays, they will be able to do that.

Another issue that is very important to many families is that we want to eliminate the lifetime limit kinds of considerations that in too many insurance policies have required people once they have exhausted their limits to pay out of their own pockets. We think that if you're insured, you should be insured across the board.

We also believe that we should bring down the cost of deductibles. Deductibles will still be present, but at a much lower level than they have been up until now.

So if we take all of these costs, we will have, we believe, a significant decrease in out of pocket expenditures both for the premium share as well as co-pays and deductibles for most people who are currently insured.

For about 20 to 22 percent of those who are insured, they will pay a little bit more, but they will be getting more comprehensive benefits because they are now paying too much for catastrophic or major medical policies, often with a very, very large deductible. Those deductibles will be dropped. Their benefits will increase. So, over a lifetime, they will also realize cost savings, even though initially may pay a little more.

And for about 12 percent of the people, they will pay more for about the same benefits. Those are largely young, single people who now benefit from an insurance system that is really skewed in their direction. Because those of us who are older, anyone who's ever been sick pays much more than they should while young and single people pay less than they should in terms of being part of an entire community pool. So they will pay a little more in these early years. But they, too, will realize benefits over their lifetime.

SEN. KENNEDY: Thank you.

Senator Kassebaum?

SEN. NANCY LANDON KASSEBAUM (R-KS): Mrs. Clinton, as you know, I've been concerned about the health alliance structure and have worried about the size, the monopolistic purchasing power potentially and sweeping regulatory authority, and I wonder if I could just go through some questions,

nd maybe it might clear up some of my questions and maybe others have as well.

In Kansas, for instance, there are only six employers who have 5,000 or more employees. Now, it's my understanding 5,000 employees is the cutoff and everyone below that must be registered and work through the alliance.

MRS. CLINTON: Senator, it's 5,000 nationwide. So, if there employers in Kansas who are part of larger companies, even though their employment levels in Kansas may be less than 5,000, if the aggregate nationwide is 5,000 or above, they can be part of a self- insured alliance.

SEN. KASSEBAUM: Do all insurance dollars, when you make this contribution both as employers and employees, go into the alliance?

MRS. CLINTON: Yes, for the guaranteed benefits package. Now, there will be, we anticipate, not only supplemental insurance, but new insurance markets for products like long-term care. And those will go directly to insurers or if an alliance wants to contract with an insurer in order to handle those dollars, it could be done that way. But there will still be an insurance market outside of the alliance.

SEN. KASSEBAUM: For, you say, long-term care? Will it be designated what type of care there would be additional markets for?

MRS. CLINTON: For anything that is outside the guaranteed benefits package, so that, for example, if a person wanted more mental health benefits or long-term care, the alliance would be able to offer those through health plans. But there would also, we anticipate, be an independent insurance market as well for benefits that people wanted to buy with their own dollars in addition to the premium dollars.

SEN. KASSEBAUM: Well, for instance, if you're with Blue Cross/Blue Shield and that had been your long-time carrier, but they did not opt to go into the alliance or the alliance didn't want to, I suppose, have them as part of the insurers participating, do you have any choice at that point of where you go?

MRS. CLINTON: Well, Senator, what we would anticipate is that Blue Cross and other insurers would be in the business of running the accountable health plans, so that although the alliance is the collection point for the premium dollars, it is not the delivery point for care or the management of care.

And in our conversations with a number of insurance companies, what they are moving toward is what they are already doing, which is to help organize networks of physicians and hospitals into the delivery points; so they would in effect become the managers of the accountable health plans. So if you were part of Blue Cross, Blue Shield now and the Blue Cross, Blue Shield health plan were one of your choices, much as we now have with the federal employees' plan, the money all is in the federal government; that's where the money is paid out of, but you get a big list of those plans that you can sign up for, and Blue Cross, Blue Shield is one of them. In the future, in the alliances, it will be just the same kind of model. The money

/ill go into the alliance, as it does now with the federal government, but the choices available will be perhaps, you know, the local HMO, the Blue Cross, Blue Shield health plan, maybe the local hospitals have created, you know, the Lawrence Kansas plan, or whatever it might be; so that there will not only continue to be a role for insurance companies in managing and delivering care, but we anticipate that it may even be an expanded role in that area.

SEN. KASSEBAUM: So you could go outside the alliance for the purchase of your insurance?

MRS. CLINTON: Well, no, let me make sure that -- let me walk through this. If you are an employee now, or an employer, you make your premium payments directly to the insurer and the insurer then decides, in some instances, which doctors or hospitals you can attend, or you have a fee-for-service plan, and then you pick and the insurance company reimburses your doctor.

In what we are proposing, the alliance is the body to which the money is paid. But the accountable health plans are what you now think of as your health plan, whether it's Blue Cross, Blue Shield or some health maintenance organization or some other form of health plan. So even though the money goes into the alliance and it is pooled there in order to get the most purchasing power, the way it happens now with the federal government, so that the alliance, just like the federal government, or in Minnesota, like some of the very large purchasers of care there, in California like the (Calpers ?) system, they stand there with all of this purchasing power. Then the health plans , like Blue Cross and the others, come and say, "We can deliver the guaranteed benefits package at this price with these kinds of extra benefits." And then each year, every consumer, as you do now with the federal plan, you will get a brochure about all of the plans. The alliance is merely a collection agency, basically. Every plan that is qualified has the right to bid for your money, and you then tell the alliance, "Send my money to Blue Cross," and that's how you get your health care.

SEN. KASSEBAUM: I just got a note that my two -- I have two minutes remaining. But just to briefly say, however, the alliance is appointed by the governor or the legislature of a state?

MRS. CLINTON: Right.

SEN. KASSEBAUM: The governor?

MRS. CLINTON: Well, we're -- you know, we're open -- the governors think that it ought to be the governors; legislators think they ought to have a role.

SEN. KASSEBAUM: But they have a great deal of authority in setting out some very firm guidelines, and then I suppose, responsible to the guidelines of the national board, who supersede, do they not, some directions to the alliances?

MRS. CLINTON: What we would like is to have federal guidelines -- for example, what is a qualified health plan, and what is the benefits package? -- and then each alliance would implement those federal guidelines.

But we also want to give some flexibility to alliances because we know that, you know, western Kansas is not the same as Kansas City. So we want some flexibility so that an alliance could have some opportunity to maybe do things a little bit differently in one part of the state from the other, but they would all have to meet the basic federal guidelines of what the health plans would have to be.

SEN. KASSEBAUM: Thank you.

SEN. KENNEDY: Senator Pell?

SEN. CLAIBORNE PELL (D-RI): Thank you, Mr. Chairman. And I congratulate you on choosing this room, where so many historic events have occurred, for this hearing on a subject and a program whose time has not only come but we're seizing it, and I hope under the leadership of Mrs. Clinton, we will move ahead with it.

I think the affection and regard of the country for you were shown at the State of the Union speech, the joint session speech, when the applause was louder than I've heard for anybody who was not the principal speaker themselves in the 33 years I've been in the Senate, and the affection and regard is universal, I think.

The question specifically that I have in mind concerns unemployment. This little -- your eyes may be better than mine, you can see -- shows that the unemployment in my state of Rhode Island is far worse than it is in any other state of the union, on the average in the country as a whole. Who would pay the premiums on this health plan when one is unemployed? Would it be the employer? There is no employer. Would it be the public, or who?

MRS. CLINTON: It would be the public through the federal government. The federal government will provide the insurance share for the unemployed. And when someone is employed and unemployed during the year, there will be a combination of contributions from the employer and employee when the person is employed, and then the federal government will subsidize the remaining necessary premium contribution.

SEN. PELL: In that regard, how does this little card work for (those things ?). It was presented to me. It's got somebody else's name, I regret to say, on it. But how does it work in fact? Is it like a charge card, a credit card?

MRS. CLINTON: That's the way we would like to see it work because one of the ways we think we can save billions of dollars in this system is to move toward electronic billing, to move toward single forms, to try to simplify the collection of the health care dollars, and we would like to see it working as a credit card in which we will have much more economies of scale in terms of collecting and paying out money throughout the system.

SEN. PELL: Thank you.

The columnist, Ann Landers, wrote a column which, without objection, I'd like to see inserted in the record.

SEN. KENNEDY: It will be inserted.

SEN. PELL: Thank you. In which it points out the number of deaths

rom guns. And as you may know, the annual cost of hospital care associated with firearms treatment is $1 billion. In Rhode Island alone, the estimated annual health care costs attributed to those killed by firearms between 1984 and 1990 was $22 million. What would be your reaction to the thought of introducing legislation that would have a tax on firearms, and that tax devoted to the health plan?

MRS. CLINTON: Well, senator, that is not part of the president's proposal, but I think that there is interest in that proposal. I was asked the same question yesterday in the House, and -- you know, targetting some kind of payment for violent crime to our health care system might be something worth considering.

SEN. PELL: Another question: that is the research in the hospitals. We have in my state a very fine teaching hospital, and I'm curious how the president's health plan will impact on the quality of the research. As you know, when you have a research institution it increases the quality of care. It also increases the expense.

MRS. CLINTON: Right. That's a very important question and one that we have talked a lot with the deans of our various medical schools around the country.

We believe that the academic health centers ought to be what we would call the kind of quality foundation for this health care plan. Rather than reinventing the wheel and creating any new kind of bureaucracy or entity to keep track of quality and to try to determine outcomes related to procedures, we would like to see that research and that kind of quality reporting function really housed our medical schools around the country. We think they are fully capable of doing that work.

And we also know that many medical schools and academic health centers have higher costs because their care that they deliver is so highly specialized. So we have some special provisions to help support financially those academic health centers so that they are available to patients not only in the states where they are, but also around the country if they've developed a certain technique or procedure that should be used because of its importance.

So we take very seriously the role of the academic health centers and have some provisions that we think will strengthen their position in the health care system.

SEN. PELL: Thank you very much.

MRS. CLINTON: Thank you, senator.

SEN. KENNEDY: Senator Jeffords.

SEN. JAMES M. JEFFORDS (R-VT): Thank you, Mr. Chairman, and first I want to commend Senator Kassebaum for all of her help and leadership on our side of the aisle, and I want to commend you, Mr. Chairman, for your efforts leading up to this important occasion. I know that you are delighted as I am that the process is now underway to finally make health reform a reality.

I also want to commend you, Mrs. Clinton, for your efforts,

particularly for your and your staff's willingness to work with all of us, my party especially. I know it was helpful for us, and I hope it was helpful for you.

I am sure managing your task force of 500 was a tough job. But I suspect it was nothing compared to the task force of 535 that are here on the Capitol Hill that you now have to deal with. Thus, the toughest part certainly remains before us.

The principles that guide your effort and most of the major policy choices you have made mirror my own. You have made a great start, but a vast amount of work still needs to be done. I hope we can improve upon your proposal, particularly with regard to financing, bringing costs down, and promoting good health.

To do so, I am convinced, will require the talents and energy of Republicans as well as Democrats. No party has a monopoly on wisdom or experience. And you in your role as the first navigator, knowing better than most that we are sailing to rather largely uncharted waters, I think it is critical to the country that this be a bipartisan effort. I know of no better way to ensure it than to join as a cosponsor of your legislation upon its introduction. I will do so.

But I want to do more than this. I want this bill to be broadly bipartisan. And I pledge to do what I can to make this a bill Republican colleagues can support. I have been thinking about our nation's health care problems for many years and have definite ideas on what our health care goals ought to be and how they can be accomplished.

I don't think anyone would disagree with the administration's goals.

Everyone in this nation needs the security of knowing that no matter whatever else happens in their life, they can count on the fact that they have good health care, good quality health care. We need a much simpler health care system with far less paperwork. Finally, we need to be sure that our new system will get health care costs under control.

I look forward to working with you, the administration, my colleagues on both sides of the aisle on this essential effort. I agree with the administration's approach and will do what I can to ensure that the historic proposal becomes law next year.

Now a question -- I don't --

MRS. CLINTON: May I just say thank you very much, Senator Jeffords.

I know that you share the president's and my belief that this is an issue beyond partisan politics, and I think most of the members of this body share that same belief, and we will look forward to working with you and other Republicans. We've learned a great deal from you and the work that you had done, and I read your bill, I read Senator Kassebaum's bill, we've learned a lot about the appropriate way to address our health care needs, and I'm very grateful for your commitment today to be a co-sponsor and to work with us so that we can make that this issue is beyond politics and that we get the very

›est possible resolution for the American people.

SEN. JEFFORDS: I thank you for those words, and we're all dedicated to help.

First I want to, as a question -- I want to applaud your efforts with respect to state flexibility, and someone might accuse me of being a little parochial in this, but you know Vermont has been working very, very hard to come forth with their own health care plan, and they are concerned, though, that they may be restricted by the national plan which we come forth with, so I think success in reform and getting an approval depends upon the states being able to support it.

I understand that you have indicated an openness to changes, but to what extent do you feel state flexibility is important to your proposal?

MRS. CLINTON: I think it's very important, Senator, and Vermont is just one of several states that has shown tremendous leadership in moving ahead and really demonstrating to the country the kinds of steps that needed to be taken. So we want to maximize state flexibility.

On the other hand, we have to recognize that there are states that have been very blunt in saying they don't want anything to do with health care reform. It is not an issue they feel comfortable tackling, and they don't want the responsibility. So striking the right balance between those states that really should be encouraged to move forward and given the framework to move forward in and the kind of federal program that will be needed to insure security for every American so that states that don't want to move forward will be motivated to do so is one of the balances we have to strike, and we will certainly look forward to working with you in making sure we strike that right balance.

I personally prefer maximum flexibility. I think the problems in Vermont are different from the problems in Arkansas, and I want both states to deal with them responsibly, so I think that's the way we should approach this.

SEN. JEFFORDS: My final question will test a little bit of that flexibility in the sense of the state of Vermont's desires. My question is under the Clinton plan, will the state of Vermont be allowed to require that doctors be paid the same rate whether they see someone young or old or whether they work for a large company or small company?

MRS. CLINTON: Do you mean an all-payer rate system for physicians?

SEN. JEFFORDS: An all-payer rate system.

MRS. CLINTON: Yes, I was asked that question yesterday by Maryland. Maryland already has an all-payer hospital system. They're developing an all-payer physician system, and I think that that is one of those areas that we would permit states to move forward on if that's what they thought was in their best interests.

SEN. JEFFORDS: Thank you. I look forward to working with you. Thank you, Mr. Chairman.

MRS. CLINTON: Thank you very much, Senator.

SEN. KENNEDY: We just want to express certainly our appreciation to Senator Jeffords for his support. We're obviously eager to work with all of our colleagues to try find important common ground. We welcome it.

Senator Metzenbaum?

SEN. HOWARD METZENBAUM (D-OH): Mrs. Clinton, as I sat here, I was thinking to myself that you and your husband are truly unique, because both you and your husband are knowledgeable about the specifics of this program. And I have served here with five different presidents, but I remember the record of many other presidents as well. And I don't remember any other president, and certainly no other presidential spouse, that was as fully involved and fully knowledgeable about a legislative program as the two of you are. Your husband the other evening, the president, taking questions for over two hours and then, as I understand it, staying for another hour answering additional questions. I think the American people probably hasn't -- have not realized that you're just totally unique in the fact that you have not only said "I'm for this program. It's a great piece of legislation; I'll sign it." Whatever the case may be. But you know this program. You're a part of it. You helped create it, as well as did the president. And I think the American people have a right to be very proud.

And as I sat here this morning and I heard my colleague Senator Jeffords speak, I said to myself, "I don't know what it is that creates Republicans of that flavor, but he follows Bob Stafford and George Aiken, Jim Jeffords, and I feel very proud to have the privilege of serving with him.

Having said that, let me ask you a couple of questions. We're talking about a program that now costs about $940 billion a year, almost a trillion dollars a year. I am concerned to see how we go about consumer control, consumer -- not alone window dressing, but actually having consumer rights. We'll have health alliances, 50 percent by employers, 50 percent by consumers. But the employers will be an integrated group in all probability. They'll work together. I'm concerned how does the consumer, really the American public, get their voice heard and have a right to control this system, not just be a party to it.

MRS. CLINTON: Well, Senator, we believe that the principal difference in what we are proposing is that, for the first time ever, consumers will be making the decisions that count. They will be deciding which health plan they will join. To go back to Senator Kassebaum's inquiry, it will be the consumer, not the employer and not the alliance and not any government agency, whether it be Medicaid or anything else, which will determine what health plan a particular individual decides to join.

Every year, consumers will be, in effect, voting with their feet if they're not satisfied with the service they got or they've met somebody that they prefer in a different plan. Well, they will be able to make that decision. So that the ultimate market and competitive forces that we think will lead to high-quality health care being delivered most efficiently will rest upon millions and millions of individual consumer decisions. The richest

erson and the poorest person will have the same vote, because they will each decide, you know, where they want to go. And that will make a difference in how health care is delivered.

Secondly, as you point out, the kind of alliance structure that we are envisioning will be governed by an employer representative and consumer representative board, with consumers having 50 percent of the seats that are on there. And I would anticipate, given the kind of interest in health care that we are all seeing, there will be a very active consumer constituency in which people will be making all kinds of judgments about health plans, will be getting information out to each other. I think we'll see a lot of very positive consumer activity.

And then the last thing I would say is that for the first time consumers will have good information about quality and will be able to make decisions. That will in turn, I hope, drive the hospitals, the physicians, the insurers and others to be responsive because they will have to deliver the quality information and then it will serve as a basis for both the representatives at the alliance level and the individual consumer to make decisions.

SEN. METZENBAUM: Would it make good sense to put some limit on administrative expenses that see to it that insurance companies operate efficiently? As you know, average insurance company administrative expenses today run about 25 percent. Medicare administrative expenses run about 3 percent; and Canada has administrative costs of 1 percent. And I'm concerned that whether it's Blue Cross, Blue Shield or the Prudential Insurance Company or the Metropolitan Life Insurance Company, whatever the case may be, that those -- they all will build in a factor of high administrative costs. And I'm concerned as to whether -- there won't be enough competition to drive the down and whether or not we as legislators out not to be placing some limits on the administrative costs.

MRS. CLINTON: Senator, I don't believe that will be necessary, for the following reasons. If we reform the insurance market and we particularly reform the non-group and small group market, we will be eliminating a lot of the administrative cost that currently is in the insurance system. If we further begin to eliminate preexisting conditions and make it clear that people cannot be denied coverage on the basis of underwriting and determining how much of a risk that they present, that will eliminate an additional very large portion of the administrative expense that currently drives up costs within the private insurance market.

I think those two changes will have a big impact on the kinds of decisions that insurers make, and they will then find it in their interest to become more efficient and to make decisions more quickly on the basis of trying to get the highest quality care to people at the lowest possible price. So I don't think that we need to regulate that. I think the market will take care of that as we make the kinds of changes that we hope you will make in the legislation to eliminate preexisting conditions, to reform the insurance market, the administrative load will go down dramatically.

SEN. METZENBAUM: Thank you very much, Mr. Chairman.

SEN. KENNEDY: Isn't that the case with the California public employees, too, about 1.5 percent administrative costs?

MRS. CLINTON: That's right. And that is in effect a very large alliance, I mean as we think about it, and it has been able to drive a very hard bargain with the insurers who provide the services through the plans that are available to the members.

SEN. KENNEDY: Senator Coats?

SEN. DAN COATS (R-IN): Thank you, Mr. Chairman.

And, Mrs. Clinton, thank you for appearing before us. I hope this -- what I say isn't -- I hope I'm not the first dark cloud to appear on the horizon today for you. And I hope what I say is not interpreted as being partisan politics, because I do agree with every member on this committee, and with you, that there are inefficiencies and distortions in our health care system that are robbing people of care that they need, and it's costing all of us more money than we ought to spend. And I think we all agree that reforms are needed and necessary.

The question is not whether but how we go about doing it.

I have joined some senators in offering a proposal to deal with those reforms. It's different than what you're advocating. And it's primarily different because it's based on some different assumptions.

I would like to just outline four of those assumptions and then ask the question as to whether or not you think those assumptions are valid, invalid, and if invalid, why, and how we might address that.

The first assumption that we're operating under is that government, for all of its good intentions, is less efficient than the private sector. My experience with government, my constituents' experience with government is that it is -- because it is not driven by a market system, does not have a profit motive -- is less efficient. I think anybody who stands five minutes in a post office and then goes and visits UPS sees the difference between a government- run operation and a private-run operation. If we look at the state level, I just the last two days have gone through the process of helping my 16-year old son attain a driver's license. It has been a nightmare for my wife and I to go through the lines and the forms and the delays just to get a driver's license.

The second assumption that we're operating under is that political process often, almost always overwhelms the marketplace. Outside my office every day that we're in session, there is a steady stream of people coming to try to influence the political process saying, "Include our program, include our benefit." And whether it's health care or any other aspect of what government does, it seems that the ultimate decision is not a marketplace decision but a political decision, and therefore, we're concerned that a health plan which basically says these are the benefits that will be available will simply invite many more saying, "Include us," and whether it makes economic sense or not, they will try to garner enough support from the

olitical process to be included.

Thirdly, it's my experience and our assumption that costs that government estimates for the costs of a program are always grossly, grossly underestimated. I went back and looked at the congressional record for when we enacted Medicare, and the projections that were listed by Congress for expenditures under just Part A of Medicare -- they ran those out to 1990. They said by 1990 we would be spending $9 billion a year on Part A of Medicare. The actual expenditure in 1990 was $67 billion, 7-1/2 times the estimate. So we may estimate figures here today associated with this health care plan. My experience is, like every other program government gets involved in, it grows, partly because of this political process and the inefficiencies, it grows far beyond our estimates.

And our final assumption is that a great deal of health care expenditure is, as your husband pointed out in his speech to the Congress, caused by human behavior, choices that we as human beings make.

Now, I appreciated your husband saying we must do much better than this, but my experience is that human beings react to incentives, positively to rewards and negatively to penalties. It seems to me that any health care plan that is truly going to modify human behavior and therefore help hold down health care costs, whether it's smoking, excessive drinking, unwarranted sexual practices that lead to disease, on and on -- lack of exercise, overeating, et cetera -- that, if we're going to effect that, we need a system of rewards or a system of penalties. Why should someone who is exercising behavior that results in lower health care costs be paying the same thing as someone who is disregarding that? And why shouldn't there be a differential?

Those are some basic assumptions on which we are basing our plan. I don't think I see those assumptions in your plan. Are my assumptions valid? If not, why are they invalid? And how are we going to reconcile the difference?

MRS. CLINTON: Senator, those are--

SEN. KENNEDY: Just before Mrs. Clinton answers, we -- over in the House, they restricted Mrs. Clinton to two minutes, one for the question, and she had to sandwich her answer into that two minutes. We've developed marvelous skills here, where within our five minutes we ask a lot of questions and let you take the time. We want to give you the assurance that you take whatever time you want to respond to the cumulative questions of our colleagues.

MRS. CLINTON: Thank you.

SEN. COATS: Since we didn't have opening statements, I thought I'd slip mine in in my questions. (Laughter.)

MRS. CLINTON: I appreciate that, Senator. And let me start by saying that I don't know that any of your assumptions in general are wrong. But in particular, as applied to the health care system, I don't believe they are applicable. And let me run through them. And, in fact, what we are trying

) do is to create a system in which there truly is some kind of a market and some kind of competitive pressures that will enable us to move this health care system to a much more efficient level than it current is operating on.

Your first assumption about government being less efficient than the private sector is not true in the health care system as it's currently structured. I think that one of the senators earlier referred to the fact that the administrative costs in Medicare are much less than they are in the private sector. The private sector has become much less efficient in health care delivery, in health care pricing than you would think it should be, but it has done so because of the kinds of incentives it has followed.

So that, for example, the heavy administrative percentage that you will find in the private sector insurance market is due to a very clear decision, which is the more money we can spend making sure we don't insure people who might cost us money, the more money we will make. So, therefore, the kind of underwriting practices and the kind of selling practices that are aimed at insuring people are aimed in part at eliminating from coverage people who might be a cost on the insurance system.

And in order to choose among everyone sitting in this room who is and who is not a good risk, that takes a lot of time and a lot of manpower, a lot of personnel cost. And so I think that, if you look at the way the current private sector operates, you will find an enormous amount of efficiency -- Dr. Koop has pointed out not only on the insurance side, but on the medical decision-making side.

Now, part of that is driven by decisions that are made in government as well as in the private sector. But government followed the private sector in deciding to reimburse for medical care based on procedure and on tests and on diagnosis, on the kind of fee for service model that we have grown up with in our country.

So in both the private sector and the government sector with respect to health care we do not have a real market. And you will find a great deal of inefficiency in the private sector in the health care market.

Someone has pointed out recently that many of our industries have had to become more efficient in the last 20 years because of external competition. We are now producing high quality cars in our country that are very productive and are really giving a good run for the money against our competitors. But it took outside competition to come in and do that. We have to create a competitive marketplace. We do not currently have one.

The second point about the political process overwhelming the marketplace is also in general true, and we have to be very careful about that in fashioning this health care reform. Senator Kassebaum and I have talked about this, because in her bill she puts the decision about what benefits will be covered at the level of the national board to take them out of politics, to take them out of the halls so that you don't have people grabbing as you walk down the hallway saying "Include this," "Include that," "Include my favorite particular kind of treatment."

We thought very hard about that, and I had a very good meeting with Senators Kassebaum and Danforth in which they, I thought, very clearly explained why they favored that approach. We decided that initially we should have the benefits package approved by the Congress so that individual citizens could know what was in it. But then we agree that any changes to it, any enhancements to it should be moved to the national board, as the Kassebaum-Danforth bill had originally suggested, because we don't want the political process overwhelming the marketplace. And we agree with you that that's something we have to guard against.

The third assumption about cost estimates by government being underestimated is absolutely right, but in the health care system cost estimates by the private sector have also been grossly underestimated. And I think in large measure you would see a parallel in the increase in government expenditures that is at least equal to if not slightly below the increase in private sector expenditures in the health care system. And those two go hand in hand.

It is very difficult for you as a senator to make projections about what Medicare or Medicaid will cost because what happens is you set a certain amount of money to be available in the budget. And what the private sector does is to shift costs that they don't get from the budget out of your decisions onto the private sector. And what the private sector consistently has done both in employers buying insurance and insurers pricing insurance and doctors making decisions is consistently to underestimate what health care costs and, I would argue, what it should cost.

So this is an issue that is not just a government issue, this is a private sector issue. And one of the reasons we want to have some market forces and some competition in the system is so that cost estimates can be made on the basis of delivering health care not on a diagnosis-procedure basis, but on a per capita basis in which decision-makers -- insurers, doctors, hospitals, and others -- have to make decisions so that costs will be kept down, that we no longer write a blank check.

And finally, I think that there is no doubt that human choices drive health care costs like it does in most other areas of our lives, and what we are trying to do is to have a system in which everybody is part of that system, because to leave some out who make bad choices is a cost to us whether we like it or not.

Everyone who makes a bad choice who is uninsured or who is insured who drives our costs up will eventually cost us something, either in more tax dollars, or in higher insurance premiums. If we have everybody covered and everybody in the system so that we finally can stop the cost shifting, then I think health plans and individuals will be able to make cost conscious choices that will give them the benefits of their decisionmaking. But I think until we get everybody in the system, then the human choices that will inevitably drive health care costs one direction or the other will continue to be shifted on to the backs of those who choose not to, but nevertheless will pay the cost for them.

SEN. KENNEDY: Thank you very much.

Senator Dodd?

SEN. DODD: It's hard to follow that answer, that was so brilliant in response, in my view. (Laughter.) To just bring you back down to the real world here, first of all, let me just say in response to -- and I have great respect for my colleague from Indiana. He and I -- we would have not passed family and medical leave legislation without Dan Coats -- picking up on the points you made, Mrs. Clinton, about the bipartisanship, but I appreciate your mentioning that because this committee has had great success through that vehicle.

But frankly, the notion somehow that someone going to your local post office as opposed to going to UPS, or a 16-year-old waiting in line to get a driver's license or a 16-year-old showing up with his parents because he has cancer or a tumor trying to access the medical system in this country is profoundly different, and we may have differences about how best to address this system, but I think drawing comparisons between systems where people have choices and problems where people have no choices is completely unwarranted, but I appreciate the points that are made by that comparison.

Let me begin, as well, if I can very briefly, by commending our chairman. This is an extremely important issue and you rightly pointed out at the outset that for many of us here who have arrived in the last decade or so this has been fairly new, but for the chairman of this committee, this has been a lifetime commitment, his public service, going back, as I recall, with the Kennedy-Corman (sp) legislation, Ribicoff Long (sp), my predecessor in the Senate, the great debates, Senator -- Congressman Dingell's father deeply committed to EhealthF EcareF. So there's a long history here, but the chairman of this committee has worked tirelessly from the day he arrived to this day, and it's an extremely important day for him as chairman of this committee, that we are finally going to end up dealing with this issue. And I didn't want to begin my remarks and questions to you without recognizing his tremendous contribution to what we've achieved already in that particular fight.

Let me turn to a particular constituency that is of great interest to you -- your involvement with the Children's Defense Fund,

and your involvement in Arkansas over the years with regard to children. A quarter of the population of this country is under age 18, and yet a third of the uninsured in this country are children. Of the 37 to 38 million, 12 million have no insurance. In my state, 54 percent of the uninsured are children in the state of Connecticut, the most affluent state on a per capita basis in the United States.

In many ways, the current system is really stacked against children. Adults arguably have some choices about where they can go, but children are entirely dependent upon what happens to their parents.

If you lose your job, you lose your insurance, your child does immediately. Preexisting conditions. Children's needs, particularly in the

reventive area, are different than others. Again, I'm preaching to the choir on this particular issue, but I don't think there ought to be too much debate here about that particular constituency and our common determination to see to it that these -- the most innocent, in many ways, in our society -- are getting the kind of proper care and coverage under a system presently, as I said at the outset, that is stacked against them.

I wonder if you might just spend a couple of minutes focusing -- you rightly talked about women at the outset of your remarks, but I think children -- they don't have lawyers, they don't have the right to vote, they don't make campaign contributions. My fear is in this debate they're going to be left side and brought in as sort of an afterthought, and I hope that's not the case. And if you could just spend a couple of minutes addressing that particular constituency, I'd appreciate it.

MRS. CLINTON: Senator Dodd, I'd be happy to, and I want to thank you for never forgetting that constituency and the work that you have done over the years to make sure that children's needs are not forgotten. And I suppose on an emotional level it's the most important thing to me because I don't know that anyone can look into the eyes of a child who is sick and has been made sicker because of decisions that had to be made on the basis of cost that kept a parent away from getting care when needed without feeling that there is something seriously wrong with the way we are taking care of our children.

And I don't think there are any stories that have moved me more than the stories of parents who have just given up everything in order to take care of their children's health needs. I mean, it is a bizarre situation to have a country in which there is parent after parent -- and we can give you their names and their addresses and their phone numbers -- who had to give up a job when they lost their insurance, whether it was taken away from them because of a child's illness or whether it was priced so high that they could no longer afford it, to go on welfare to be able to take care of their children's medical needs. I mean, that is absolutely the wrong message. It's the wrong message that you have tried to send, that Senator Coats with his work on behalf of children has tried to send, and it is something we have to end.

I think that one of the great benefits that we will have from health care reform is insuring the kind of primary and preventive care that all children need to be healthy. We will cover vaccinations. We will cover well-child care. I mean, I have to confess, like many people before I had children, I didn't think about what my insurance policy did or didn't cover, and I remember the shock I felt when I realized that my very good insurance policy would not pay for the well-child exam. They would pay if Chelsea were sick and I brought her to the hospital for some kind of treatment, but they wouldn't pay for me to make sure she was kept well. And I thought that was absolutely backwards then, and I still believe that it is.

So, if we emphasize primary and preventive care for children,

'hen I think we will begin to reverse what has been a neglect of our children in our health care system if we en that no parent, whether that parent loses the job that they had or can't find a job or whatever their circumstanc might be, will have to worry about taking care of their children, and we will once and for all end this travesty of having people give up jobs to go on welfare to be able to take care of their children.

It's one of the reasons why the Academy of Pediatrics has endorsed this plan because they see first hand every day the costs of what it means for parents to wonder whether they can afford the x-ray that the doctor says they should have or whether they can fill the prescription that they leave the doctor's office with, holding in their hand.

You know, for years, I worked as a member of the board of directors of the Arkansas Children's Hospital, and I could -- I just have never walked into that hospital without a combination of such gratitude and also such emotion. And I just don't want any parent ever to have to worry about whether or not they can afford to take care of their child. I don't have to worry about that. I cannot imagine what that must feel like. And we need to end it, and this would help us do that.

SEN. DODD: Thank you very much.

Thank you, Mr. Chairman.

SEN. KENNEDY: Thank you very much.

Senator Gregg.

SEN. JUDD GREGG (R-NH): Thank you.

And let me associate myself with the accolades which are very appropriate, and the depth and substance of your responses and input on this subject has been of great benefit to this country, I believe, because it's focused so much attention on it. But, like with so many issues like this, this is complex, it's interwoven, it's a tremendous matrix with a lot of different strings running through it, and the devil tends to be in the details.

And as I've read through the program a couple of times, and I have to admit that I'm not as substantively up to speed as I'd like to be, but tried to get there, I sort of scratch my head because in a lot of areas, the boot doesn't seem to fit the binding. For example, there's the desire, and it's a very legitimate one, one I support, to get significant savings in health care, $280 billion, Medicare and Medicaid making up most of that. But, at the same time, there's a proposal -- and $91 billion of deficit reduction, which is obviously a good cause.

But, at the same time, there's five major new entitlements proposed: drug entitlement; long-term care entitlement; an early retirement's entitlement; the entitlement to everyone who doesn't have health care now; and small business entitlement, which is a huge one, in the benefits package. So, there's a -- my experience with government tells me that if you're putting in place entitlements of those size with those costs, you're going to drive costs, you're not going to be able to control costs, and that the savings which are desired and legitimate in trying to obtain will be very

ard to realize.

Secondly, there is the -- and so, there the boot doesn't fit the binding. Secondly, there is the issue of flexibility, which is again very important. I know your husband's role as governor, he was totally committed to states' rights and making sure the states had proper power. Governmental states' rights and simplicity are very appropriate roles.

But I look at this national board, and the power which is being laid at the feet of this national board is awesome, especially in its relationship to dealing with the states. I made a list of the powers, and I know you're familiar with them, but they go on considerably, and they're all extremely substantive, from the capacity to control the structure of the alliances to the capacity to set premiums that the alliances deal with. And really, when you look at this national board, as I see it, it's probably going to be more important to get on the national board, the seven-member board, than get on the Supreme Court of the United States. That's the level of influence that this board is going to have in driving health care policy, especially at the state level.

So, I don't see the flexibility and I don't see the simplicity. I see rather an organization that is dominant at the center to the detriment of the states' capacity to have flexibility.

So I don't see where those fit.

And then there's this whole question of competition, which is the way you drive costs. And you've certainly spoken about that this morning. But underlying this competition you've got standby price controls, you've got a proposal which basically is global budgeting in the capacity of the national board to review the premiums that are set, and you've got the question of the national board itself, which essentially, to simplify it and to characterize it, is a nationalization of the health industry; to take 14 percent of the health industry, which is in the American economy, comes under the control of that board. So I don't see that competition exists there.

The states have flexibility only to the extent that they basically follow what the federal government guidelines are. If a state wishes to do something other than health alliance, if a state wishes to do something other than single payer, then as I understand it, that flexibility is extremely limited.

So the debate here, as I see it, is not over universal coverage or security. Those are goals that I accept. It's not over the well- child programs or primary care. Those all have to be in whatever package comes through. As I see it, the debate here is over whether or not there should be universal control centralized in the hands of a few to the detriment of the many -- the many being the states and the legislatures and the governors and the people in the local communities who traditionally have made these health care decisions.

And I guess my question goes to this issue. As I understand it, the powers that lie here are that if a state does not come forward with a

'an -- and you alluded to this earlier -- which conforms to federal guidelines, which was the phraseology I believe you used, or federal framework, then the national board deems that the state is not in compliance; and then they tell the secretary of Health and Human Services this and she then has the power to withdraw from the states all financial support that's going to the states and all functions which Health and Human Services deals with. Secondly, the national board then has the authority to draft a plan for the states and institute it. And thirdly, the secretary of the treasury has the authority to unilaterally, without even congressional approval, as I understand it, assess a tax on business activity within the states.

Are those three powers appropriately described? If they're not appropriately described, could you give me your definition of them that lie with the national board's decision that a state is not in adequate compliance?

MRS. CLINTON: Well, Senator, we view what you just described as an absolute last resort. And the only reason that it's even in there is because, very honestly, there are some states that have told us privately that they just don't want anything to do with health care reform because it's just too complicated. And then there are other states like Vermont and Florida and Washington and California and Hawaii and Minnesota that are chomping at the bit, they can't get there too soon.

So what we're trying to do is to give as much encouragement to states as possible. And we will enhance the flexibility. As I mentioned with Senator Jeffords, any ideas that you have, and particularly I'd welcome yours as a former governor, that would give states that kind of flexibility, we're ready to look at and to extend.

But this is a federally-guaranteed program. We do want every American to have access to the same benefits, so that if you live in New Hampshire you've got them and if you live in Arkansas you've got them. And if we have a state, for whatever bizarre combination of reasons, that doesn't want to do anything, they don't want to make their own choices, they don't want to do what Maryland has done or what Minnesota has done, they don't want to do anything; they don't want to guarantee the benefits package to their citizens, they just don't want to get into the business of trying to be a leader and a state that takes that responsibility, then we believe there has to be some fallback position. Now, I think it is highly unlikely.

I can't even imagine a political circumstance in which a state would not be willing to do what it needed to do, and given flexibility, what it thought was right for itself.

This is not a program like some programs in the past where only a few people have been affected by them. This is a program that will affect everyone, so I imagine that the political situation in most states will lead every governor I've ever met and every state legislature I've ever heard about to do what they think is right for their state.

But in the event of some unforeseen circumstance where a state

efuses or is unwilling to do so, we do thing there needs to be some kind of enforcement mechanism so that if you live in one state you're not denied what you would have if you lived across the border or in any other state. And that's the only reason that that's in there. We honestly don't see it ever coming into play, but we needed something there as -- going back to Senator Coats example -- as a kind of stick as well as a carrot.

If there are additional ways that you would like to see state flexibility considered, if there are additional ideas that you think would meet the basic requirements of providing universal coverage within a state and doing it in a way that it appropriate to a particular state, we are -- you know, we welcome that. We want to hear more about that.

And let me just say a final word about the national board. The national board is meant to be a coordinating and advisory board. If the way we have described some of its functions sound too regulatory, we want to take a look at that. That has not been our intention. We wanted to perform the functions of being available to -- in the worst case, as I've just described, help make sure a state does what it should do, and its ultimate responsibility to its citizens, but it's mostly there in a kind of monitoring advisory capacity. And we'll be happy to sit down and go through the very specific powers and to talk why we think they are necessary, and to have your response to that.

SEN. GREGG: Thank you.

SEN. KENNEDY: Senator Simon.

SEN. SIMON: Thank you, Mr. Chairman, and we thank you for your leadership which has -- I think everyone agrees has been superb. Let me also join Senator Dodd in thanking the chairman, Senator Kennedy, for his yeoman work through the years in this field. We're all grateful to him.

You mentioned in your opening remarks this room where we have had many historic gatherings. One thing is different. In every other involvement here, Democrats were over there and Republicans were over here. I hope it is significant -- Democrats are moving to the right, Republicans are moving to the left in this room here. (Laughter.)

To my colleague, Senator Pell, who brought up the question of violence and health , I would be happy to join him, if we need additional revenue -- let's have a 25 percent tax on handguns and a 50 percent tax on assault weapons, and we would be helping the health of this nation in more ways than one, so Clay Pell, if you want to move in that direction, I'll join you on that.

One word for all of my colleagues as well as those in the administration. I think it is important that we move expeditiously here. If this drags on too long, people are going to look at the -- focus on the minutiae, they're going to distort. Absolutely we ought to hold hearings like this and we'll hold plenty of them. We're -- the chairman this morning was talking about 29 hearings. Let's focus on everything we should, but let's move and move rapidly so that we give the American people what they're entitled to.

You opened your remarks talking about research. There are those who say, in the pharmaceutical industry, that this is going to hurt research.

There are those in the university community who are concerned about the research aspects. I would be interested in your response to their concerns.

MRS. CLINTON: I can understand those concerns, Senator, because this has been an issue that we have really struggle with. We have tried to balance what we consider the necessary kind of investment in research and development that we want to see biomed companies and pharmaceutical companies pursue as well as other research that is perhaps located on our campuses.

But with respect, particularly to pharmaceutical and other kinds of research, we have dilemma. There are some in this body, as you well know, who believe that pharmaceutical pricing has been unjustified, much too high, not related to a return on the investment into the research and development of the products. There are others who believe that it is one of our most profitable industries and that it has been a great boon, both in job creation and in bringing down medical costs and human suffering because of the kinds of investments and that it's only fair for those companies to realize a good return on those investments. Both are probably right -- both positions -- and what we have got to figure out how to do is to encourage research, make sure there always is a fair and profitable return on the investments in research, but not permit the kind of pricing that has caused our drug prices to rise at three times the rate of inflation, and causes drugs that are produced in this country with a combination of government-funded research and private research to be sold at less of a cost overseas than they are sold to the taxpayers who paid for the research.

So we've tried to strike a balance, and that balance would ask that as we move forward with prescription drugs being available to Americans, which will put more money into the pharmaceutical industry, that Medicare, for example, be permitted to have a discount on the price of those drugs. We think that that is a fair request for the kind of dollars that will be going into drug companies. We also think, with respect to breakthrough drugs, there ought to be some review and then the publishing of information about those drugs that would be widely available to consumers -- not to stop them, not to chill their development or their marketing, but to make available information about what their real costs and what their efficacy is as anticipated by the research.

But I mentioned yesterday -- and I'm still very struck by the story I heard just a few days ago of the specialist at Mayo Clinic who discovered that a pill that is used to de-worm animals is useful in helping people with colon cancer, and he teamed up with one of our major pharmaceuticals, and they did the research together, and it wasn't, as he described it, very complicated research. It was merely to make sure that the components in the drug used for animals were safe for humans and that it would have a good

effect on humans. And at the end of this work, the company began to manufacture the drug, and the only difference, as he described it, in the drug was that it was made smaller because sheep will have to swallow a bigger pill than the rest of us do. Well, the net result is that if you went into a vet or you went into an animal feed store, you'd buy that pill for six cents; if you wanted to prescribe it for your patient for colon cancer, it would cost six dollars a pill.

Now this physician said that he had always been a strong believer in the use of pharmaceuticals, he had been a strong supporter of the pharmaceutical industry because he had seen with his own eyes what miracles could be done. But he could not, for the life of him, understand what the costs were that would permit that company to recover that kind of profit on that particular pill.

So that's the kind of concern we have. How do we get to market with good research, supported research, the kind of help that our people need? How do we insure that our pharmaceuticals continue to grow and be productive, and how do we be sure that we get good value for the dollars we spend? So that's how we've tried to balance that.

SEN. SIMON: Thank you. Thank you, Mr. Chairman.

SEN. KENNEDY: Thank you very much. Senator Thurmond.

SEN. THURMOND: Thank you, Mr. Chairman. Mr. Chairman, I would like to join my colleagues in extending a warm welcome to the first lady, Mrs. Hillary Rodham Clinton, an able person who is dedicated to improving the health care of our people. Now Mrs. Clinton, it is a pleasure to have you here this morning.

Mr. Chairman, we all agree that our health care system needs comprehensive reform. However, while we attempt to address the problems of our health care system, we need to preserve the successful parts of our present system.

As you know, America now has the highest-quality health care system in the world. We need to maintain the quality of services for the 85 percent of Americans who currently enjoy health care coverage and cover those currently without a health care plan.

Mr. Chairman, I believe we should ensure that coverage is available to all Americans. We should not allow the cancellation of health care coverage because of illness not allow coverage to be denied because of a preexisting condition. Further, I believe that coverage should be portable. If some individuals lose their jobs or decide to change jobs, they should be free from the fear that they would have to take a reduction in the amount of health care coverage or that they may lose it entirely. We must preserve the ability of Americans to choose from
a variety of health care plans and to choose their primary physician. We should provide patients with information that will help them make cost effective choices by providing patients with this information and the ability to choose. We would encourage competition and raise the quality of care

›rovided.

Mr. Chairman, if we provide information and incentives concerning preventive health care, I believe we could prevent many of the health care problems we have today. Each of us must take responsibility to practice preventive health care -- proper diet, reasonable exercise, and an optimistic attitude toward life promote health. The savings incurred by practicing preventive health care are not easily imagined, but surely they are cheaper and cause less suffering than practicing curative medicine . I strongly suggest that serious consideration be given to including preventive health care in any program that is adopted.

Finally, Mr. Chairman, the cost of the health plan is the number one health issue to Americans, according to the Wall Street Journal. Americans do not want their health care costs to rise and the quality of health to diminish because of sweeping new government controls over the health care system. We must find some way to pay for these reforms without an undue burden on business, or taxpayer or others.

Again, Mr. Chairman, I would like to welcome the first lady here today. Mrs. Clinton, thanks for your testimony, and I look forward to working with you to address the health care problems facing America today.

I have two questions. If time doesn't permit, I'll just ask one.

Mrs. Clinton, some antitrust experts in the health care field compliment the recent DOJ-FTC statements of antitrust enforcement policy as being useful and clear summaries of existing enforcement policies. However, the antitrust experts are concerned that the policy statements do not significantly change current antitrust enforcement policies. The question is, do you contemplate that additional policy statements from the enforcement agencies will be forthcoming or will other antitrust adjustments be necessary as part of health care reform?

MRS. CLINTON: Thank you, Senator. And could I just say amen to your opening statement? I thought -- especially the emphasis on primary and preventive health care is absolutely on target, and you are a living example of that that I hope everybody will pay attention to. (Laughter.)

Senator, we did believe that we made some progress, and we want to particularly thank Senator Metzenbaum and Congressman Brooks for their support for the statements that were made by the Department of Justice and the FTC. We are still concerned that physicians do not know whether or not they can join together to become accountable health plans either on their own or with hospitals, and we do want to clarify that because I think it's very important that doctors around the country feel they have the same opportunity to offer an organized health plan to their communities as insurance companies or HMOs currently do. So, we are still looking at that. We are working with the AMA about that. We are going to try to clarify it. And if we think any clarifying legislation is necessary, we will be recommending that, and we would welcome any ideas you have as to how we could achieve our common goals about the antitrust enforcement so that we can have a health care system that

:ally is competitive.

SEN. THURMOND: Thank you very much. My time is -- I won't have time to ask the second question. We'll submit it for the record, if you don't mind answering that.

MRS. CLINTON: Yes, sir.

SEN. THURMOND: Thank you, Mr. Chairman.

SEN. KENNEDY: Thank you very much.

Mrs. Clinton, Senator Harkin, as you know, is the floor manager for the HHS appropriations legislation and is on the floor and has been there all morning. And he deeply regrets he couldn't be here.

Senator Mikulski.

SEN. BARBARA MIKULSKI (D-MD): Thank you very much, Mr. Chairman.

And, Mrs. Clinton, really a cordial welcome here today. I believe you are the first first lady in American history to come before the United States Congress and offer testimony on social policy. The other two first ladies who came offered comment on a policy initiated by others, but I believe you are the first first lady to come who is actually the architect or the chief architect of a plan.

I would like to compliment the president for attempting to achieve a national goal of safety and security for all Americans in the area of health care and the effort that you've made in taking that national goal and trying to operationalize it into a health plan. It is not easy to operationalize idealism. It is not easy to operationalize noble intentions. But I believe that you and the president have undertaken to do that, and I think we see it reflective in the plan that you've put forth here today. You have taken the ordinary stories of people and translated them in the most significant public policy initiative in three decades.

I think all of us owe accolades to the core benefit package that has been established that emphasizes prevention, primary care, and personal responsibility, and understanding the needs of women, children and the elderly. The fact that we are so -- our conversation is focused on so many details is a tribute to what is already agreed upon in the conversation, particularly related to the core benefit package and the emphasis on those three areas.

My question goes to picking up on the health alliance. I truly believe that what you want to achieve is a combination of marketplace discipline and yet allowing mission-driven plans focusing on those ideals to go into place. I'm concerned, Mrs. Clinton, that if the emphasis -- with the health alliance, they will be able to choose the plan, and I'm concerned that if the criteria is solely or primarily cost, the cost of the plan, mission-driven plans, those that are

primarily operated by non-profits, those providers that serve either urban areas or rural areas, that will, by the very nature of who they serve, be high cost, be pushed aside, and that it's not that we'll have too little of marketplace activity or too little competition, but we will have

oo much, and that instead of having a community of health care, it will all be focused only on the marketplace.

Could you comment on that?

MRS. CLINTON: That's a very important question. And, you know, as you were talking, Senator, I was thinking back to our morning at Jimmy's Diner and all the people who told us their stories, and every one of those was a responsible, tax-paying, hard-working American citizen, every single one of them, and every one of them was having trouble getting affordable health care that would be available to them.

And I think it is important that we have a system in which many different kinds of health plans can compete; but I guess I see it a little bit differently. I see the mission-driven -- which is a wonderful phrase -- the mission-driven health providers being more than ready to step into this system. And let me just give you a few examples of what I mean by that.

If you look at our plan, it is remarkably similar to the plan put forward by the Catholic Hospital Association. The Catholic Hospital Association worked for two years before my husband was even elected president, came up with a plan in which they talked about having networks of health care providers competing for business that would be provided to people in their communities and individuals would be making those kinds of choices. If you look at the Catholic Hospital Association, they have been providing health care of high quality, often under very difficult financial circumstances, in areas that nobody else wanted to serve, in many instances around our country. They are certainly mission driven. Under our system, they will be advantaged because they have taken so many charity cases, they've provided so much uncompensated care, they have provided care in inner cities and rural areas where there was a very large uninsured base that couldn't compensate them for their services; now all of a sudden they will be getting funds coming in through reimbursement that will enable them to be even more competitive.

I'll give you another example. If you take the Mayo Clinic, it is a multi-specialty, non-profit clinic. Doctors are on salaries. They make the decisions about how they provide the care. They provide care at a cost that is much less than many other sectors of the health care economy because they've made decisions about how to be more cost- effective, high-quality providers. So I think there are many examples around the country where the mission-driven, those who have made decisions to provide high quality even when they don't get compensated, like many of our Catholic hospitals, or to provide it on
a different model than the for-profit model like Mayo Clinic, are going to be extremely well positioned to become health providers to many more people.

Now, in order to assure that, these networks are going to have to be created with sensitivity to the populations to be served, and we're hoping that, going back to Senator Thurmond's question, that there will be whatever antitrust and other kinds of problems in the way of doctors and hospitals banding together that more providers will find it profitable, will find it

ossible to stay in business and provide health care because we're going to insure the uninsured and we're going to provide reimbursement where before there was none, particularly for the mission driven.

And I guess the final point I would make about that is that I have seen in my discussions now a growing awareness on the part of many of the large hospitals and large insurance companies that if they want to compete for the business of everyone who now can buy health care through the alliance, they're going to have to make partnerships with community health centers -- with that inner-city Catholic hospital, with those minority providers who are the traditional providers in an inner-city area. So I actually think these partnerships will further enhance the opportunities for those who up until now have been kind of pushed into the corners of the market because they weren't able to be competitive because they took on more people and cared for more people who couldn't pay an adequate reimbursement than maybe some other providers have.

SEN. MIKULSKI: Well thank you for the answer to that question. It is reassuring to hear that. And we look forward to further discussion. You exactly identified those facilities that I'm most concerned about -- the Catholic hospital like Mercy in my downtown Baltimore; Siani Hospital, which is undertaking care to inner-city people and new immigrants and Soviet Jews who have refugeed in this country, and so on.

I'd like now, if I could, to change to the issue around the elderly. There was some talk about a Medicare Part C and the preserving of long-term care. You and I both lost our fathers to wrenching situations. And then, as you know, many families have had to spend-down to qualify for government help. So while there's been family responsibility, the cruel rules of government have often pushed people into family bankruptcy. I wonder where you see the plan heading in terms of providing a safety net for long-term care that does provide for family responsibility but does not set people up for family bankruptcy.

MRS. CLINTON: Well, that's -- I don't think there's any issue that
I hear more about from both older people and people our age whose parents are getting into situations where they need some kind of continuing care.

We have a couple of parts of this proposal that I think will help. One is that we want to extend long-term care coverage by making sure we've got in place the services that older citizens need. And so to that end, we want states to develop more home-based care and community-based care that will be reimbursable and will be much more available. We also want to raise the spend-down limit so that families don't have to impoverish themselves to the extent we require now before they're eligible for nursing home care. We want to provide reimbursement for sub-acute care at nursing homes rather than in the much more expensive hospital setting.

If you take these various pieces, you can see how each meets a need that is not met now, starting with home-based care. We do not provide the kind of financial support that many families would need in order to keep

an older relative at home, and it is a very penny-wise and pound-foolish policy, as well as one that I think is unfair to families. If a family wants to take on the responsibility, some little bit of help, whether it's a visiting nurse or some other person to come in to help or provide respite care, is the right thing to do and it's much less expensive than having someone go into a nursing home.

With respect to community-based care, I would only repeat the example that I saw the first time I visited an adult day care center in the last rune months; it was at Saint Agnes Hospital in Philadelphia. That hospital wanted to provide a service to the community, so they told families that if you keep your older relative at home but you both work during the day, then bring them to the hospital. We'll watch them during the day; if anything happens, we'll be able to provide medical care. Well, the hospital had to charge something, and the hospital tried to keep the costs as low as possible, but they had to charge about $35 or $40.

Well, that's about $200 a week for a working family. That is more than most working families can afford to pay. And so the net result was that because there was no reimbursement help for working families, most of those families, according to the St. Agnes medical staff, were forced to put their relatives in nursing homes, which then cost the state and the federal government much more than maybe helping to support a $35 or $40-a-day charge.

And then finally, with the sub-acute care, I mean, you know that under Medicare many older patients and disabled patients, patients who are under very severe medical conditions and often on life support are kept in hospitals because if they are moved out of the hospital government assistance for their care stops. I did not have to face that issue with my father, but I would have if he had not died.

And so all of a sudden, what you think you have available in terms of financial assistance ends. And many doctors have me as favors to families under great financial and emotional stress they keep patients in hospitals far longer than they should because they know to discharge them to a nursing home or discharge them to home is an unconscionable psychological and financial burden on many families.

We need alternatives to that, and providing this kind of long-term care -- reimbursing for sub-acute maintenance care and nursing homes -- will help so many families. And those are the things we want to provide.

SEN. MIKULSKI: Thank you very much, Mrs. Clinton, and thank you for the kind words you said about the Maryland program.

SEN. KENNEDY: Very good.

Senator Hatch.

SEN. ORRIN G. HATCH (R-UT): Thank you, Mr. Chairman.

Welcome to the committee, Mrs. Clinton, and I just want to say it's always good to be with you, always good to see you again. I also want to thank you for elevating our nation's dialogue on these critical health care issues. I think you've done that single- handedly. And you and the president

have clearly done your homework on this issue, and you deserve a lot of credit, in my opinion, for your hours of study and your eloquent defense of the administration's plan. So I for one personally admire you for getting into this battle -- (laughs) -- doing what you've done, and I want to work with you on this.

I agree with all of the principles for reform which the president articulated last week. We do need to provide health security for our citizens. We do need to reduce costs. We do need to reduce bureaucracy. We do need to eliminate fraud and greed.

All of those are important, but the problem is, we don't need to create more problems than we fix. And that's what people are worried about with a massive, sweeping change in our health care system. It's a matter of great, great concern to a lot of us.

It's no secret that I have some problems with the administration's approaches to health care. For example, I don't believe that we need a National Health Benefits Board to really determine what health care should be in this country. I believe more employer mandates would be devastating to job creation. And, of course, there's always the question of how are going to finance this beast? It's a very, very tough question. But I look forward to seeing the details, looking at the plan when you get it done, hopefully within the next couple weeks. And as I've said before, I want to work with you and help you to the extent that I can. I'm afraid there's a lot of work to do, no matter what or how we look into this particular issue.

I'd maybe just ask one specific question, and that's this. I know this sounds trite, but price controls didn't work in the '70s, and I don't think they're going to work any better now. And obviously, we all want to get health costs under control. I raise the same issues that you've already discussed with regard to innovation and technology. But I'm afraid that global budgeting is going to result in rationing, pure and simple. And in order to control costs, you simply have to control volume as well in order for it to work. So I think it would be useful if you could walk us through exactly how the global budget will work, explaining how the costs are going to be restrained without reduction in quality of care, choice, access, or technical innovation.

And let me just say this: one of my friends, a really great author in this country who's a doctor, an internist, Robin Cook (sp), who wrote "Coma" and the recent best-seller "Terminal."

He is writing a new novel that should come out before the end of this year which will show the horrors of and the nightmares of global budgeting and government management of health care . I think we'll all want to read it because it will be right in point with what we're discussing here today. And I know you're concerned about those matters, too -- but if you could walk us through how the global budget would work, explaining how the costs -- how we can constrain costs without the reductions in quality care, choice, access, technological innovation, et cetera.

MRS. CLINTON: Senator, that's obviously one of the key issues, and let me start by saying that the term "global budget" is really a misnomer because there is not any intention to, in any way, budget every health expenditure that any American would make. That is not at all the intention. But it is to budget what would be the guaranteed benefits package, but anything that any individual wished to spend is clearly available for that individual to do. The marketplace will be there for individuals to take advantage of.

But with respect to trying to provide some budgetary discipline with the delivery of the guaranteed benefits package, we are operating on the basis of several beliefs about the best way to do that that I'd like to share with you. The first is that rationing already takes place in our country. It happens every single day in every single community, and it is done by removing people from the insurance rolls, it is done putting barriers to access, it is done by making it much more difficult for some people to pay for their health care than for others. And the net result is that many people are already suffering the effects of rationing because we have a kind of non-system of health care in which those of us who are able have the benefits of the very best health care in the world. But if we compare ourselves to some of our competing countries, on many health indicators, we do not do a very good job for our entire population. So rationing is already happening. And in fact, what we want to do is increase the market and increase the competitive forces that will make health care more available to the entire society.

The second point is that there has now been, I think, very convincing work that I would like to share with you and to provide to you about what we are currently doing with respect to delivering health care across our country by the kind of differences in costs that exist from one part of our country to another, and a number of people have been studying this. This is what Dr. Koop has been doing since he left being surgeon general. He and Dr. Winberg (sp) at Dartmouth are two of the leading researchers in this area. If you have, as we currently do -- in just one of our programs, take Medicare -- a 300 percent differential between the delivery of care in Miami, Florida and the delivery of care in Wisconsin, or as Senator Durenburger never tires of pointing out to me, a 100 percent or 200 percent differential between Minnesota Medicare delivery and a place like Philadelphia with no difference in quality that anybody can point to, that points out very clearly that there is a huge amount of inefficiency in the way we are delivering health care right now.

Now why is it that if health care has been delivered at one-half the cost in New Haven, Connecticut, compared to Boston, Massachusetts, or one-third the cost in Wisconsin compared to Miami, Florida, or many other examples I could point out to you, why hasn't the whole market figured out that they can deliver health care more efficiently if they followed what Minnesota has done than if they follow what another community has done.

Well, that is because, going back to Senator Coats' example, we don't have any incentives, in fact we've got the wrong incentives, in the health care system as it is currently structured. We reimburse on a basis of diagnostic treatment, on procedure, not on the basis of what is the quality outcome that will be delivered for a particular population.

I showed yesterday, and I have got it, I think, again today, this consumer guide that makes the point better than I could. It's called, "A Consumer Guide to Coronary Artery Bypass Graft Surgery." It is put out by the Pennsylvania health care cost containment council. What Pennsylvania has been doing for a number of years is going to every hospital that performs coronary bypass surgeries, finding out how much they charge and what happened to the patient, how many died, what kinds of recovery and other problems did they have.

In that one state, you can get the same operation for $21,000 or $84,000. There is no difference in quality. In fact, if you look at this consumer guide, the hospital that is delivering the surgery for $21,000 is doing as good or better a job than hospitals delivering it for two or three or four times that amount. There is no current incentive in our system to move any other hospital in Pennsylvania to close that gap.

We think by creating a market-driven, competitive system and by providing good consumer information, we will begin to see hospitals get those costs more in line with each other. So, in fact, instead of rationing care, if more hospitals in Pennsylvania delivered a high- quality coronary bypass at $21,000, you'd have more people taken care of than you do currently when the cost is $84,000.

The way we view the budget is as a backstop. It will not come into effect in the vast majority of cases. Because we believe that good information and decision-making on the part of providers will begin to move this system in a more rational way so that we will have better-quality health care for less money. We view the budget as a disciplinary backstop. It is available in the event that a particular region such as those whose costs are already so high doesn't begin to bring them into some kind of comparison with their neighbors who provide high quality at a much lower cost. So, the budget is there, not to be imposed, but to serve as a backstop.

And I know my time is up, but we could go through very technically and explain how it would be enforced in the event that it should be triggered, but we really don't believe it will be triggered in most instances if people pay attention to what we know is out there about how to provide quality health care at less cost.

SEN. HATCH: Well, thank you.

Thank you, Mr. Chairman. That's all I need to ask today.

SEN. KENNEDY: Thank you very much.

Senator Bingaman.

SEN. JEFF BINGAMAN (D-NM): Thank you, Mr. Chairman.

I'll join all the others in congratulating you, Mrs. Clinton, and the president for your leadership and also Senator Kennedy for his long

ecord of leadership on this issue.

I wanted to ask you about the cost containment part of it because I know that's central to your plan. One of the suggestions -- I introduced a bill last year based on work that the Jackson Hole group had done, and an essential part of what they proposed, what I proposed, in that bill to contain costs was a limit on the amount of the employer's contribution which would be tax free to the employee. And I know that Alan Enthoven (sp) has continued to urge that that be considered in this plan.

It does seem to me that if I have a choice of a high-cost plan that perhaps is doing bypass surgery at $84,000 a crack and a low-cost plan that's doing bypass surgery at $21,000 a crack, we ought to build all the incentives in we can for me to choose the low-cost plan, and making me pay tax on the increased cost of going to the high-cost plan would, I think, be a strong incentive.

What's your thinking for not including that in what you're planning to propose?

MRS. CLINTON: Well, Senator, let me start by saying I don't think that in a competitive market where health providers are coming to get your dollar and mine, and we're making the choice, that there are going to be very many providers that will be able to afford the $84,000 bypass surgery very much longer. They're going to have to become more cost-effective because they will have to charge the difference. We are asking consumers to make cost-conscious decisions. If I choose to join the most expensive health care plan, I will pay the difference, and that will be the choice that I make.

But the issue about taxing health benefits is one that we have really struggled and worried over because we have a great deal of respect for Alan Enthoven (sp) and for the people who have worked on managed competition, and believe that we have a managed competition system in many of the features that we've adopted. But we have several big problems with, starting with the taxing of health care benefits immediately when the plan began. And they include the following.

If you start a health care reform proposal that will affect the whole country, we know that people are starting at different levels of insurance right now. Some people have bargained for their health insurance, some employers have offered health benefits as a competitive device to keep employees and to hire employees, so we're starting with differing levels of health insurance.

The guaranteed benefits package that we are offering we believe is a very good benefits package, and it does emphasize primary and preventive health care, but it does not include some of the features that are available in insurance policies that are currently insuring millions of Americans. So to say at the very beginning these millions of Americans are going to be worse off than they would be without reform struck us as unfair. So what we decided to do instead was to say we intend to impose a tax cap but we want to give everybody enough notice, employers and employees, so that they can get ready for it, so that they can see how our system operates, so that they can

eel secure that they're not giving up benefits that they've either bargained for or paid for in wages. So we do believe in a tax cap, and a tax cap will be added, but it will be several years out, after the system has actually gotten up and consumers can see what the benefits are for them.

The second is that to impose a tax cap right now would be to raise taxes on over 35 million working Americans. I don't know how we could do that. I don't think the president feels comfortable coming to you and saying, "Remove the tax treatment for health care benefits, and oh, by the way, that's a tax hike on 35 million Americans," and I can guarantee you once your constituents figured that out, you would hear a lot from them because they would think it was unfair, also.

But I do think it's fair to say we want you to make cost-conscious decisions. And we have seen companies where this has worked; we have seen states where it has worked. The state of Minnesota decided it would only pay its employer share for state employees into the lower cost plan and people switched. Many employers who have given lower cost alternatives to their workers have saved money because people have switched.

So that's our thinking behind it. Yes, we believe it's a tool. Yes, we want it included. But to do it now would result in a tax increase on over 35 million Americans, which we don't think at this point in time is fair to do.

SEN. BINGAMAN: Well thank you for clarifying that. It's obvious you've given it a lot of thought.

Let me ask one other incentive-related question. One of the incentives that exists in the present system of health care is an incentive not to smoke. Most -- or at least many health care providers or plans give you a discount if you do not smoke. That, as I understand what you're proposing, that would not be available.

You have an assessment provision in the plan, or contemplate one, for employers of over 5,000 who decide to opt out. I think you charge them a certain percentage. Why does it not make sense to maintain some kind of additional cost for individuals who choose to smoke or for employers with workforces that choose to smoke? Would that not put the incentive where you want it, as we talk about responsibility in the health care system?

MRS. CLINTON: Well, Senator, I think that we ought to take a close look at that again. You know we are going to propose taxing tobacco, which we consider a disincentive to smoking, and we hope particularly for young people. If there is a way, without getting back into the problems caused by experience rating and underwriting practices that draw lines between people, where we can just target certain very limited behaviors, we will look at that again, because I share your same belief about trying to encourage wellness and discourage harmful behaviors. But we don't want to start down a slippery slope where then, well, you know, young people are healthier than old people so young people should pay less than old people, you know. Once we get back into that, then we are back into all of the

dministrative costs and the underwriting practices that eliminate people from care, and we don't want that to happen. SEN. BINGAMAN: No, I agree entirely. And I think your decision to just impose the tax on tobacco products made a lot of sense and was an exception to the community-based plan and might be in this other area as well.

Thank you, Mr. Chairman.

SEN. KENNEDY: Senator Durenberger?

SEN. DAVE DURENBERGER (R-MN): Mr. Chairman, Mrs. Clinton, thank you. Let me begin by saying that the people that I represent like you a lot. Many of them even trust you, which is very unusual for people that work in this town. And I think it's because you're one of the first national leaders to take responsibility for actually getting something done, and they feel that. And even though they may not know enough about the plan or not trust the financing and so forth, I must say that the sense of responsibility for doing something has not been lost on my constituents. They also appreciate your mentioning Minnesota so often, but on the second round I wish you would mention Massachusetts a couple of times. (Laughter.) But it is a unique constituency and I've been blessed to represent it for a long time and whatever I have to say by way of a question will reflect our experiences in Minnesota.

One of the things that I hope we can agree on, and I'm just going to suggest one, but we don't have to do it now, is I think we need a goal for all of this that people can relate to -- I mean, why are we doing all this? -- so we don't get bogged down in all of the mechanics.

And I've always used the goal of equal access to high quality care or to a system of high quality care through universal coverage of financial risk, and then, I'd like to add, and a community commitment to the health of our citizens.

There's nothing in there about basic benefits or insurance companies or health alliances or any of that sort of thing, but it's an important measure because as we undertake this task there's two really important things that we don't have in our country today that we need to get to it. One is cost containment, and the other is the goal of universal coverage. And so my question is going to be a question I've discussed with you before, and that is why can't we do one before the other?

In order to devise an effective reform strategy, we somehow have to figure out how to get the costs under control, and the reality from my experience has been that people control costs. People control costs. And this is particularly true if you want to maintain high quality. Government can control costs by putting lids on things, but then something else loses in the system: you go to rationing your quality or whatever. But the reality is in whatever we buy, whatever we use in our society, it is people -- people -- that contain the costs.

Communities as markets are very, very important, because communities are a series of relationships between people who have certain needs and people who can meet those needs. It's in communities where you have

are-givers -- in our context, the medical -- care-givers and consumers meeting on a daily basis. So the reality is that communities across this country are containing costs.

You have mentioned Minnesota. You've mentioned other states. There are employer coalitions. That's a sense of community. There are multi-specialty clinics, and you've mentioned one of them, David Nexon's (sp) favorite, but there's also the Cleveland, and then there's Oxner (sp), and there are smaller ones in many of our communities. There are efforts to increase consumer information. You mentioned Pennsylvania. They're all over the place.

All of this is being done in communities. And the reason I need to stress this is that it is communities that make the difference, it's not state governments. Nothing that's happened in Minnesota has happened because the state government said it needed to happen. It happened because people wanted it to happen. And you've already mentioned Duluth and the difference between Duluth and Philadelphia and Wisconsin and Miami and so forth.

So the issue is, really, how do we spread this across the country? And there the issue is, what's the government role? And this is the issue that's dividing some of us: what is the government's role in all of this? And I'm going to suggest two.

The first is the national government ought to set the rules for a sound marketplace. If we want high quality and we want cost containment, if we want more for less, we need to get productivity, we need dynamic markets, what are the rules for dynamic markets? And it defies any logic of any experience I've had that 51 states can come up with rules for markets, for products like health care and medical services.

So the second part of the goal is the issue of universal access. And there the government role is probably even clearer, although even Republicans differ on this.

The first role is the state role, and that is to make services available to people who can't get them from a market. And most of us who know anything about markets know that markets can get you higher quality for a lower price, but they can't do equity. They can't get doctors to go out into this part of northern Minnesota, you know, where there's only two people per square mile. They can't get good diagnostic equipment into certain areas. Only government can do that. So, one of the responsibilities of government is to make services available, and that's going to require subsidies, and that's one of the things that state governments really ought to be concentrating on, and they're not doing it today. They're leaving it to some medical marketplace.

The second is the affordability of the premium prices that we now pay for our coverage, and clearly that's a national issue. Tomorrow, you'll be before the Finance Committee, and we'll talk about low- income, elderly, disabled, and doing something about our policies. And before this committee, you'll talk about the employer's role and so forth.

But I'm sort of setting up this question by saying we have to get to a market, we have to get the people to contain the costs, and we have to get the government to make the access to the system affordable in some way. Right now, the American people, as reflected by the people in my state, believe that you can get to a market without universal coverage. We're doing it in Minnesota. Even though there's cost shifting, we're moving to a market. It's happening in Utah and Oregon and in parts of New York and lots of other places. They're moving to cost containment, even though there exists some cost shifting. So, I have a hard time with the notion that you have to have universal coverage in order to make a market work.

But even more important than that, it seems that -- we've already talked about the fact that Americans don't want their taxes raised. You've just said they don't want their taxes raised on their benefits. We all know the difficulty you have there. And beyond that, beyond that, the reason they don't want their taxes raised is they're not sure the plan's going to work. And is there not then some value in demonstrating that our particular or your particular approach to markets and medicine, which no one has seen before, actually works in some communities in this country before we move to a national, universal coverage system?

MRS. CLINTON: Senator, as always, you ask the most interesting and challenging questions because of your concern and commitment to this issue. And I've appreciated greatly the times we've spent together talking about this.

And I guess I would answer in this way, that we have seen markets beginning to work, the ones that you named. We know, we believe, the conditions that markets need to be able to work effectively, and we do need to define whatever the government role is in creating that national market so that we will have a sound and effective one.

The problem that I have in putting cost containment before universal coverage or vice versa is that in any decent marketplace, you would have people flooding to Minnesota to figure out how to keep costs down. You'd have people flooding to the university in Duluth to figure out how to train more family care providers than are trained by any other medical school. You'd have people lined up at Rochester, New York's boundary, saying show us how you keep those costs down in Rochester, New York.

That has not happened. And it hasn't happened because there is no market there and there is no real pressure for that market to be created by the kind of market that there would be if somebody thought they could buy a car for one-third the price in one state than they would in the other. You'd have an exodus into that state.

Part of the reason there isn't is because we don't have either a good theory for cost containment with the right incentives built in that will move the market in that direction across the country and not just in the pockets where it's moving. And the other is there are all these escape valves because we don't have universal coverage.

People don't feel the pressure to move because they can always shift their costs to somebody. And maybe we have states in which there is beginning to be a market, but then the neighboring state doesn't follow that example because they're still writing the blank check and they're still getting reimbursed in the old way which is a lot easier than to come together to figure out how to make that market more dynamic.

So from our perspective, looking at all of the factors you laid out, it seems to us we have to proceed in tandem. And I know that's a more complicated way, perhaps, to proceed, but we think it guarantees a better outcome as we move in this direction. And I will look forward, as I always do, in talking to you in more detail about how to fulfill the government role that you've outlined and the universal coverage while we obtain cost containment.

SEN. DURENBURGER: Thank you.

SEN. KENNEDY: Senator Wellstone.

SEN. WELLSTONE: Thank you, Mr. Chairman. First of all, Mrs. Clinton, when Senator Mikulski was talking about other first ladies that have testified, I think of my heroine, Eleanor Roosevelt, and I thought maybe a quote from her words would help you through this journey where all too often politics can be so tough and all too cynical. Eleanor Roosevelt once said, "The future belongs to those who believe in the beauty of their dreams." And maybe I'm just, you know, a romantic, but I think somehow that applies to this journey.

I also am very honored to be here, and I look at this committee hearing and your presence with a sense of history because the pricklings in my fingertips tell me that after over a half century of political struggle -- after all, Franklin Delano Roosevelt talked about some kind of national health insurance or universal health care coverage in 1935, we are as close as we have ever been as a nation to adopting some kind of major health care reform that will provide humane, dignified, affordable care for people.

I think we have crossed the divide and we're no longer debating whether or not we'll have universal health care coverage, but what kind. And I would thank you and I would thank the president, and I would thank the chair of this committee for that.

Now, for an abrupt transition, in Minnesota you said to me -- I told you that as a strong single-payer advocate I was going to continue to press hard, and you said to me that if I didn't press hard, you would worry I was in need of health care -- (laughter) -- so in that spirit, I will press hard.

First of all -- and I'm going to try and do this under five minutes -- some of the concerns that were raised today I'm just going to highlight and then go to my central question. I do believe that Senator Mikulski raised a tough set of issues because when I talk to people in the cities and in the rural areas, they don't see yet the public health and the community health care clinic infrastructure, and they're not quite sure where

ıe poor are going to fit into these networks, who are, after all, competing on the base of price. And I think that's a valid concern.

I appreciate how willing you've been to work with many of us on the mental health, substance abuse, but I still think on outpatient co-pay are too high, and I worry about that as well. And as long as we're going to talk about long-term care, and I think of the people that I meet in Minnesota, I think we have to have a time certain for comprehensive package of benefits and for universal health care coverage. We can't overpromise, and we have to be clear about when we're going to come through.

Now my question. The thing that you say that is so powerful, the thing that the president said that was so powerful is there's a card, and there will be a comprehensive package of benefits, and no one can take that away. And I think we're also talking about quality of service.

Now when we talk about quality of service, I would like to zero in on a technical point, but I think it's basic, and that has to do with the average price plan. And for those who don't know what the average price plan is about, that means that in any given state, if one plan in a state or a region is $800 and another plan is $300, that 80 percent employer contribution will go to the $500 average price plan.

MORE

----------35th add missing----------

36thadd

MRS. CLINTON: And you're absolutely right, and none of us do. I mean, what we are trying to create, as Senator Durenberger said, is a dynamic market that responds to price and quality and gives real choice to consumers, unlike what exists in many places now where there is no choice whatsoever; you don't have a low, medium or average or high plan, you've got very little access. And we want to increase that and we're going to watch that very carefully.

SEN. KENNEDY: Thank you very much. We have one final questioner here, our good friend Senator Wofford, who has been one of our real leaders on health care , and we'll hear his questions now.

We know that you have another hearing to testify, so we will not have a second round of questions, although we'll ask our colleagues if they do have questions to submit them in writing. And after Senator Wofford, if there is a member that wanted to say a very brief final comment, we'd entertain that as well.

Senator Wofford?

SEN. HARRIS WOFFORD (D-PA): Mrs. Clinton, I'm happy to join Senator Jeffords and others as a cosponsor of this bill because I think it not only reflects my own bill of a year and a half ago, but it's designed to meet the tests that the president put to us, and they were the tests that I put to the people of Pennsylvania two years ago.

Mr. Chairman, you have carried this ball through thick and thin over the years, and too many of those years have been thin years. Harry Truman was beaten back when he tried to advance this ball half a century ago,

and Richard Nixon 25 years ago. But I believe this time, thanks to a president of the United States who is committed and to the first lady of the land and the extraordinary work that you have done, Mrs. Clinton, we're going to take the ball across the goal line this time. You won't fix the common cold, but I do think that you are going to -- we together, as we press hard, are going to fix many of the major problems of our system that are vexing the American people.

Before I ask the question I want to ask about early retirees and workers compensation and possible savings there in this system, I would like to introduce you to someone behind you who helped me advance the ball up in Pennsylvania, Dr. Robert Rynick (ph), who was the -- Robert, stand up a minute -- a leading ophthalmologist of Pennsylvania, who said to me, when we were talking about how to reform the health care system, "Senator, we can reform the system, we can decide how if we set the goal. And I just wish you'd take this Constitution and take it to the people of Pennsylvania and say, in this Constitution if you're charged with a crime you have a right to lawyer; it's even more fundamental if you're sick to have a right to a doctor."

I took the ball from him and ran with it, and you're throwing the great ball to us now to make a reality of that.

On early retirees, I'd be interested in your reminding this hearing what you're proposing there, including any comments you have on any short-term measures to stop the sound -- the great retreating sound of companies pressed by their own cost crisis withdrawing from reducing or cancelling the benefits for early retirees.

MRS. CLINTON: Thank you, Senator. But before I start, I must say that none of us might be sitting here if it had not been for your courageous campaign that was waged on providing health care to every citizen of Pennsylvania. And that was a call that went out around the country with your victory, and I'm just pleased that you will be part of actually delivering on that promise to your people and to the people of this nation. And I'm very grateful for the leadership you've shown on this issue.

I know of your deep concern about retirees, particularly those are being denied health benefits which they thought they had, in a sense, paid for through collective bargaining agreements and through other agreements with employers over their work lives, and it is a serious problem. And it is a problem both for the individual who is, perhaps, unpredictably in their lives denied health care when they most need it, and it is an economic problem for many of our companies which have labored under much greater costs than their competitors in trying to meet their health care needs.

We have proposed that the burden of retiree benefits of those who retire between the ages of 55 and 65 after a certain set period of work who are not yet eligible for Medicare be taken off of the backs of the employers and be shared between the employers and the federal government. We have costed this out at about $4-1/2 billion a year. We believe it is sound public policy because it does release an enormous amount of economic potential in

he marketplace by taking this burden that some employers bear but most do not. The employers would continue to be responsible for a portion of the payment under their contracts or they could make some kind of lump sum payment, but the federal government would pick up the rest, which would guarantee health security to those individuals who are caught between their work lives and Medicare eligibility, which we think would be an appropriate kind of security to extend to them with their making the contribution as they were able. And if they went to work after they retired, they would be required to do so.

SEN. WOFFORD: Do you have any thoughts on a stop-gap measure such as some of us are proposing between now and when we deliver the goods of a universal, affordable health security system?

MRS. CLINTON: We will certainly look at that. I'm aware of the legislation that you have sponsored and your strong statements on behalf of that legislation. Obviously, we hope that the Congress will deal with health care reform expeditiously so that it may not be necessary for any transition or stop-gap, but we will certainly keep that under consideration.

SEN. WOFFORD: And any last words or first words on worker's compensation and how it will be included in this as a way of savings for business?

MRS. CLINTON: We very much would like to see the worker's compensation health care benefits integrated into the national health care system. We think that would be a great benefit to small business particularly, but to all business that are now paying increasingly high worker's compensation premiums. We also would like to work toward an integration of the entire worker's comp system if we are able to make adequate substitutes for workplace safety and the kinds of inducements for safety that the current system provides through the experience rating of insurance premiums in that system. But at the very beginning, we would like to begin by integrating that portion of worker's comp into the health care payment that the employer and employee would share and having the accountable health plans then contract to deliver the kinds of health services that workers might need, including rehabilitation services.

SEN. WOFFORD: Thank you.

SEN. KENNEDY: We computed the time. We find Senator Kassebaum had one minute left, and it seems she has one very small question. And I think we'd like to just -- (laughter).

SEN. KASSEBAUM: The advantages of being a ranking member and a thoughtful chairman. I appreciate it, and I appreciate, Mrs. Clinton, all the time you've given. But there is a witness coming tomorrow, and I would kind of like to get your answer to this question.

I'm sure each and every one of us here have at one time or another tried to help constituents in our states raise money to cover costly experimental procedures, particularly transplant procedures, and have done fundraisers and so forth. In this case, this is a mother who has a malignant melanoma whose self-insured -- her employer's self-insured plan

doesn't cover costly procedure -- experimental procedure.

She has gone through all the traditional treatment protocols and they haven't worked, and they're recommending a bone marrow transplant. Would such a procedure be covered under the plan as it's devised now -- the costly experimental procedures, transplants?

MRS. CLINTON: If a procedure is truly experimental, so that it has not yet proven in appropriate research trials its clinical efficacy for treating a certain disease, it will not be considered for inclusion in the guaranteed benefits package, but accountable health plans, as they do now, will certainly be free to offer any procedure that they choose to do so. Once a procedure is still considered experimental but provable, then it may be considered by the national board to be included in the benefits package. So there will be some time lag there.

What we have been telling people in the condition of the woman you described is that health plans currently make available around the country some procedures that other health plans do not. There are some that provide reimbursement for bone marrow kinds of procedures with respect to breast cancer and other kinds of cancer, and other plans which do not. We believe that that will continue to be the case, but now the consumer will be able to choose the plan that does provide that kind of treatment so that there will be a clear up-front commitment if -- we provide the service even though it is still considered maybe experimental and not totally proven, you or I will be able to join that. Or we will be able to buy in the supplemental insurance market coverage for that, which is not now readily available.

So we think that the net effect will be that this woman, and women like her, will have much greater choice to gain coverage for this procedure before the national board were to decide it could be part of the benefits package as a matter of course.

SEN. KASSEBAUM: So you wouldn't appeal to the alliance? The health alliance would not make a decision regarding --

MRS. CLINTON: Well, the health alliance would in the first instance decide whether it was going to offer that service, and if it did, then it would be part of the benefits that the health plan itself were to offer. And what we also think would be available is the point-of-service option that we want every plan to offer, including the closed panel HMOs, that that would then be a referral. There might have to be some additional payment, but it wouldn't be the kind of horrific costs that now are faced by individuals who are out there all by themselves.

And I'd be happy, in preparation for your witness tomorrow, Senator, to have written down exactly what our procedure is with some examples and some scenarios as to how we believe it would work, if that would be helpful.

SEN. KASSEBAUM: Thank you very much.

SEN. KENNEDY: Just a closing brief comment for any senator. Senator Dodd?

SEN. DODD: Thank you very much, Mr. Chairman. And just very

riefly, if I can. One, I just wanted to -- I appreciate your comments about the pharmaceutical industry. Senator Simon raised the issue and you talked about trying to find this mix here. And I just -- and I know you're aware of this, and like any other industry there are good guys and bad guys, I guess. But important to note, I think, that it takes on the average about $400 million and 12 years for a product to go from laboratory to market, and only about one in 5,000 actually make it from the laboratory to the market.

And so as we look at individual pieces here and it can cause our level of anger to rise. But looking overall at the incredible contribution overall that that industry has made to the health of this country is something that I think needs to be emphasized. And I raise that in the context -- and maybe you'd made a brief comment on it, if you would -- I've listened to you countless times -- and talk about the role of the private sector, how important it is, that whatever plan we develop be extremely sensitive to small business in this country, how critical that component is to this country's economic success. There is out there this notion somehow that this is anti- business, that this is particularly anti-small business.

Nothing could be further from the truth for those of us who have listened to you and listened to this plan get developed. And I wonder if you might just take a moment to comment on that particular broad criticism that I think many of us hear from our particular constituencies.

MRS. CLINTON: Well, Senator, I really appreciate that opportunity.

I guess I'd start by saying I think it would be hard to design a system that is more anti-business than the one we currently have, in which business bears the bulk of responsibility, pays most of the bills, and has until very recently had very little to say or very little control over the kinds of costs in the health care system that have increased their costs and, in many industries, lowered their competitiveness.

What I believe is the fairer approach to what we are doing is to recognize that business has borne the burden for taking care of most Americans. Ninety percent of those Americans who are insured are insured through their employer. And what we want to do is to build on the system and to begin to make it work for all businesses.

Those businesses, large and small, that have been responsible, provided health care benefits, deserve to have some kind of cap or some kind of discount, some kind of effort made to help them control their costs, because they've having such a hard time doing that. And that's particularly true for small business.

For those businesses that have not insured, but who may have wanted to, we want to make it affordable for them. We are very sensitive to small business concerns. You know, my father was a small businessman. He never employed more than one or two people his whole business career. My mother worked with him. He never had health insurance for himself, his family, or his employees. It was just something that could never have been

possible as the market was currently constructed because it was so heavily weighed against small businesses.

And what we want to be able to do is to build on what works and to fix what's wrong. And what's wrong is an insurance market that prices too many businesses for their insurance too high and prices others totally out of the marketplace. And I think if we create some insurance market reform, businesses today that are scared to death of the insurance market and worry when they hear us talking about insuring everybody that they are going into the same market that has been so hard for them in the past will realize we're talking about an entirely different set of pricing and of opportunities for coverage, and that for small businesses, we're going to provide it at a discounted rate and we're going to cap the amount that any small business has to contribute that has low-wage employees, that is below 50 employees.

And I just don't think that we could come up with a plan that would build on what already works better than to try to bring in those businesses that don't insure at an affordable cost and bring down the costs to those who are already insuring. And that's what we are attempting to do in this plan.

SEN. DODD: I thank you for that answer.

SEN. KENNEDY: We've kept you beyond the time that was designated, but we'd be glad for Senator Jeffords to make any comment?

SEN. JAMES M. JEFFORDS (R-VT): No.

SEN. KENNEDY: No? Are there any further comments here? Dave?

I just finally want to personally congratulate the president and you, Mrs. Clint, for the fashioning and the shaping of this proposal, and not only for its development, but for really the momentum and, in this case, the bipartisan momentum which has really been created. Obviously, there'll be adjustments and changes as the legislation moves along, but I daresay that this has been really a perfect launch. If Congress, Republicans and Democrats, can do half as well in meeting our responsibility as you have and the president has, we'll get a good, workable, effective program for all Americans. And we thank you very much for your presence here today.

We will meet tomorrow, have hearings on the health security and savings, and we have a vigorous program of hearings. We want to learn, and we are enormously grateful to you for your presence here and, most importantly, for your responses and the illumination that you've given to so many different questions.

The committee stands in recess.

MRS. CLINTON: Thank you, Mr. Chairman.

- END -

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30-Sep-1993 08:18am

TO: (See Below)

FROM: Jeffrey L. Eller
Office of Media Affairs

SUBJECT: hrc transcript from p.m. 9/29

HEARING OF THE HOUSE EDUCATION AND LABOR COMMITTEE
CLINTON ADMINISTRATION HEALTH CARE REFORM PLAN
CHAIRED BY: REP. WILLIAM D. FORD (D-MI);
WITNESS: HILLARY RODHAM CLINTON
WEDNESDAY, SEPTEMBER 29, 1993
For Internal Use Only -- Not for External Distribution

REP. FORD: I'd like to announce that the first lady can be with us for two hours, and in the interest of ensuring that all members of the committee have an opportunity to ask their question, we're going to limit opening statements to one minute each to the chair and the ranking Republican and the chair of the Labor-Management Subcommittee and the ranking Republican on that committee. I'll ask unanimous consent, without any objection, all opening statements presented by the members will be inserted at this point in the record.

The other part of this that I want to mention to you is that we'll operate on a two-minute rule instead of the traditional five- minute rule, and I'll have to be very strong in enforcing the two- minute rule with those little lights down there; otherwise, we're going to leave junior members of the committee without an opportunity to have their question. And I'd ask the cooperation of the members.

Did I leave anything out, Bill?

REP. BILL GOODLING (R-PA): Not that I know of. I think you covered it all.

Mrs. Clinton, it's a real honor for this committee to have you here. I would observe that you've set some kind of a record, I believe, not only in appearances by a first lady more times than all of the other first ladies put together who deigned to come to the Congress and talk to us, but in the number of major committees that you've testified before in just this week. It's almost at the same frenetic pace that we've seen you operate at this year in doing what we thought at the beginning of the year, very frankly, even the most optimistic and hopeful of us, was not going to be possible.

The work that you and your task force have done across this country in gathering together the wisdom and thought of so many diverse groups of people and individuals in our society to put together an

understandable outline of a possible successful universal medical care program for American citizens is the most exciting thing that we've had a chance to be a small part of.

This is a one-in-a-generation opportunity, as I perceive it. I had the good fortune to be here when we passed Medicare, and I've been proud of that for many years since, except we didn't go far enough. We ran out of gas with the war in Vietnam and other things taking our presidential leadership away from us.

Then the Clintons came to town. And for the first time, many of us who have spent a good many years here actually had hopes that you were going to bring enough attention to this issue to ignite the American people behind a genuine effort to provide universal medical care.

We believe that we've reached that crucial point because now the discussion has changed in the Congress from whether we need such a plan to how best do we do such a plan. And I'm sure that by the time we're through with this, not only in this committee but others, we will incorporate the best of Republican plans with the best of the president and your plan and the best of anybody else's ideas that look like they'll make your objectives as articulated by the president a week ago Wednesday come true. There are very high hopes in this country riding on your success, and this committee will, I assure you, work to do everything we can to make it come to pass.

Mr. Goodling.

REP. BILL GOODLING (R-PA): Thank you, Mr. Chairman.

I, too, want to welcome the first lady and congratulate her for bringing health care reform to the forefront in the American debate. Since the president's program and the minority's program have the same six major goals in mind, we should be able to work out something in a bipartisan fashion. I would hope that would happen because I believe it's very important that something as major as this -- we're talking about a trillion dollar part of our economy -- be done in a bipartisan fashion. So we will look forward to the details so that we can offer our suggestions and recommendations in ways we think it can be changed to be even better. That would be our hope. So we look forward to this period.

And then also I want to thank you for coming before the task force that I served on on several occasions so we could exchange ideas. And I think it helped us, and I hope it helped you. And, of course, I know you remembered long-term care and home care, because you heard that several times before us. So again, thank you for coming, and we look forward to participating and being a part of a reform system that will benefit all Americans.

Thank you.

REP. FORD: Thank you very much, Mr. Goodling.

Mr. Williams. Mr. Williams is the chairman of the subcommittee that will carry the lion's share of the burden for hearings around the country on this. If you want a hearing anytime of the day or night anyplace in the country, see Pat -- (laughter) -- and he'll take care of it for you.

REP. PAT WILLIAMS (D-MT): Thank you, Mr. Chairman.

Mrs. Clinton, welcome. You are, as you know, the nation's 38th first lady. It was May 27th, 1789 when our first first lady, Lady Washington, joined her husband, the nation's new and first president, in New York following an arduous coach ride from their home in Mount Vernon.

At the time, it was written -- and I quote -- "If providence

itself had divinely intervened, a woman who better looked and played the part could no have been found."

Well, since that first first lady, America has celebrated its president's wife -- Abigail and Bess, and Mary Todd, and Jackie, and Nancy, but none, Mrs. Clinton, have had in their husband's first ear the effect that you have had on a critical, major, domestic issue. Americans are lucky more than a few times in both their choices of presidents and particularly fortunate in their president's choice of a wife. And if providence had divinely intervened, I think we could say of you what people of the time said of that first lady 38 ago -- we're delighted you're here. We're delighted with your aggressive and intelligent work on this important piece of national legislation. And my committee members and I look forward to continue working with you, and we thank you for working with us to this point.

Thank you, Mr. Chairman.

REP. FORD: Now, Mrs. Clinton, I would invite you -- I noticed in many, many meetings that I have attended with you that you rarely have notes, and if you have them you don't bother with them too much. I've seen you write a speech literally Abraham Lincoln style on the back of a piece of paper on the way to a college commencement and give it as if you had practiced it for weeks. So you proceed in the way you feel most comfortable to put on the Record here what you want in the way of a national health program, and then we will open it up to questions.

MRS. CLINTON: Thank you, Mr. Chairman. I want to thank you and the members of this committee for the extraordinary help and openness you have shown to me and to others working on behalf of the president in the last months concerning reforming our health care system .

This committee has been willing and very ably been willing to address some of the major issues facing our country and some of our most serious social problems. I know the president and the nation particularly appreciate your work on the Family and Medical Leave Act and the National Service Bill.

In the months ahead, your commitment to confronting the greatest domestic challenge of our day will be critical to our nation's future. After years of stalling and false starts, we all now have an historic opportunity to accomplish what our government has never succeeded at before -- providing health care for every American citizen, health care that is secure and can never be taken away.

You know better than I the countless tales that come across your desks, that meet you as you travel around your districts, that are told to you at town meetings. You hear from those who have no health insurance and used to have it, but a job was lost, a family member was sick, a preexisting condition prevented existing coverage from being continued. You, like I, have had to talk with parents who have actually given up jobs and gone on welfare to get medical benefits because there was no other way to take care of a sick child. You have had the kinds of conversations and heard the stories that are really behind why we are here today.

The statistics, whether we talk about the two million people who lose their insurance each month for some time or the 40 percent of insurers who refuse to cover people with preexisting conditions, can, if we are not careful, be just that, only statistics. And the stories and the human face that we need to put on this problem can, if we are not careful, fade behind the statistics, the details, the problems that we read about. So, I hope, as we move forward in this great national discussion, that each of us has in the back of our mind the picture of some person who will be helped by what we will do. And we will keep and remind each other of the stories of the real people who stand to gain because of the action you will take.

The human dimensions of health care reform are only one part, although the most important part, of what we are facing. We also know, and you know better than most in the country, the economic dimensions of what confronts us. We have seen the federal budget continue to hemorrhage because of health care costs that could not be kept under control. We have seen state and local budgets likewise hemorrhage because they were unable to keep up with the soaring costs of health care. For the first time ever in our history this year, the states of our country will pay more for health care than they pay for higher education. Many states and many cities have been forced to lay off police officers, to refuse that neighborhood's plea for more police on the streets because they have to keep paying more money into a system that is not providing any more or better care, but which continues to cost us more every year.

What we have to confront now is the opportunity of preserving what is best about our health care system. And there can be no argument; we have the best health care system in the world for those of us able to afford to access it. But we also know, if we are honest with ourselves, that while we must preserve what is right about the American health care system, we must also fix what is broken, because what is broken is in danger of undermining even further what is right about American health care.

When the president launched this effort to try to come forward with a proposal that you could seriously debate and move toward enacting with appropriate changes, he came to that from the perspective of a governor; he came from wrestling with budgets from a state where you always have to balance the budget, a state where if revenues don't match expenses you have to cut across the board. He knew very well what the costs were that were driving his budget, like every other state budget, to the kinds of difficult choices that all of us have seen faced.

He asked that we look at every possible alternative to try to come up with a proposal that would help to solve the health care problems that we have. He was committed to a very simple principle: preserve what is right about our system and fix what is wrong. To achieve that goal, we explored a number of different options and we looked at plans that work all over the world and those that work right here at home that offer high-quality

health care to people at an affordable price. We looked at countries that provide health care through a single-payer system or through a public/private system. We looked at how much it costs to do that. We looked at the kind of experiments and models that we see from our own state of Hawaii to California's pension retirement system, to Minnesota's large employers, to Rochester, New York's system, and on down the list of what worked in many of our own states.

We concluded that what was best for us to do and to present to you was to take what works in our system and to build on it. And what works for most Americans who are insured -- 90 percent of Americans who are privately insured are insured through the employment-based insurance system . After lengthy review, we concluded that the best system for this country is to build on the system we already have -- the employer/employee partnership. It is a uniquely American solution to an American problem. It is the least disruptive option that we could consider because we have used this system for 50 years or more and most Americans are familiar with it.

Most Americans who are insured get their insurance through their workplace. It is a partnership. Everyone -- the employer and the employee -- share the burden of coverage. No one is able to escape some responsibility; everyone participates. If we take the existing system that we currently have and add to it those businesses that do not currently insure and those employees who do not currently contribute to any health insurance, we will have gone a very long way toward solving our health care financing problems without changing the way it is currently done for most people right now.

This is the proposal that we have developed, with great sensitivity toward the costs that it would require for those businesses that have never provided insurance and their employees. We know it can work because we have one state, Hawaii, where it is working, where it has worked for a number of years, and where the unemployment rate has consistently been below the national average.

In our attempt to structure an employer-employee-based system that would cover all of the employed, we have been particularly sensitive to the needs and requirements of small business. Small business today falls into two categories, those who currently insure and those who do not. If one looks at the profiles of the currently- insuring small business sector, it is, by and large, the fastest- growing part of the small business community because it offers health insurance as a benefit that it understands is a competitive advantage.

For those small businesses that do not currently insure, we have structured this system so that they will receive a discount. They will be able to enter a reformed insurance market in which the kinds of discrimination against non-group and small-group insured businesses will be eliminated. They will be able to enter an insurance market in which preexisting conditions will be eliminated. And they will be able to pool their premium dollars with those of many, many other small and medium and large businesses as well as individuals in order to obtain the best possible

price for insurance.

In addition, small businesses of 50 or fewer employees and with low-wage workers will not only be protected with a discount in a reformed insurance market but will have the amount of money they have to pay for a premium capped. We have also been very sensitive to the costs in the Workers' Compensation and health parts of many businesses' expenses, and we intend to integrate those costs into the system.

For these and many other reasons we could discuss, we believe that this is not only the fairest but the most feasible way to move toward universal coverage.

Obtaining universal coverage is, we believe, a condition for being able to contain costs in the entire system. They go hand in hand.

We also think that extending the employer-based system to all employers and employees removes the subsidization that has existed between some employers now who have not only paid the premiums to insure their own employees, but because their neighbors down the street or their competitors in the business have not, they have indirectly subsidized many other businesses as well.

The issue of how we best finance health care reform, and particularly achieve, universal coverage is one that I know will be vigorously discussed in the next months. We concluded that amongst the alternatives that are available, which include either a very large tax that would replace private sector investment or an individual mandate which would put the entire responsibility on the individual and, we are concerned, disrupt employment patterns now, particularly those that provide insurance, that therefore the best way is to take what we know what Americans are familiar with and make it better, make it fairer, and make everyone within it responsible. Until every American has health security, no American is fully secure, and neither is our nation.

No solution will be perfect. But if we can agree on reforms that are fair, compassionate, workable, practical, then we believe we can all reach the destination that the president described in his speech last week. With your help and your continuing counsel that you have been so willing to provide up until now, I am very confident that we will achieve this goal and that all of us will be able to look into the faces of those Americans whom we see every day and know everyone we see is finally secure in the health care they deserve to have.

Thank you, Mr. Chairman.

REP. FORD: Thank you. And I'm going to -- we've called the floor to ask them to hold up the vote. To members who would like to leave and vote and come back as quickly as possible, we'll start with the questions while you're gone. You have two minutes and 30 seconds. (Recess.)

REP. FORD: (Sounds gavel.) Mrs. Clinton, while we still have members coming back, we do have members here who would be prepared to go ahead, and we can maximize our opportunity with you if we do proceed at this

time. I'd like to recognize Chairman Bill Clay.

REP. WILLIAM L. CLAY (D-MO): Thank you, Mr. Chairman.

And thank you, Mrs. Clinton, for coming over. Let me say that I hope you'll accept my invitation as chairman of the Post Office and Civil Service Committee to visit with us next week and explain the proposal of the 9-1/2 million federal and postal employees.

During the last decade or so, millions of organized workers negotiated generous health care benefits from their employers in lieu of wage increases. And many of these companies have reluctantly granted these benefits. As I read it, the standard benefits package proposed by the president is not as generous as some of these negotiated health benefit packages. So, my question is -- are two questions. Will these workers now suffer a reduction in health benefits after having given up wage increases to get them? And, secondly, what does the president's proposal do to ensure that these hard-fought-for gains are not taken away?

MRS. CLINTON: Congressman, the answer to the first is that there should be no discrimination against those plans that already exist that provide greater benefits for a considerable period of time. The comprehensive benefits package that will be guaranteed is a good one, but there are some health plans, not just those that have been negotiated, but have been offered by employers, that do have benefits that are in excess of what will be guaranteed.

Those will be grandfathered in for a number of years. They will continue to be available by either negotiated agreement or employer offering. Because we share your concern that while wages have remained flat for much of the last 15 to 18 years, compensation has increased, where it has increased, and that is not universal, by putting benefits into the entire compensation package. So, we do want to permit negotiated agreements and employer agreements to be able to continue.

Now, at a certain point, and we anticipate it will take about 10 years to get to this point, we believe that the guaranteed benefits package will have been improved with some additional benefits that we will propose to be added in a phased-in way over the next 10 years. At that point, then employers still may continue to provide additional benefits, and they can be bargained for, but benefits over the guaranteed package will no longer be tax preferred, but that will not happen for at least 10 years.

REP. CLAY: Thank you.

REP. FORD: Mr. Petri.

REP. TOM PETRI (R-WI): Thank you very much, Mr. Chairman.

Thank you for appearing before our committee. As I understand the president's proposal, when choosing a health plan, the employee reaps all the benefits at the margin of being price sensitive as to premium costs since the employer's contribution is a fixed dollar amount; that is to say, 80 percent of the premium of the average cost plan.

But in terms of cost sharing under fee-for-service plans, the president's plan does not allow for anything similar to that. The employer

pays a flat 20 percent of the fee, so that at the margin, he or she has only a 20 percent incentive to be price sensitive. So I'd like to know how you would react to allowing fee-for-service plans to use more innovative cost-sharing strategies.

For example, a fee-for-service plan might pay a flat 80 percent of the average price of a medical service in a particular market, or the plan might pay all of the first 60 percent of the average price plus half of any remainder up to 100 percent of the average price prevailing in the market. In that case, if the average price for the service were $100 and the consumer obtained the service for that amount, he or she would still pay $20, or 20 percent out of pocket and get $80 from the health plan. But if you went to a lower-priced provider, he'd split the savings 50-50 with the plan, and if you went to a higher-priced provider, he'd pay all of the extra cost above $100 himself. This kind of cost-sharing structure gives the consumer a stronger incentive to be price sensitive.

Would you consider something along these lines to help control rising health care costs?

MRS. CLINTON: We will certainly look at that proposal, Congressman. We believe that putting the decision-making into the hands of the consumers -- especially because it's not just the 20 percent premium cost that will make them price conscious, it is the differential in co-pays and deductibles within the various plans that will also make them price conscious -- that will really help move this marketplace to become a market, which it is not now. But we would be happy to look at your proposal and to report back to you how we would analyze that, and I'll be glad to get that done for you.

REP. PETRI: Thank you. I have (12 ?) other questions I'll submit. I don't know if you or your staff would have a chance to address them or not.

MRS. CLINTON: We will. We will absolutely address them, Congressman, any questions that you have.

REP. PETRI: Thank you.

REP. FORD: Mr. Murphy?

REP. AUSTIN J. MURPHY (D-PA): Thank you, Mr. Chairman. Mrs. Clinton, thank you for donating so much of your time and devoting so much of your time and talent to a major concern of all of our peoples.

In southwestern Pennsylvania, we're served with small businesses, hospitals with under-200-bed capacity, family physicians, elderly, and workers who are employed in agriculture, small business and small industry. Both the providers and the patients continue to tell me that a major problem with the current system is that it caters to big business, big hospitals, big medical groups, and big insurers. And I'd like to know, in the proposal that the president and you have been crafting, what specifics do you recommend to alleviate these concerns for what we consider is smaller towns or smaller areas, less-populated areas in our country?

MRS. CLINTON: Congressman Murphy, the providers and patients in your district are right that much of the health care system is driven by big institutions, and that smaller and medium-sized, whether they be businesses

or hospitals or groups of doctors, are becoming less and less able to have any control over their own destinies when it comes to health care. We have a number of features that we think will help reverse that situation in southwest Pennsylvania as well as other places in the country.

First of all, by pooling the purchasing power that will come from putting small and medium-sized businesses and individuals and self- employed and farmers into the same purchasing pool, what we call the alliance, they will for the first time be able to drive down the rate that insurance costs them, just the way some big businesses can drive a good bargain with insurers now. That has not been available to the rest of us, and we will be able to enjoy that.

Secondly, by insurance market reforms, which particularly will benefit the non-group and the small-group insured, we will see big savings because we will see the administrative costs that are now associated with providing insurance decrease because there will not be any need for them. Right now insurers, as you know, make their money by drawing lines between people, trying to get the best possible deal. That will no longer be permitted.

Thirdly, with the idea of networks of care, of integrated service delivery networks, there will be opportunities for small hospitals and for groups of doctors in rural areas to join together and to be linked with not only themselves and neighboring towns but perhaps going as far as Pittsburgh to be part of some integrated delivery network, where they are all part of delivering the care, they stay right in their own hometown, but they get the advantages that come from being part of a bigger system even though they stay right where they are.

And I think finally it is very difficult in many rural areas of our country to stabilize any kind of health care system, because in rural areas you have a higher proportion than usual of uninsured people. By making sure everybody is insured, by giving 100 percent tax deductibility to the self-employed, to the farmer, to the small business that is a family enterprise, you will be creating an insured pool that you don't have right now in southwest Pennsylvania. And because everybody will be in the system you will be able to support more providers than you can now.

And I guess finally I would just say we have some incentives to get more providers into rural areas: to forgive the loans of medical students, to have more technological developments that will link rural providers with those in small cities and large cities. And I know something that's particularly important to you because of your wife's profession, we think nurses ought to be better utilized in both rural and urban areas because they can provide care at many levels of primary care need in a very cost effective, high quality way.

So those are some of the things that we think will enhance care in your particular district.

REP. MURPHY: Thank you.

Thank you, Mr. Chairman.

REP. FORD: Mr. Kildee.
REP. DALE E. KILDEE (D-MI): Thank you, Mr. Chairman.

Mrs. Clinton, as you know, in my congressional district of Flint, Michigan and Pontiac, Michigan, the largest purchaser of health insurance for both active and retirees is the automotive industry. The three CEOs were at the White House this morning with your husband. I happened to be with them there. And under that system currently all of the premium is paid by the employer. Will there be any taxation of the premium when it is fully covered by the employer?

MRS. CLINTON: No. We have decided, congressman, that although we would set a proportion for an 80-20 contribution that if an employer chose to pay 90 or 100 percent that that would be permissible. It's only, as in answer to the previous question, when the benefits exceed the guaranteed benefits package at the end of the total phase-in period -- in about ten years -- then the provision of benefits over the guaranteed package will be taxable. But up until that point, no. And in terms of the mix of the employer-employee contribution, no.

REP. KILDEE: So the benefits over a certain level after ten years would be taxable, but the difference between 80 percent and 100 percent would not be subject to taxation.

MRS. CLINTON: That's right. We believe that that is still open to negotiation between the parties, if that's what they choose to do.

REP. KILDEE: All right. Thank you very much, Mrs. Clinton.

REP. FORD: Ms. Roukema.

REP. MARGE ROUKEMA (R-NJ): Thank you, Mr. Chairman.

And Mrs. Clinton, I am deeply sorry that I was not able to be here at the beginning of your speech -- your statement. And I deeply regret that I missed my one minute of fame. (Laughter.)

I have a lot of questions specifically relating to the question of corporate alliances and our direct jurisdiction. But if you will forgive me and if the chairman will forgive me, I think there will be many other opportunities for us to go into the corporate alliance questions as it relates to ERISA jurisdiction and in more detail than I think we want to go into today. But I do have, because of my concern about the quality of care, what I think are misunderstandings of how those cost escalations have gone up.

I wanted to give you two case studies that were recently given to me by a cardiac surgeon at the University of Medicine in New Jersey in the Newark location. And give me your insights and perspectives on that based on your study.

The cardiac surgeon indicated -- and this is not a question about immigrant care, it's a question about uninsured care, Medicaid, okay? An immigrant came in from a Third World country for surgery on a tumor. During the examination the doctors found that there was a pronounced heart murmur. In addition, there was an infection to the heart. She was kept in the

hospital for several weeks to clear up the infection. Her heart valve proved to be defective and it was replaced, which is major cardiac surgery. She is still awaiting her operation for the tumor. This has gone on for many months, and she has received excellent care, the cost of which is uncompensated care to the hospital that exceeds $500,000 and may reach a million before she finishes getting the excellent care that she's entitled.

This has gone on for many months, and she has received excellent care, the cost of which is uncompensated care to the hospital that exceeds $500,000 and may reach a million before she finishes getting the excellent care that she's entitled.

In contrast, the surgeon has a friend who happens to be his barber. And the barber has insured his family for approximately $4,000 and was told by the insurance company that, if he paid another $2,0000, there'd be no problem with his -- with any preexisting condition he might have. Needless to say, that proved not be true. His insurance was cancelled. He's a hard-working man who has always tried to take care of his family. And now he cannot afford the open- heart surgery that he needs.

Could you give me your perspective on that and how this program will address those problems?

MRS. CLINTON: Those are two very good stories to illustrate exactly what's wrong, and they are --

REP. ROUKEMA: (Off mike) -- New York and New Jersey today.

MRS. CLINTON: And they could be repeated, as you know so well, Congresswoman, all over this country, in every city in New Jersey and every other city represented here.

Well, let's start with the uncompensated care, the woman who is in the hospital and who is being taken care of. She is receiving the care she should, but it is being paid for by all the rest of us. It is being paid for by raising our taxes at the state and local and federal levels. And it is being paid for by increasing the cost of insurance. Now, you could not draw, perhaps, a direct line between the uncompensated care being given the woman and the extra $2,000 being requested from the barber, but there is an indirect line there. The reason health insurance premiums have gone up, and particularly gone up for small business and for family-owned businesses and for the self-insured, is because we have so much cost-shifting going on in the system. And that cost-shifting is then paid for on the backs of people who are insured, who continue to be asked for more and more money.

What we would propose is that, if this woman in your first instance has ever worked at all or has any family member who has ever worked at all or if she is on EMedicaidF and has worked or has a family member who has worked, now for the first time they and their employers will be making some minor contribution. It might be with a small business as little as $350 a year, but it will, when aggregated with many others like her, help to pay for the costs of hospital care like you have described.

With respect to your barber, that will not happen. No preexisting conditions will be permitted. Insurance companies will not be allowed to draw

those kinds of distinctions and eliminate some people from care by making it cost more than they can afford or having fine print in an insurance policy so that, when you need treatment, all of a sudden you find it is not covered. This barber and the heart surgery that he needed will be covered. And based on the comprehensive benefits package that we think should be available to every American, the $4,000 that he is paying now is about what it should cost. It should not cost more than that, you know, give or take a few hundred dollars depending upon where you live.

And so, in both of those instances, we think this plan will help address the problems that are presented to the hospital, to society, and to that individual family.

REP. ROUKEMA: Thank you. I think you've covered the bases there, with only caveat which I would like to advance to you, and you've heard me say this before. I want all of those things to happen that you've just outlined, but I don't want the cost of it to be charged to my constituents who currently are enjoying good care from good employers who have been good citizens. I don't want them to have subtracted from their care eitr quality of care or extension of care or cost of care.

MRS. CLINTON: And you have made that point so well in all of our meetings, and I must say that the two issues that are involved in that -- the one that you raised with me several times about taxing benefits that are already in existence --

REP. ROUKEMA: Yes. Correct.

MRS. CLINTON: -- I know that there are members of this house, and particularly Republican members, who believe strongly that taxing benefits in order to force lower-cost plans is the appropriate way to go. I agree with you, Congresswoman. That would be a direct tax on more than 35 million Americans who have paid either in lost wages or in their own out-of-pocket costs for those health benefits. And I just don't think at this point we could turn around and tell 35 million Americans like the ones in your district we're going to make these reforms, but you are going to be worse off after we do it. What we've tried to structure is so that well-insured will pay the same or less than what they pay now for their benefits. And we think that will be true for about 63 to 65 percent of Americans. Another 20 percent or so will pay some more, but they will get more benefits. These are people who have only a catastrophic policy or only a major medical. The benefits will get will be better for them because they will be more comprehensive and they will be cheaper over time because they will have locked-in benefits at an affordable price.

Now, there will be some people -- about, we think, 12 percent or so -- who are going to pay more, but they are predominately young, single people who have gotten the best rates from insurance companies because insurance companies love to insure them because they're not old and crotchety and nearly sick or filled with aches and pains like the rest of us as we age. And I said yesterday, you know, we have a lot of young people around the White House who are in their twenties, and several of them have come up and

said, "You know, I mean, I'm never going to get sick." And I say, "Well, that's fine; then if we could figure out a way for you to sign a release that, if you ever have an automobile accident and you're lying on the side of the road, we all drive by you because you're not insured, then you don't have to be insured. But that's not the way life works. Believe it or not, some day you, too, will be old and you may also be sick."

So for that group of our society, they will pay a little bit more for their benefits, but as they get older, they will pay less because they will have gotten insured in a system where everybody is covered.

REP. ROUKEMA: Thank you.

Thank you. That's a very comprehensive response.

REP. FORD: Mr. Williams.

REP. PAT WILLIAMS (D-MT): Thank you.

Mrs. Clinton, you will recall from our trip to Montana a few months ago -- the first lady, Mr. Chairman, came to Montana, spoke with a couple of thousand Montanans. You'll remember, I think, Mrs. Clinton, that among the people you talked to were several who worried about what would happen in the next several years, perhaps out as far as ten years if nothing is done. That is, what will happen to their premiums, claims denials, reduced benefits, costs? We haven't heard much yet in this debate about the cost of continuing down the same path. Would you address that?

MRS. CLINTON: You're right. I had a great time in Montana -- (laughs) -- congressman. That was --

REP. WILLIAMS: We enjoyed having you.

MRS. CLINTON: And you're right, because I think that every time we talk about the future and what this reform should be, we ought to remember the system we have right now.

You know, some people have said to me, "You know, this reform sounds complicated," and I have said "Well, take a few minutes and sit down and try to explain to somebody the system we have right now." I mean, all of you should try to do that. I have tried to do that, and if you want to get complicated, try to explain what we now have in this country: who's in, who's out, under what conditions, based on what you pay, whether you've ever been sick. You know, it just is unbelievable.

But what is absolutely clear is that the average American family now pays something over $7,00 for their health care. That's premiums and out of pocket expenses. Without any change in the system, without insuring one more of the 37 million uninsured, the average American family will pay more than $12,000 by the year 2000. And we'll have seen a reduction in wages of about $650. You will also continue to see very flat wage levels in this country as more and more money is poured into benefits in a way to try to keep workers and keep productivity and keep some kind of competitive advantage. You will also see the continuing hemorrhaging of the budgets at the federal, state, and local level.

So I don't think anyone who looks at this system as it currently

is operating can have much confidence that it can continue to function very well for most people into the future.

And I would add yet another issue that I think is important. Some people in talking about reform have said "Well, how will you be able to maintain quality, get everybody in, and not have to make some hard decisions about who gets care and who doesn't get care?" Every day in this country people are denied care. They are denied the kind of care they need because of inability to pay for it or access to it.

Some of you may have seen over the weekend a very moving article by a pediatrician in Boston who wrote about what it's like to have families coming in, and when they are told "Here is what you need for the medication for your child," or "Here's what we'd like to do to X- ray," they say they can't afford it, they'll just take their chances. We have a lot of that going on right now.

In the current situation if it doesn't change, we will have even more of it, and we will truly have a two-class health care system: for those of us able to afford it and access it, and then whatever is left for everybody else. And I always am of the philosophy that, you know, there but for the grace of God go I.

None of us knows what will happen to any of us, or any family member whom we love, in the next 10 years. And we just need to be sure that we have a health care system we would like to be able to use and that we would want our family members to be able to use and to be able to afford to use.

REP. WILLIAMS: Thank you.

REP. FORD: Thank you.

Mr. Goodling?

REP. WILLIAM GOODLING (R-PA): Thank you, Mr. Chairman. I have several questions that I will submit that they asked me back in the district.

This is a more formal question that I'll ask, so I'll refer to my notes, and it deals with how the subsidies to the alliances will be allocated. It's my understanding that in the regional alliances there will be billions of dollars provided to subsidize the unemployed, the early retirees, the premiums that are capped between 3.5 and 7.9 for smaller and large employers. And my question is, first, to what extent will these subsidies be funded from existing programs -- Medicare, Medicaid -- whatever the federal government may have, spending reductions, cigarette tax and so forth.

And secondly, what kind of formula will the national health board use to allocate the subsidies to the regional alliances? And if it isn't enough money that they allocate, how is it paid for?

MRS. CLINTON: Congressman, I would love to supplement what I say in writing because that's an extremely complicated and important question. But let me just try briefly to answer your concerns.

The money for the subsidy will come from several sources. It will come from the pooling of the federal resources that are currently being used

to help support our existing system that we will no longer need to put to those uses. Let me give you one example.

You all know about disproportionate share. Those are the payments that go to states and local governments to support institutions that have a very high rate of uncompensated care -- to get back to the question about the woman in the hospital. There will be a dramatic decrease in uncompensated care once everybody is taking responsibility and everybody is making a contribution. That source of funds will be available.

In addition, there will be a tobacco tax that has been talked about that will raise money for the next several years at the rate of between 75 cents and a dollar, and that, too, will be available for the federal subsidies. There are other kinds of sources of federal funds that will become available as savings are realized. And I will give you one example of that.

You heard Congressman Kildee mention the auto companies. Our auto companies are currently paying very high rates of insurance for their insured employees. In a system where everybody is in and the risk is shared across the entire community, the amount of money that that industry will pay will be decreased. As it comes down, there will no longer be money put into tax-free benefits like health care, but we hope it will go into wages, new investments, profits, those kinds of investments and other expenditures that are taxable. That will increase the amount of money coming into the treasury. And we have costed this out with the Treasury Department, and that is another source of the federal funds that will be available to support the system.

But I'll be happy to submit a very detailed list of how all of that works. But the money that we will spend for the unemployed and for the retirees have all been costed out on an annual basis, and there are funding basis, and there are funding sources identified that will support each of those.

REP. GOODLING: Thank you very much, Mr. Chairman.

REP. FORD: We do note that we have some slippage in time, and in order to provide the courtesy that each of our members deserve in asking a question, I want to again remind the members that we do have a time limit. We also want to comply with the first lady's time constraints here.

We now recognize Mr. Owens.

REP. MAJOR OWENS (D-NY): Like most of my colleagues, Mrs. Clinton,
I applaud the package that -- the basics of the package that you have presented. The administration has done a very good job. I do worry, however, about the complexities of administering certain parts of it. And I'm a cosponsor of the single-payer option, H.R. 1200. And I wonder, you do say in your plan that states would have that option of
a single-payer plan. Under what conditions would you allow states to play out that single-payer option under your plan? Would federal agencies be instructed to do everything possible to facilitate the successful establishment of a single-payer plan in the state, or would it be seen as a

competing idea that the bureaucracy might be hostile to? Have you thought that through, and can you elaborate, please?

MRS. CLINTON: Well, I hope not because we want to give a lot of state flexibility, Congressman, to states. And the single-payer option would have to be adopted in a state by legislative enactment, and so long as the state guaranteed the benefits package every American is entitled to and were able to demonstrate that it could reach universal coverage and that it could competently carry out the provision of health care, we don't think there should be any obstacles.

This is something that we have been requested to provide by states that are particularly concerned about their size. In fact, Congressman Williams' state is one of the first that asked me to be sure that this were an option, not that they're going to do it, but that it would be an option that they could at least consider because Montana has, what, 880,000 people, I guess, right? And a very huge land mass. And so, they were concerned about how to promote competition and a market in some parts of that state where there were no people except very sparsely populated. So, we think this is something that states should have the right to consider, and we certainly intend to make it as hospitable an environment for them to consider it as possible.

REP. OWENS: There are a lot of people in the large state of New York who think it's a good idea, too.

REP. FORD: Mr. Sawyer.

REP. TOM SAWYER (D-OH): Thank you, Mr. Chairman.

Mrs. Clinton, my thanks are the same as those of my colleagues.

One of the jurisdictions that this committee enjoys is the whole question and definition of who is an employer and who is an employee. And one of the other cross-currents that we're concerned with, of course, is higher education. We know you've taken care of dealing with independent students, full-time students up to the age of 23, I believe. But with the changing demographics of the American campus, with the enormous gray areas in different kinds of employment, I include full-time independent students beyond that age, stipend- supported teaching assistants, work-study program participants and even National Service Program employees, do we have a clear definition of, in circumstances like that, who is the employer and who is the employee and how people in these kinds of circumstances are covered under the health care program? MRS. CLINTON: Well, Congressman, I hope we do, but let's take a look at it to make sure, because you raise some categories of people. And I would assume that you would trace the source of payment and consider that the employer, but there are some issues that I see imbedded in your question that we need to be very conscious of. So, if we could, let us look at those categories and make sure that my understanding of how it would be done is accurate and get you back something in writing for your consideration.

REP. SAWYER: Thank you.

REP. FORD: Mr. Gunderson.

REP. STEVE GUNDERSON (R-WI): Thank you, Mr. Chairman.

Mrs. Clinton, I think I've figured out a way to extend two minutes into a long Q&A period.

As you know, we in this committee have jurisdiction over the Department of Labor. And in the absence of the actual legislative vehicle, there seems to be a lack of detail on the role of the Department of Labor in implementing and policing the health care alliances. If I understand correctly from what I've read, they will have a role to regulate the -- define and regulate the operating standards of a health care alliance, the financial operations. They will be responsible for setting up a guaranteed insurance fund and the like.

If you could explain to us both what the role of the Department of Labor will be in regulating this health care delivery system and contrast that with HCFA or HHS in particular so we understand what our jurisdictional responsibility is and is not, that would be helpful. And if at some point in time, you would send to this committee some indication of what you see as the potential cost and creation of a regulatory system in DOL from a budget perspective, that would be helpful.

MRS. CLINTON: Well, Congressman, we hope that this division of responsibilities will be cost-effective because we're trying to build on what the Department of Labor has historically done. And let me just run through the list of responsibilities that we have assigned to the Department of Labor.

The first would be to ensure that all employers fulfilled the obligation to provide health coverage through a qualified health plan. In other words, making sure that employers are doing what they're supposed to do under an employer-based system. The only comparison we have is the state of Hawaii, which has, as you know, an employer-based system, and the Department of Labor there administers this compliance function with two people. I mean, it should not be, we don't believe, unless it just gets caught in the Washington bureaucracy monster, it should not be a major responsibility, but one that they will have oversight over.

In addition, there will be large employers who will want to form corporate alliances, their own self-insured alliances.

Just as with ERISA now, they will be submitting their plans to the secretary of labor, and the secretary of labor will review those plans. There will be a determination in the event of a merger or acquisition or bankruptcy as to how the health obligations would continue in a self-insured corporate alliance that will also be part of the secretary's responsibility in the event that those conditions were to pass.

If a corporate alliance does not have the fiduciary capacity to sustain itself, then that would be brought to the attention of the secretary of labor, again pretty much paralleling the kind of ERISA responsibilities that are currently delegated to the secretary of labor. And then there are specific duties under that, which we will enumerate for you, which will be in the legislation, but I'll be glad to have a letter sent up to you in order to

demonstrate the particulars under those two big areas of the employer-employee relationship and the corporate alliance that we think the secretary should carry out, and we'll do our best to give you our estimate about any additional costs that might be involved in that. We've asked the department to be costing that out for us.

REP. GUNDERSON: In the interest of my colleagues, if you would also follow up -- I'm unclear as to what the regulatory authority of DOL is regarding the operations of a health alliance versus what would be the traditional, should we say, state or local regulation of that health alliance. I've gotten mixed signals in those discussions and would like to understand that much better.

MRS. CLINTON: Just in general, the DOL obligation runs primarily to the corporate alliance, so the general health alliance which everyone else is using to purchase their insurance through will not have DOL involvement.

REP. FORD: Mr. Payne?

REP. DONALD PAYNE (D-NJ): Thank you very much.

Madam First Lady, let me also congratulate you on your commitment and the knowledge that you have shown in this very complicated task. Your efforts to the country are certainly appreciated.

Let me ask this question. After some research on the subject, I have found that managed competition rests on the concept of competing quality and service among health care providers, where they would compete for business based on the quality of care provided to patients. The concept operates under the assumption that there are many providers from which to choose. I realize that your proposal rests on the concept of competing plans; however, medically- underserved areas such as urban areas like Newark, where I live, do not have large numbers of physicians from which to choose. What incentives, then, will be extended to physicians to serve in medically-underserved settings like an urban area of Newark?

MRS. CLINTON: We intend, Congressman, to have incentives for both underserved urban and underserved rural areas because we agree with you that in the absence of providers, there cannot be any competition in order for the consumer to have choice and to get a better deal in the health insurance that he or she buys.

So we have looked at several things that we need to be doing. We need to have a concerted effort in providing motivation and incentives for people to go into underserved areas, and so to that end we tend to kind of resurrect and fund the National Health Service Corps, which provides young physicians the opportunity to pay back their loans or to have loan forgiveness if they are willing to spend time in cities such as Newark or others that are underserved.

Additionally, we want to provide linkage between the providers who are already there, and the clinics, and the hospitals that are there by labeling them what we call essential providers, which means that we know that they need to be there in order for people to be able to have access to health care. And as an essential provider, there would be some funds targeted to

help support those institutions in those areas.

Additionally, in underserved communities now, one of the biggest problems is the number of uninsured workers. In Newark or in any other urban area, people have income, but they do not have access to health insurance, which is priced out of their market, or they work for employers who do not help them by providing health insurance. Once everybody is insured and everybody is making a contribution, there will be financial incentives for more providers to offer services in underserved areas. Part of the reason they are underserved now is that that combination of Medicare and Medicaid, coupled with uncompensated care for the uninsured, makes it extremely difficult for all but the most mission-driven providers like religious hospitals and other community health centers -- for them to be able to sustain their practice in those areas.

So the combination of increasing the providers, providing essential community provider support, and getting some reimbursement to go into the system because everyone will be insured, we think will provide the kind of service that the people in your district deserve to have.

REP. FORD: Mrs. Unsoeld.

REP. UNSOELD: Thank you, Mr. Chairman. Thank you for all the work you've done, and thank you particularly for changing the role model of our future children's books because you certainly have done that, and my grandchildren are going to appreciate it.

I liked what you had to say about not wanting to discourage the states, and I come from Washington State, where we have a lot of similarities in the proposal. Three years ago -- two years ago, we urged states to improvise because we didn't think -- we didn't know we were going to have you around to help us do this, and how do we not wipe out what they have done, because I would hate to tell them that all of their endeavor and hard work was just wasted. For example, overlapping in tax -- cigarette t -- tobacco tax, the difference in threshold of what the self-insurer employer would be -- 5,000 or 7,000, and there are other things like that. How, practically, can we handle that?

MRS. CLINTON: Well, I think that with those states like yours and your neighbor, with Congresswoman Mink's state of Hawaii, that have made so many innovative reforms and moved forward without any national program -- we need to be very sensitive to that, and we need to look at those states and make sure that they do have real flexibility to continue doing what their legislators have voted for, and what on a bipartisan basis they have supported.

Everything in the plan the president has presented is in place somewhere in America, or has been passed in legislation somewhere in America. We know there is evidence this will work, and we get that from states and local communities and individual providers who have made those kinds of decisions. But we're going to have to look at it on a kind of a case-by-case basis, because we want to strike the right balance between having appropriate flexibility so that states can pursue what they think is best for them and

having the federal framework so that a guaranteed right to health security is absolutely an American citizens, whether he lives in Washington, or Arkansas, or Florida. So you'll have to work with us and help us, and certainly I know you will represent the concerns of the state of Washington so that we strike the right balance.

REP. UNSOELD: Because many of the states that have made progress have come to this committee for ARISA waivers, for example, this is the subcommittee and the committee. We hope you will make use of us.

MRS. CLINTON: Yes, we will.

REP. FORD: Mr. Armey.

REP. ARMEY: Thank you, Mr. Chairman. Mrs. Clinton, let me also express my appreciation to you for the work you've done and your willingness to come before this committee today, and tell you what a joy it is to see you here.

MRS. CLINTON: Thank you. REP. ARMEY: I listened to the chairman's opening statement, and while I don't share the chairman's joy on our holding hearings on a government-run health care system, I do share his intention to make the debate, the legislative process as exciting as possible.

MRS. CLINTON: I'm sure you will do that, Mr. Armey. (Laughs.)

REP. ARMEY: We'll do the best we can.

MRS. CLINTON: You and Dr. Kevorkian. (Laughter, applause.)

REP. ARMEY: I have been told about your charm and wit, and let me say -- (laughter) -- the reports on your charm are overstated and the reports on your wit are understated.

MRS. CLINTON: Thank you, thank you very much.

REP. ARMEY: (Laughing) -- let me turn to the compassionate side of my nature for a moment.

Let's imagine a typical American family. The husband has an internist he likes, the wife has her gynecologist with whom she is confident and comfortable, the children have a pediatrician they like. Is there any chance under your plan that this family would have to go to doctors other than the doctors they've known and relied on for years?

MRS. CLINTON: I hope not. I can't say that in every instance, in every family that it would not happen, but with the guarantees that we will build into this system, that for example, every region, every community has to have access to a fee-for-service network that every network that every doctor can join with the assurance that no provider of health care through any of these plans can any longer discriminate against doctors so that doctors will have the choice to be members of more than one plan.

We think it will be unlikely, but I cannot tell you that it would never happen.

But in this kind of plan that we're proposing, for most Americans they will have greater choice. And for those of us who are insured with doctors whom we like, we will be able at least, at the very least, to choose the fee-for-service network in which all of our doctors participate, if that's what our choice happens to be.

REP. ARMEY: Thank you.

MRS. CLINTON: Thank you.

REP. FORD: Ms. Mink.

REP. PATSY T. MINSK (D-HA): Thank you very much, Mr. Chairman.

I, too, want to add my words of commendation, Mrs. Clinton, for your total grasp of this very complicated issue. And I know that members of Congress are going to deal with not only the broad issues that you've raised, but also the nitty-gritty. And some of those are somewhat troubling, and I asked a couple of questions the other day having to do with the part-time.

I do have a nanny problem. How are you going to provide in this plan for the part-time workers, assuming that initially they feel they can make their contribution and survive with the matching that the government will provide so that they could have the same premium benefits that everybody else in America would enjoy? But somewhere along the line there might be some difficulties that are unexpected in

a family such as a single mother with two or three children. What mechanisms would be put in place to protect such a person so that along the way the concept of universality is never lost and that this individual riding up and down the roller coaster of life will always have the comfort of knowing that there will be a health plan there available for her family, notwithstanding her inability to come up with her premium matches?

MRS. CLINTON: Well, congresswoman, in the kind of part-time work category that you're describing, we know people go in and out of work, they work different numbers of hours, different weeks of the year. Sometimes they don't work at all. And this is a particularly important group of people to try to cover because temporary, part-time work is one of the fastest-growing parts of our economy in large measure because employers who even insure prefer to get employees at a level below what the insurance requirement would be so that they don't have to provide those benefits.

And it causes a lot of uninsured, uncompensated care for the individuals and for society. If an individual works at any time during the year, there will be a contribution which that individual and the employer make that will be minimal because they will be largely low-wage employees, and the discounts and the caps as to the contributions will apply. If that person during the year no longer is working, then they will be subsidized out of the federal government pool because we want to have a true safety net. Right now the only safety net is to fall into welfare. We are going to take the Medicaid program and integrate it into the health care program so that there will be a seamless process by which people will come in and out of employment, they will not have to go into different programs, they will continue to be covered.

The insurance premium will be paid in the first instance by the employer-employee contribution, the second instance by the federal government making that contribution on behalf of the individual if that individual is unemployed. So we think we have covered the entire work cycle as people go in

and out of it.

If a person is an independent contractor and therefore they will be responsible as a self-employed individual, they will make their small contribution; the rest of the subsidy will be provided by the federal government. The portion that the individual has to pay will be tax deductible because it is going to be treated as though they were a small business. So we think we've taken care of all the different kinds of employment situations and nobody will lose their coverage at any point during the year. They will be continually covered.

REP. MINK: So if an individual under those circumstances is unable to make the matching premium, no matter how low it is, what will be the mechanism for collecting those unpaid premiums that that individual or family should have paid if they could have?

MRS. CLINTON: Well, there will be a collection mechanism so that when they start to work again, they will make those contributions, so that it will be collected eventually, but the care will not be denied and the coverage will not be denied in the meantime.

REP. MINK: I appreciate very much the reference to Hawaii because I do feel we have a premium plan in Hawaii, but one of our most difficult areas has been how to cover this part-time segment of our society, so we continue to have a 3, 4, 5 percent. Although we have tried to be comprehensive, this area has been elusive. And so I think that in looking at our plan, we have to find some way to make sure that these individuals are covered. We have a gap program now to try to cover these individuals in Hawaii, but we're not offering them the same program that everybody else has.

Now, in trying to accommodate coverage for a state like Hawaii into this comprehensive plan, are we going to be allowed under this plan to retain these provisions that we've worked out over the last 17 or 18 years?

Because we're not in this 80-20 percent. We have a cap on the amount of money than an employee can be required to pay, and that cap is very low. It's 1-1/2 percent of the payroll. And as a consequence, if we move into the requirement as one of the bases of a waiver, then for a large percentage of our population, their contributions will have to increase.

So it is a concern that people are raising and hoping that there will be a mechanism for Hawaii to opt out and still havthe basic requirements adhered to so that universality can be accomplished.

MRS. CLINTON: And we will be sensitive to that.

REP. MINK: Thank you.

REP. FORD: Let me remind the members that we're running very tight on being able to accommodate everybody here. And I don't want to be impolite to anyone, but I'm going to start banging this thing when the light turns to red after this.

Mr. Andrews?

REP. ROBERT ANDREWS (D-NJ): Thank you very much, Mr. Chairman.

Mrs. Clinton, thank you for the effort you put forward on this and for coming to this committee so many times. We appreciate it.

I had a woman in my office yesterday who lost her job as a bank teller in 1992. She is unemployed. Her husband works for a small business that does not offer health insurance. So the family is uninsured. She's looking for work and hopefully will find it in the next couple of months. I wonder if you could tell me under the proposed plan what would have happened to that family had the plan been in place and what will happen to them if she succeeds in finding
a job in the next couple of months.

MRS. CLINTON: Congressman, because she and her husband had both been employed, they would have each made a contribution. If they had children, one of them would have made a slightly bigger contribution to take care of the children. And each of their employers would have made a contribution, and depending upon the size and financial ability of the employer, they would have made a contribution that was appropriate to them. That would have covered them for the entire year. Then, even though she lost her job in this year, they would still have remained covered. There would have been no interruption in their coverage whatsoever.

Now, the following year, if she is still unemployed, then they have two choices. The husband can insure the entire family, which includes his wife. They can claim that she is unemployed and, although he is employed, he's going to cover himself and the children, and as an unemployed worker, she can get some help for her insurance. When she becomes employed, then she goes back into the employee pool. But the coverage never stops. It always continues for them.

REP. ANDREWS: Would the coverage be offered by the same provider? Let's say that she had signed up for an HMO in her region. Would that provider continue to provide her coverage even though she was separated from employment?

MRS. CLINTON: Yes, sir.

REP. ANDREWS: How often will the re-enrollment periods be? Once a year?

MRS. CLINTON: Yes, annually.

REP. ANDREWS: Thank you very much.

MRS. CLINTON: Thank you.

REP. FORD: Mr. Fawell?

REP. HARRIS FAWELL (R-IL): Thank you. After seeing how you impaled my comrade in arms here -- (laughter) --

MRS. CLINTON: I just couldn't resist after his most recent comment.
I apologize. I couldn't resist.

REP. FAWELL: Well, I shall proceed most cautiously, with great respect. (Laughter.)

MRS. CLINTON: Nobody's quoted you saying anything to me, Mr. Fawell, so --

REP. FAWELL: Well, that's fine. (Laughter.) That's good. (Laughter.) A key to your plan is based on the assumption of savings, an

assumption which Senator Moynihan at least had some trouble with and used the word "fantasy." In turn, a key to the envisioned savings is price controls upon both the private and public sector of health care. But in 40 centuries, and as recently as 1971, '73, price controls have not worked either in terms of controlling prices or in terms of quality and/or rationing of that which is subject to price controls. What makes you think price controls will work this time?

MRS. CLINTON: Congressman, I don't think price controls will work this time, and we want to move away from what is in the current system in both the public and the private sectors, where individual procedures are given a price. That's what happens now in Medicare and Medicaid. It's what happens now in many of the private insurance plans.

We do believe there needs to be some kind of a budget in both the public and the private sectors. And what we think would be the appropriate way for the private sector to function is for them to reorganize themselves. We believe there are great savings in the private sector if health care is delivered more efficiently and that as those savings are realized, they will compound, because other providers will see how efficiently care is being provided. And there are many examples of that around the nation.

But in the event that it does not move as expeditiously as it should once a market is actually in place, we think there needs to be a budget that would have some way of trying to keep premium increases in line with what would be the rate of inflation, plus population growth. We do not anticipate that budget ever being enforced in most instances. We see it as a backup. But we want to get away from the micromanagement, price control, individual procedure approach that has not worked and move toward a per capita system in which the decisions are made by the individuals who should make them, the doctors and the hospital administrators and those people. And we think that will work better.

But I know there is some disagreement about even having a premium cap as a fallback backstop. We just think it would be a good budget discipline to stand behind the competitive forces.

REP. FAWELL: Thank you.

REP. : Thank you.

Mr. Reed.

REP. JACK REED (D-RI): Thank you, Mr. Chairman.

Mrs. Clinton, I want to thank you -- thank you very much, Mrs. Clinton, for joining us today, and I want to also commend you for your extraordinary efforts. You talked about integrating the worker's compensation system into health care reform, and I feel this is a great opportunity to address a very serious problem for small businesses. Could you elaborate on your thoughts on how the integration will take place, but particularly with attention to the benefits that will accrue to small business because of this?

MRS. CLINTON: Yes. As you well know, worker's comp benefit prices have gone up even faster than health care in most states. And what we intend to do is to take the health care portion of worker's comp and integrate it

into the universal health care system. And so, that when small businesses come to pay for their contribution to their employees' health care, they would be having the opportunity to combine a part of their worker's comp benefits so that they wouldn't be paying duplicate, that the employee would be receiving health care benefits in their health plan, and it would be funded by the contributions from the employer and the employee.

We also would like to see the entire worker's compensation system changed and integrated into either an unemployment maintenance system or a health and rehabilitation/lost wages system. And we intend to set up a commission to look at all the states and to work toward doing that. But in the short run, we want to take those worker's comp health care benefits and remove them as an extra burden on business and have them become part of what the employer pays for when they pay for health care.

REP. REED: So that when we're talking about what small business might have to pay to be part of the health care system, there'd be a compensating savings from any business with respect to workers compensation costs?

MRS. CLINTON: Yes, sir.

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

REP. FORD: Mr. Roemer?

REP. TIM ROEMER (D-IN): Welcome, Mrs. Clinton. And six months ago,
I certainly admire the commitment and concern you brought to this issue, and now greatly admire the knowledge and expertise and energy that you bring to this issue, and we look forward on this committee to working closely with you.

There's the old saying that an ounce of prevention is worth a pound of cure, and we're hopeful that this plan will bring an ounce of prevention and a pound of cure to a very much ailing and broken health care system in this country. And one of my concerns with this health care system is how it affects our children and how it affects future generations. And I know you, too, share that concern with your work on the Children's Defense Fund.

Could you share with the committee how we will address problems for our children, where we currently rank 19th in infant mortality, and how this plan will put more emphasis on primary care check-ups for our children and immunizations and inoculations; and how we can encourage more frequent visits for primary care for those children and how we can get them accessed to our community health care clinics, particularly in inner city areas.

MRS. CLINTON: Mr. Roemer, thank you for your concern about children's health . And I well remember our visit together where we met all of those children at the community center. And --

REP. ROEMER: Mrs. Clinton, I hope you don't have to buy Ninja Popsicles for the whole country if you talk about this --

MRS. CLINTON: Well I was grateful, though, to at least try one! (Laughter.) And I thank you for that. . Under the guaranteed benefits

package, the kind of preventive services that you and I want for all children will be available: prenatal care, immunizations, well-child care -- and it will become the standard so that everyone will have the obligation and the responsibility, because they will now have the insurance coverage, to be sure their children do get those kinds of preventive services. In addition, we will make primary care more available. We hope to increase the number of primary care physicians who are available in all regions of our country.

The American Academy of Pediatrics has endorsed the president's plan because of the emphasis on children and preventive care for children. And I just have to believe that if we finally get every child into the system, if we make sure that prevention is emphasized, that we will see these statistics that I think are embarrassing and shameful for our country begin to decline, as they should. And we anticipate that happening and will look forward to working with you to make sure it does.

REP. ROEMER: Thank you very much.

MRS. CLINTON: Thank you.

REP. ROEMER: Nice to see you again.

REP. FORD: Mr. Engel.

REP. ELIOT L. ENGEL (D-NY): Thank you, Mr. Chairman.

Mrs. Clinton, you certainly have our accolades and our gratitude for the work that you've done. I was so happy to hear the president mention about expansion of senior citizen programs, particularly prescription drug programs and long-term care and in-home care. We know that those are things that seniors across the country really look for. I'm wondering if you could comment on some of those expansions.

And also, New York has less of a percentage of uninsured than most other states because we provide very generous benefits to many of our people in need. There is a concern that there might be a lessening of health coverage. For instance, mental health coverage is provided to many Medicaid patients, and in the new plan there seems to be less of a coverage than New York currently gives. Can you also allay some of our fears that as a result of the quality of care that New York has been providing that we will not have a lessening of care? And also with the maintenance of effort requirements in the health plan, that states like New York don't lose care and at the same time wind up subsidizing other states as well.

MRS. CLINTON: Congressman, I will get you answers on the last two that are specific to New York, and in the time I have let talk about prescription drugs and long-term care, because you are right. Those are the two concerns we hear most from older Americans because they are the two biggest gaps that older Americans face with our existing EMedicareF program. The kinds of prescription drug benefits that older Americans need will enable them to meet their medication needs in a much more cost effective manner than they now can. We think that's good not only for the individual, but also for society because too often older Americans are self-medicating, are choosing between prescription drugs and food at the end of the week or the end of the

month, are seeing their life savings eaten up by very high drug prices. And so if we can provide the kind of prescription drug benefit that the president has proposed we will not only meet a great need, we think we will save money because 23 percent of the hospital admissions for older Americans in many parts of our country are due to conflicting drugs or inadequately ingested drugs or from the kind of decisions older Americans make where the little pill bottle says "Take four times a day" and they say "Well, if I take one time a day it'll last four times as long," and it doesn't work, so they end up back in the hospital. It's those kinds of decisions we think are costly that having a good, solid, affordable prescription drug benefit will help us control.

And in addition, the long-term care piece is so important because right now there is not adequate support for home-based and community- based care, and we need to provide that. It's the right thing to do, it preserves individual and family dignity, and it saves money if it's done.

REP. ENGEL: Thank you very much.

REP. : Mr. Scott.

REP. ROBERT C. SCOTT (D-VA): Thank you.

Mrs. Clinton, I want to congratulate you again, as you've been congratulate before, for your hard work. It's already been mentioned, your work on the Children's Defense Fund and also has not been mentioned, your work on the Southern Regional Task Force on Infant Mortality.

So the work on prevention and the work on health care is not new.

I want to congratulate you on your plan. It provides not only the preventive care and the mental health but also universal access. I applaud you on the funding mechanism. It appears fair except for the regressive tobacco tax. Subsidies to alleviate the hardships of small businesses and low-income workers. One thing that I think is important for the low-income workers is that we not saddle the employers with a mandate that will cause job losses, and you've been sensitive to that. And also, the disincentive in our present system for people getting off welfare. You say that people move onto welfare. Those already on welfare can't move off because they don't have the health benefits.

So, without asking a question, because obviously I have to run and catch up with my colleagues to cast a vote, I would just like to point out the sensitivity that I have for the low-income worker and also point out my concern that they keep their card, however it's paid, they'll keep their insurance.

MRS. CLINTON: Yes, sir.

REP. FORD: And I think that's been worked out. And whether the subsidies will be for the 20 percent or the 80 percent, and how the subsidies actually work. But I think the point that you've already taken care of is, however that complication works, the person will have coverage throughout their life, coverage that cannot be taken away.

MRS. CLINTON: That's right. And Congressman, I want to thank you for bringing up the welfare (lock ?) program. We think there are somewhere

between 500,000 and 600,000 Americans who we could move from welfare to work but for the fact that they are dependent upon their medical benefits that they would lose if they were to move off of welfare, and that is a terrible indictment of our welfare system.

Thank you.

REP. : Mr. Ballenger?

REP. CASS BALLENGER (R-NC): Thank you.

Mrs. Clinton, happy to be with you. And sadly, we're going to have four straight five-minute votes in just a second, so let me quickly say that I'm a small business owner down in North Carolina, I have 200 employees, and because of the problems we had with health insurance, we got together with 32 other small businesses in western North Carolina and formed a self-funded association. And our insurance costs have gone down for the last two years because we are just being better run than we were before.

But let me ask you a question. My understanding is that employers having fewer than 5,000 full-time employees are forced to give up their current self-funded plans and contribute instead to a regional health alliance. Under what circumstances would employers who are currently covered under a self-funded association plan that operates in several states or nationwide be able to continue their coverage by electing their former plan? Is such a thing possible?

MRS. CLINTON: Congressman, that's a good question, and several members have asked us that in the last few weeks as the plan has been circulated, and we will take a hard look at that as to whether or not an association with 5,000 members could be equivalent to a corporate alliance and try to draw some parity there.

Of course, we're concerned about a couple of things that we'll have to try to work out the details about. One is that we don't permit any return to the kind of experience rating that used to work against you as a small business owner, that we don't in any way discriminate against any group of either employers or employees, either inside or outside of the alliance, and that any who are self- insured under any circumstance have to provide the same kind of benefits as would be available inside the alliance.

But we will take a look at that and see whether there is some equivalence there that we could draw. Of course, I think that what you've found by moving into that larger group is exactly what we think will be found for all small businesses when they move into a larger group. They will exactly see what you have seen, only I would anticipate even greater savings because of the larger economies of scale that will come to even the larger pools. But we will get you an answer specifically about your inquiry.

REP. BALLENGER: The one difference I see is the fact that we run the alliance and in the new system it appears that the alliance will run us.

MRS. CLINTON: Well, the alliance will be governed by a board that consists half of employers -- employer representatives and half of consumers, who will be, by and large, employees or other citizens of the area, so we've tried to structure it so that it will have the best features of exactly the

kind of approach that you have found successful. And we're continuing to look at that to make sure that it does have those features because we don't want it to run you. We want the employers and consumers who are paying the bills to run it. That's the whole change we're trying to bring about, so instead of having insurance companies or government bureaucrats dictate what the conditions are, it will come from the grass roots up for everybody.

REP. BALLENGER: Thank you, ma'am.

REP. : Mr. Becerra.

REP. BECERRA: Mrs. Clinton, thank you very much for being with us, and I, too, applaud all of the efforts that you have made, and of course, the president as well.

If I could follow up on something that the gentlewoman from New Jersey raised with regard to the immigrant women, I hope we don't lose sight of the fact that whether or not it's an immigrant women who is costing us $500,000 to $1 million for that particular heart transplant or heart surgery, if it's a middle-class person, an immigrant, wealthy or poor person, no one will ever pay the $500,000 to $1 million health bill through his or her own pocket. We will all end up paying for that particular procedure, and I think that's important to note.

Further, as -- more in terms of the issue of the immigrant, it seems to me that the question is not so much will we have to pay more for someone else, but how is it that all of us who reside in this country will contribute our fair share to pay for the health care which we will all at some point need -- as we all say from cradle to grave -- and it seems to me we have to find a way to provide money to the pot.

But I'm a bit concerned that because we're talking in terms of citizens and those who are lawfully here that we neglect those who are here without documentation, and oftentimes, they are the people that put the food on our table, that sew the clothes that we wear, take care of the children that we have, yet when it comes to their health care we often find that they may not be covered. I just wondered if you could comment on that.

MRS. CLINTON: You are right, Congressman. We do have a distinction in this plan. The guaranteed health benefits and the health security card will be available to American citizens and legal residents. They will not be available to undocumented workers and illegal aliens .

Now we know that we will continue to have large numbers of such workers in our country, and we know that they will need medical care, so we will continue to provide funding to support emergency care and public health kinds of services that are required.

But we've tried very hard to deal with the legitimate concerns of many, in many communities our country, that they do not believe we should do anything that might encourage any more illegal immigration, that we need to take care of, first and foremost, our citizens and legal residents who are here struggling and deserve to have health care and may often themselves be uninsured or not taken care of. And that's the approach that we've taken in this proposal. But we still provide emergency care and public health care to

anyone who's in the country who needs it.

REP. : Mr. Green?

REP. GENE GREEN (D-TX): Thank you, Madam Chairman.

Mrs. Clinton, it's great to have you here, and after Pat Williams said about he's glad that the president chose you as his spouse, after almost 24 years, my wife has convinced me that she chose me as her spouse and it wasn't the other way around.

Let me ask a question, though, on how this relates, since we are the Education and Labor Committee and I'm on Labor Management, so we'll do this, but I also spend a lot of time on the education side of it. The administration has proposed as part of the elementary- secondary re-authorization that we use -- the schools also provide health care screenings for children. And I was wondering if the security health plan would provide that, or would we have to also dip in our education funds that we're struggling to use. And I would hope it would be an umbrella plan when we talk about it. Health care includes, you know, obviously screenings and preventive care that I know you've talked about on a great deal of -- a great many occasions.

MRS. CLINTON: You know, I'm afraid I'm not familiar with what the provisions in the education bill currently are with respect to that, but I'll be happy to look into that. And we do, in the health care reform, propose some public health outreach kinds of initiatives, including bringing services to schools where we think that students may be more easily accessed. But I'll have to give you a specific answer about the relationship with the education bill, Congressman. I just don't know the answer to that.

REP. GREEN: Okay. Thank you.

Thank you, Madam Chairman. REP. : Mr. Barrett?

REP. BILL BARRETT (R-NE): Thank you, Madam Chair.

I, too, Mrs. Clinton, like the previous speakers, thank you for your sharing of your time and your talent before this full committee. I guess, like Mr. Murphy -- his question triggered, in my thinking -- I come from a very large rural district, where the small hospitals are closing and the doctors are caught with the bureaucratic Medicare/Medicaid and going to greener pastures in the urban areas and so forth. But I also have another unique problem in that my district is elderly, percentage-wise very elderly. And I guess the question is simply this: What happens in your plan if the insurance companies elect not to bid for the alliance's business? In other words, why would companies want to if they had to take everyone? Has that been a concern for you and your task force?

MRS. CLINTON: Yes, Congressman, and we are particularly concerned about rural areas where there are not sufficient providers now. But in looking at what has proven successful in providing rural health care delivery, we think we have built in a number of those features, starting with providing an adequate funding base in your district now. Because what is often found in rural areas is not only a heavier-than-usual Medicare load, but a heavier-than-usual uninsured population. Oftentimes, agricultural areas

and small towns and small businesses don't have any insurance base in the existing market, because they have been priced out of it.

So we do believe there will be some new resources coming in.

We also want to begin to provide a better reimbursement rate for rural areas. We think the differential between urban and rural areas under Medicare has been too great. We think there needs to be some better relationship there and more reimbursement going into our rural areas.

We also want to identify rural hospitals and clinics as essential community providers, which means they will receive funding because we know they have to be there. So they will be targetted for these additional funds. And we have some work force recommendations so that it will be more attractive for physicians and nurses and others to go into rural areas because they will get their education loans paid back or their loans will be forgiven. And then, with some technological developments, we think care can be delivered efficiently in rural areas from even urban centers.

All of those things, we believe, will help your district, and we'd be glad to provide additional information to you about them.

REP. BARRETT: Thank you. And I appreciate that. As a matter of fact, my time has expired. I do have a series of questions similar and I'd like permission to submit them for your written response.

MRS. CLINTON: Yes, please.

REP. FORD: Mrs. Clinton, there are a number of members who have made a similar request. And if you'll submit them to the chair we'll send them over, and then the answers will be contemporaneous with your time on the record.

REP. BARRETT: Thank you, Mr. Chairman.

REP. FORD: Ms. Woolsey.

REP. LYNN WOOLSEY (D-CA): Mrs. Clinton, I want to congratulate you. You're providing our country with the basis of such an in-depth, meaningful debate on the most important issue that we have before us: health care reform. And I really am certain that we'll come out with the best plan in the world when we're finished, but we have to be willing to work as hard as you've worked up until this point and work together. And with that, we'll do it. One area that is of particular concern to me is women's reproductive health services, including abortion . And with the co- mingling of federal funds with this health alliances or to the health alliances through subsidies to employers and consumers, how can we guarantee that women's health services -- including abortion -- are provided at the level currently provided through private plans?

MRS. CLINTON: Well, congresswoman, what we have tried to do is to strike just that balance. We don't want to add to or subtract from the rights for services that are currently available. And in most instances where there is insurance coverage, pregnancy-related services has been deemed to include abortion where that is appropriate between a physician and a patient.

We anticipate plans that will continue, with the understanding that there are permitted conscience exemptions for providers who do not

choose to participate.

In addition, we believe that our preventive services, including family planning, will be very important in reducing the need for abortions. So we're trying to strike the balance between pretty much providing what is available now for individuals, plus increasing the amount of preventive services to try to diminish the number of necessary abortions.

REP. WOOLSEY: Thank you.

REP. FORD: Mr. Romero-Barcelo.

DEL. CARLOS ROMERO-BARCELO (D-PR): Thank you, Mr. Chairman.

Mrs. Clinton, not only Congress but I think the whole country is proud of the fact that -- the way you have immersed yourself in this subject and the grasp that you have of this subject. And I myself would like to thank you very much for what you have done, and I'm sure that you must feel very, very proud and pleased that after almost nine months of strenuous work and dedication a national health care reform proposal that will bring spiraling health costs under control and provide all American families with the peace of mind and the security they deserve has been developed under your guidance.

Until now, American citizens in the territories have been treated as sharecroppers not as equal partners in the nation since the beginning of the Medicaid program. Now, for the first time in the history of this nation, all Americans, including those in the territories, will have access to quality, affordable health care, not as a privilege, but as a right.

As you well know, throughout this whole process I worked very, very hard to make sure that the American citizens living Puerto Rico and the other territories will be treated equally with their fellow citizens in the 50 states. Today I am particularly pleased to say that all of them, including those in Puerto Rico and the other territories, have for the first time been included in a national health care program as full and equal partners.

In a nation as large and diverse as ours, any proposal to solve a complex problem such as this, no matter how good it is, is always going to be criticized by at least a few. Some of my colleagues may not like this plan, either for partisan reasons or for personal reasons or simply because they're afraid of change. And to all of them
I say that we should in all fairness acknowledge that the president and Mrs. Clinton have done an outstanding job in presenting a very well thought-out and balanced health care reform proposal. They're presenting a plan that addresses all the tough issues. The least this proposal deserves is serious and constructive thought.

And once again, Mrs. Clinton, I want to thank you for the great compassion and the concern that throughout this process you have shown for the urgent health care needs of the nation's middle class, workers and disadvantaged. And I want to thank you and the president on behalf of all of the people of Puerto Rico who will be forever grateful to you and the president.

Thank you.

MRS. CLINTON: Thank you very much.

REP. FORD: Mr. de Lugo?

DEL. RON DE LUGO (D-Virgin Islands): Thank you very much, Mr. Chairman.

Mrs. Clinton, I want to thank you very much for the help you gave us in getting into the -- this health care plan. This is the most social legislation of our lifetime, and for the first time when a president of the United States says "all Americans" it will include all Americans. I want to thank you again that you put all of us in the territories in the plan -- 4-1/2 million of us. It's going to mean a lot to us.

I wondered, has thought been given to possible technical assistance as we try to come into this plan?

MRS. CLINTON: Yes. And I appreciate your comments as well, because we mean what we say when say American citizen, and Americans should be treated the same no matter where they are. But we also recognize that there may need to be some technical assistance provided in order to ensure that what this legislation will ultimately contain can actually be delivered effectively. And we will provide that as well.

DEL. DE LUGO: Thank you.

REP. FORD: Mr. Faleomavaega?

DEL ENI F.H. FALEOMAVAEGA (D-American Samoa): Thank you, Mr. Chairman.

I suppose for want of a better term, Madam First Lady, I would like to also echo the sentiments that have been expressed by my colleagues, again extending our appreciation for the dynamic leadership that you've demonstrated in providing for our nation's health care needs. It may well be said that the soul and the spirit of our nation's health care system will be attributed highly to your leadership, Madam First Lady, and I want to commend you for that.

I think our previous colleague from the territory of Guam, a retired Marine general, said a very sentimental statement to me the other day. He said, "We are equal in war for those of us from the territories, but not in peace." And all we're suggesting here is perhaps not to forget the 4-1/2 million citizens who die in our -- in the wars that we fought and make sure that they are also provided for.

The problem that I'm faced with, and it troubles me sometimes, too -- you know, those of us -- I'm sure the president, the politicians here in the Congress, our state governors -- when something happens to you, you get first-class treatment. Recently, our governor had to be medevaced from Samoa to the state of Hawaii, which is about 2,500 miles distance. How do we provide for a system where the average American cannot afford this kind of a first-class treatment given to those of us supposedly because of the capacities that we serve as public servants? How can we provide a sense of equity for those who simply do not have that luxury? Can you help me with that?

MRS. CLINTON: Well, I think we have to start by making sure everybody has access to comprehensive health care benefits, and then we have

to determine what additional steps might be needed in order to make those benefits real to provide access. I don't know that we will ever have a system, however, in which every citizen on Samoa will be airlifted to Hawaii. I don't know that that would be at all within the realm of the possible. But what you are describing in terms of inaccessibility to certain levels of care is not unique, as you know, to the territories. We have problems like that in many of our Western states, particularly in Alaska. We have problems like that in many of our underserved urban states, where maybe the best medical center in the world is only five miles away, but it might as well be 5,000 miles away.

So what we have to do is start by getting universal coverage, getting a guaranteed set of benefits that is represented by that health security card, and then working to make sure technologically and other ways we get whatever benefits we possibly can delivered in the most cost effective, highest quality way to thereatest number of Americans.

DEL. FALEOMAVAEGA: Our president commented in his statement before the Congress that somebody -- we have to pay for this system. It's somewhat of a sad commentary in our nation -- here in our nation's capital we have people sleeping on the streets. Does the system provide for their needs -- the homeless, the poor, those who really are not able to get on their feet in some way or form simply because of unskilled work capacity? I mean, can we address their needs as well in this system?

MRS. CLINTON: We intend to address the needs of every American. There will obviously be those who fall through the cracks of whatever system we design, and we will just have to continue making sure that there is constant outreach and that their needs are met. But I think it is a good beginning to make sure everybody -- the currently insured and the uninsured -- never have to worry about ever losing their insurance coverage again. And then we'll be able to concentrate on those individuals and those regions of our country and territories where delivery of care is a problem. But we have to start by getting everybody in the system and doing the very best job we can to design it so that it provides high quality care to everyone at an affordable price.

DEL. FALEOMAVAEGA: Thank you, Madame First Lady.

Thank you, Mr. Chairman.

REP. FORD: Thank you very much, and thanks to the cooperation of the committee we did it. (Laughter.) This is not a committee that is disciplined well enough to get anything done that fast.

Mrs. Clinton, I kept my question to very last to make sure that I didn't take somebody else's time. And you and I have talked about this, and I've talked to your task force about it.

You've been to my district several times. You know that most of my constituents, notwithstanding the great universities I have there, are blue-collar workers in an industry where just the beginning of last week they announced another 75,000 jobs would be gone in the next couple of years.

When I hear about that, what instantly goes through my

constituents' mind is that the person who is working for General Motors had fully paid health insurance, and now that family is not going to have health insurance. And most of my people who lose the jobs, as they've been losing them for several years now in the downsizing of the auto industry, have right at the center of their concern that they're losing a job with an employer who's been providing as a result of collective bargaining health benefits for them. And they're not likely to get a job that either pays as much or gives them access, not even the ability to buy into a decent pool. Would you tell them now -- and I'll repeat it over and over -- whether or not the president's plan is intended to make sure that that kind of person doesn't get left out and they can quit worrying about their health insurance going with their job?

MRS. CLINTON: Mr. Chairman, that's exactly what this plan is intended to do.

This is not a plan just to make sure the uninsured are insured. This is a plan to make sure that the very well-insured, no matter what happens to them, whether they have a job or they don't have a job, will always, always have health security. And you can go home and tell all those wonderful people that I have met in your district that this plan is what will guarantee them the kind of health care coverage that they've always been able to take for granted because they had an agreement that enabled them to count on health care benefits. This will enable them, no matter whether they are still working a year from today or not, to have a guaranteed set of benefits that is a good set of benefits that will take care of them and their families.

REP. FORD: I thank you very much. That's a better message for me to take home than all the pork I could get in an appropriation bill around here. (Laughter.)

Pat, would you like to close it off now?

REP. PAT WILLIAMS (D-MT): Just to again, on behalf of the members of my committee and perhaps the full committee, thank you for the generosity in your time. And we look forward to continue working with you. We understand that the full committee and my subcommittee have significant jurisdiction because of the employer-employee mandates. We know that's the heart of your program, and we're hopeful, with continued good access to you and to those who have worked with you, and we want to assure you that you have the same kind of access to both of the chairs as well as our members.

MRS. CLINTON: Thank you very much.

REP. FORD: I almost forgot something. Our member, Karen English of Arizona, is ill today and extremely frustrated that she can't be here. She would like to submit a couple of questions and will do it in the same way that I referred to the gentleman from Nebraska. I know that Karen would be devastated that she couldn't be here to meet with you. You have met with her before and talked with her. You know she's a very valuable member of this committee.

Let me thank you for this committee and the whole Congress. You

know, I know what was going through their minds in the other committees. You made me proud to be a part, proud to be a part of our national government with your performance here and what you've been doing in front of the other committees. I think there's going to be an awful lot of young people who are going to aspire to be like you. And that will be good for this country. Thank you very much for your help to us.

MRS. CLINTON: Thank you, Mr. Chairman.

- END -

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United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

Argued April 30, 1993 Decided June 22, 1993

No. 93–5086

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC., ET AL.,
APPELLEES

v.

HILLARY RODHAM CLINTON, ET AL.,
APPELLANTS

No. 93–5092

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC., ET AL.,
APPELLANTS

v.

HILLARY RODHAM CLINTON, ET AL.,
APPELLEES

Bills of costs must be filed within 14 days after entry of judgment. The court looks with disfavor upon motions to file bills of costs out of time.

Appeals from the United States District Court
for the District of Columbia
(93cv0399)

Mark B. Stern, Attorney, U.S. Department of Justice, argued the cause for appellants/cross-appellees Hillary Rodham Clinton, et al. With him on the briefs were *J. Ramsey Johnson*, United States Attorney, *Stuart E. Schiffer*, Acting Assistant Attorney General, *Robert E. Kopp*, *Patricia A. Millett*, and *Malcolm L. Stewart*, Attorneys, U.S. Department of Justice. *Stuart M. Gerson*, Attorney, U.S. Department of Justice, entered an appearance for appellants/cross-appellees.

Kent Masterson Brown argued the cause for appellees/cross-appellants Association of American Physicians and Surgeons, Inc., et al. With him on the briefs were *Frank M. Northam* and *Alan P. Dye*.

Steven R. Ross, General Counsel, and *Charles Tiefer*, Deputy General Counsel, Office of General Counsel, United States House of Representatives, filed the brief for *amicus curiae* Speaker and Bipartisan Leadership Group.

Ronald A. Zumbrun, *Anthony T. Caso*, and *Robin L. Rivett* filed the brief for *amici curiae* Pacific Legal Foundation and the National Taxpayers Union.

Jane E. Kirtley, *J. Laurent Scharff*, *James E. Grossberg*, *Richard M. Schmidt, Jr.*, *Allan R. Adler*, *Bruce W. Sanford*, *Henry S. Hoberman*, and *Whitney M. Adams* filed the brief for *amici curiae* Reporters Committee for Freedom of the Press, et al.

Joseph Gregory Sidak filed the brief for *amicus curiae* J. Gregory Sidak.

Samuel B. Wallace, IV, filed the brief for *amicus curiae* Samuel B. Wallace, IV.

Before: SILBERMAN, BUCKLEY, and WILLIAMS, *Circuit Judges.*

Opinion for the Court filed by *Circuit Judge* SILBERMAN.

Opinion concurring in the judgment filed by *Circuit Judge* BUCKLEY.

SILBERMAN, *Circuit Judge:* This expedited appeal presents the question whether the President's Task Force on National Health Care Reform ("Task Force") and its working group are advisory committees for purposes of the Federal Advisory Committee Act ("FACA"). If they are, we are asked to decide whether FACA unconstitutionally encroaches on the President's Article II executive powers. We hold that the Task Force is not an advisory group subject to FACA, but remand to the district court for further proceedings to determine the status of the working group.

I.

On January 25, 1993, President Clinton established the President's Task Force on National Health Care Reform. The President named his wife, Hillary Rodham Clinton, as the chairman of the Task Force, and appointed as its other members the Secretaries of the Treasury, Defense, Veterans Affairs, Health and Human Services, Labor, and Commerce Departments, the Director of the Office of Management and Budget, the chairman of the Council of Economic Advisers, and three White House advisers. President Clinton charged this body with the task of "listen[ing] to all parties" and then "prepar[ing] health care reform legislation to be submitted to Congress within 100 days of our taking office." 29 WEEKLY COMP. PRES. DOC. 96 (Feb. 1, 1993).

On the same day, the President also announced the formation of an interdepartmental working group. According to the government, the working group was responsible for gathering information and developing various options on health care reform. It was composed of three types of members: (i) approximately 300 permanent federal government employees drawn from the Executive Office of the President, the federal

agencies, and Congress; (ii) about 40 "special government employees" hired by the agencies and the Executive Office of the President for a limited duration; and (iii) an unknown number of "consultants" who, it is asserted, "attend working group meetings on an intermittent basis." Ira Magaziner, the senior adviser to the President for Policy Development, headed the working group and was the only member of the Task Force who attended the group's meetings.

According to the government, the working group had no contact with the President. In addition to gathering information, the working group developed alternative health care policies for use by the Task Force. But only the Task Force, it was contemplated, would directly advise and present recommendations to the President. On March 29, 1993, the Task Force held one public hearing where interested parties could present comments on health care reform. *See* 58 Fed. Reg. 16,264 (1993). However, the Task Force met behind closed doors at least 20 times in April and May to "formulate" and "deliberate" on its advice to the President. As the government publicly has announced, in those meetings "the Task Force reviewed materials it received from the interdepartmental working group; formulated proposals and options for health care reform; and presented those proposals and options to the President." Statement of the White House Press Secretary (June 4, 1993). In accordance with its charter, the Task Force then terminated its operations on May 30.[1] All of the working group's meetings remained closed to the public.

Appellees are the Association of American Physicians and Surgeons, which represents physicians; the American Council for Health Care Reform, which represents health care consumers; and the National Legal & Policy Center, which seeks to promote ethics in government. They sought access to the

[1] The Task Force's "termination" does not render this case moot. As both parties, in anticipation of this event, agreed before oral argument, this case still presents a live controversy concerning the availability of Task Force and working group documents, which the appellees sought below pursuant to FACA.

Task Force's meetings under the Federal Advisory Committee Act. Pub. L. No. 92–463, 86 Stat. 770 (1972) (reproduced at 5 U.S.C. App. 1 (1988)). Their efforts were rebuffed by the Counsel to the President, who informed them that the Task Force was not an advisory committee subject to FACA.

Appellees thereupon brought suit against the Task Force in district court. They claimed that the Task Force was a FACA committee because it was chaired by Mrs. Clinton, a private citizen, and that the Task Force had violated FACA by failing to file an advisory committee charter. They further asserted that FACA permitted them to attend all of the meetings of the Task Force and of any of its subgroups. Appellees sought a temporary restraining order and a preliminary injunction halting the operation of the Task Force until it complied with FACA and allowed the public to attend its meetings. The government responded that the Task Force was exempt from FACA because all of its members—including Mrs. Clinton—were government officers and employees. The government alternatively challenged any application of FACA to the Task Force as an unconstitutional infringement on the President's executive power.

In a memorandum opinion issued on March 10, 1993, the district court granted in part appellees' motion for a preliminary injunction. The court determined that appellees had a substantial likelihood of success on the merits. Mrs. Clinton, the court held, was not an officer or employee of the federal government merely by virtue of her status as "First Lady." Therefore, the Task Force could not qualify for an exemption from FACA as an advisory group composed solely of "full-time officers or employees" of the government. *See Association of Am. Physicians & Surgeons v. Hillary Rodham Clinton*, Civil Action No. 93–0399, Mem. Op. at 16–17 (D.D.C. March 10, 1993) ("Mem. Op."); *see also* 5 U.S.C. App. 1 § 3(2)(iii). The court, however, agreed with the government that FACA encroached on the President's constitutional authority to receive confidential advice for the purpose of recommending legislation. But the court thought that executive prerogatives were implicated only when the Task Force

was advising the President, not when it engaged in information-gathering. The district court accordingly granted a preliminary injunction requiring the Task Force to meet all the requirements of FACA except when it met to formulate advice or recommendations for the President.

As to the working group, the district court concluded that appellees had failed to state a claim under FED. R. CIV. P. 12(b)(6) that the subordinate body was covered by FACA. Relying on *National Anti-Hunger Coalition v. Executive Committee*, 557 F. Supp. 524 (D.D.C.), *aff'd*, 711 F.2d 1071 (D.C. Cir. 1983), the court held that the working group was not an advisory committee because it was engaged in fact-gathering and did not provide advice directly to the President. The court denied appellees motion for expedited discovery concerning the actions and status of the working group, but nevertheless determined that there were no issues of material fact and that it could have dismissed on summary judgment grounds as well. Mem. Op. at 15 n.11.

The government filed this appeal on March 22, 1993. Appellees subsequently filed a cross-appeal. We have jurisdiction to review a grant of a preliminary injunction under 28 U.S.C. § 1292(a), and we expedited the appeal due to the short time frame within which the Task Force and the working group operated.

II.

The government, as appellant and cross-appellee, and the plaintiffs below, as appellees and cross-appellants, together challenge much of the district court's ruling. The government takes issue primarily with the court's determination that Mrs. Clinton is not an "officer or employee" for purposes of section 3(2) of FACA. It is claimed that as the "First Lady," Mrs. Clinton is the functional equivalent of a government officer or employee, that the Task Force, therefore, is composed solely of full-time government officials—indeed officers drawn from among the President's closest official advisers—and that thus the Task Force is exempt from FACA. In the alternative, the government reiterates its claim that FACA

cannot be applied constitutionally to the Task Force. We are urged, in that regard, to discard the distinction drawn by the district court between the information-gathering function of the Task Force and its role in advising the President. As would be expected, the government is content with the district court's ruling concerning the status of the working group, and it argues that the district court's dismissal of appellees' claim is an unappealable interlocutory order.

Appellees, on the other hand, support the district court's determination that FACA covers the Task Force because Mrs. Clinton is not an officer or employee of the federal government. However, they challenge the court's ruling as to the status of the working group, which they contend is also covered by FACA. They further maintain that applying FACA to either body raises no serious constitutional issues, and, in any event, that the district court prematurely decided the constitutional issue. Appellees also contend that the court should have permitted discovery, which would have shown more clearly the FACA status of both groups, and that a straightforward application of FACA's procedural requirements would not curtail the President's constitutional powers.

We first consider the status of the Task Force and then turn to the working group issues.

III.

Congress passed FACA in 1972 to control the growth and operation of the "numerous committees, boards, commissions, councils, and similar groups which have been established to advise officers and agencies in the executive branch of the Federal Government." 5 U.S.C. App. 1, § 2(a). As Congress put it, FACA's purpose was: to eliminate unnecessary advisory committees; to limit the formation of new committees to the minimum number necessary; to keep the function of the committees advisory in nature; to hold the committees to uniform standards and procedures; and to keep Congress and the public informed of their activities. *See id.* § 2(b)(1)-(6). The statute orders agency heads to promulgate guide-

lines and regulations to govern the administration and operations of advisory committees. *See id.* § 8.

FACA places a number of restrictions on the advisory committees themselves. Before it can meet or take any action, a committee first must file a detailed charter, *see id.* § 9(c). The committee must give advance notice in the Federal Register of any meetings, *see id.* § 10(a)(2); and it must hold all meetings in public, *see id.* § 10(a)(1). Under section 10, the committee must keep detailed minutes of each meeting, *see id.* § 10(c), and make the records available—along with any reports, records, or other documents used by the committee—to the public, provided they do not fall within the exemptions of the Freedom of Information Act (FOIA), *see id.* § 10(b). Under section 5, an advisory committee established by the President or by legislation must be "fairly balanced in terms of the points of view represented," *id.* § 5(b)(2).[2] The Act also requires that precautions be taken to ensure that the advice and recommendations of the committee "will not be inappropriately influenced by the appointing authority or by any special interest." *Id.* § 5(b)(3).

The Act's definition of an "advisory" committee is apparently rather sweeping. Section 3 states:

> The term "advisory committee" means any committee, board, commission, council, conference, panel, task force, or other similar group, or any subcommittee or other subgroup thereof (hereinafter in this paragraph referred to as "committee"), which is ... (B) established or utilized by the President ... in the interest of obtaining advice or recommendations for the President or one or more agencies or officers of the Federal Government.

Id. § 3(2). The government does not contend that the Task Force was not "established" or "utilized" by the President in

[2] FACA's "balanced viewpoint" requirement may not be justiciable, however, because it does not provide a standard that is susceptible of *judicial* application. *See Public Citizen v. National Advisory Comm.*, 885 F.2d 419, 426 (D.C. Cir. 1989) (Silberman, J., concurring).

the interest of obtaining advice or recommendations. FACA's definition contains one important proviso, however. Section 3(2)(iii) exempts "any committee which is composed wholly of full-time officers or employees of the Federal Government." And, according to the government, the Task Force was not only wholly composed of government officers, it was actually (like the Task Force we encountered in *Meyer v. Bush*, 981 F.2d 1288 (D.C. Cir. 1993)) a partial, yet somewhat augmented, cabinet grouping. Thus, subjecting the Task Force to FACA would fall outside Congress' purpose of regulating the growth and use of committees composed of outsiders called in to advise government officials. Appellees would have no quarrel with the government's characterization of the Task Force, except for the description of its chairman, Mrs. Clinton. Appellees contend that she is not an officer or employee of the federal government despite her traditional and ceremonial status as "First Lady." This is not just a technicality according to appellees; she is statutorily barred from appointment as an officer because of the Anti-Nepotism Act. *See* 5 U.S.C. § 3110(b).

The district court, finding no definition of officer or employee of the federal government in FACA itself, quite reasonably turned to Title 5 of the U.S. Code to find a definition. *See* 5 U.S.C. §§ 2104 & 2105. An officer or employee according to those sections must be: (i) appointed to the civil service; (ii) engaged in the performance of a federal function; and (iii) subject to supervision by a higher elected or appointed official. As the district court held, and as appellees correctly point out, Mrs. Clinton has not been appointed to the civil service. Reading these definitions *in pari materia* with FACA would seem to suggest that the Task Force is not exempt.

Nevertheless, it is true, as the government insists, that Congress did not adopt explicitly all of Title 5's definitions in FACA. FACA is not part of Title 5, which was enacted six years before FACA's passage, *see* Pub. L. No. 89–554, 80 Stat. 378 (1966), but, instead is only temporarily housed there as an appendix. Typically, when Congress wishes to add a statute to Title 5, it amends the Title. *See, e.g.*, Government

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in the Sunshine Act, § 3(a), Pub. L. No. 92–409, 90 Stat. 1241 (1976); Privacy Act of 1974, Pub. L. No. 93–579, 88 Stat. 1896 (1974). It did not do so when it passed FACA, but at that time it specifically did adopt certain Title 5 definitions. For example, adjacent to the definition of an advisory committee is FACA's definition of an agency, which incorporates the definition in Title 5: "'agency' has the same meaning as in section 551(1) of title 5, United States Code." 5 U.S.C. App. 1, § 3(3). But Congress actually deleted from the Senate version of FACA definitions of "officer" and "employee" that paralleled those of sections 2104 and 2105. *See* H.R. REP. No. 1403, 92d Cong., 2d Sess. (1972), *reprinted in* 1972 U.S. CODE CONG. & ADMIN. NEWS 3508, 3509. And the Code contains another definition of a federal officer which tends to support the government's position. Title 1 provides that a federal officer "includes any person authorized by law to perform the duties of the office." 1 U.S.C. § 1. That definition could cover a situation in which Congress authorizes someone who is not formally an officer (such as the President's spouse) to perform federal duties. Even if, as our concurring colleague argues, Mrs. Clinton does not occupy an "office" specifically created by Congress, she could still be regarded as an "employee."

The government would have us conclude that the traditional, if informal, status and "duties" of the President's wife as "First Lady" gives her *de facto* officer or employee status. The government invokes what it describes as "a longstanding tradition of public service" by First Ladies—including, we are told, Sarah Polk, Edith Wilson, Eleanor Roosevelt, Rosalynn Carter, and Nancy Reagan—who have acted (albeit in the background) as advisers and personal representatives of their husbands. We are not confident that this traditional perception of the President's wife, as a virtual extension of her husband, is widely held today. As this very case suggests, it may not even be a fair portrayal of Mrs. Clinton, who certainly is performing more openly than is typical of a First Lady. Indeed, in the future we may see a male presidential

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spouse, which could make the term "First Lady" anachronistic.

More persuasive, however, is the government's argument that *Congress* itself *has* recognized that the President's spouse acts as the functional equivalent of an assistant to the President. The legislative authorization to the President to pay his White House aides includes the following provision:

> Assistance and services authorized pursuant to this section to the President are authorized to be provided to *the spouse of the President in connection with assistance provided by such spouse to the President in the discharge of the President's duties and responsibilities.* If the President does not have a spouse, such assistance and services may be provided for such purposes to a member of the President's family whom the President designates.

3 U.S.C. § 105(e) (emphasis added). Of course, even without section 105(e), the President presumably could draw upon his spouse for assistance. The statute's importance, rather, lies in its assistance in helping us interpret the ambiguous terms of FACA *in pari materia*.

It may well be, as appellees argue, that many in Congress had in mind "ceremonial duties," but we do not think the presidency can be so easily divided between its substantive political and ceremonial functions. In any event, section 105(e) neither limits the particular kind of "assistance" rendered to the President, nor circumscribes the types of presidential duties and responsibilities that are to be aided. We see no reason why a President could not use his or her spouse to carry out a task that the President might delegate to one of his White House aides. It is reasonable, therefore, to construe section 105(e) as treating the presidential spouse as a *de facto* officer or employee. Otherwise, if the President's spouse routinely attended, and participated in, cabinet meetings, he or she would convert an all-government group, established or used by the President, into a FACA advisory committee.

Pursuant to this section, moreover, the President's spouse is supported by a substantial staff who are undeniably full-time government officers or employees. Therefore, the Pres-

ident could have—as the government points out—easily designated Mrs. Clinton's chief of staff as a member of the Task Force, perhaps even as the chairman, who would then be expected to report to Mrs. Clinton. It would seem quite anomalous to conclude that FACA would apply if the President's spouse were a member of the committee, but not if her chief of staff were the actual member.

The President's implicit authority to enlist his spouse in aid of the discharge of his federal duties also undermines appellees' claim that treating the President's spouse as an officer or employee would violate the anti-nepotism provisions of 5 U.S.C. § 3110. That section prohibits any "public official" from appointing or employing a relative, such as a spouse, "in the agency in which he is serving or over which he exercises jurisdiction or control." *Id.* § 3110(b). Although section 3110(a)(1)(B) defines agency as "an executive agency," we doubt that Congress intended to include the White House or the Executive Office of the President. *Cf. Franklin v. Massachusetts*, 112 S. Ct. 2767, 2775 (1992) (holding that President is not "agency" for purposes of Administrative Procedure Act); *Meyer*, 981 F.2d at 1298 (President's advisers are not "agency" under FOIA); *Armstrong v. Bush*, 924 F.2d 282, 289 (D.C. Cir. 1991) (President not APA "agency"). So, for example, a President would be barred from appointing his brother as Attorney General, but perhaps not as a White House special assistant. Be that as it may, it is not reasonable to interpret that provision to bring it into conflict with Congress' recognition of (and apparent authorization for) the President's delegation of duties to his spouse. The anti-nepotism statute, moreover, may well bar appointment only to paid positions in government. *See* 5 U.S.C. § 3110(c). Thus, even if it would prevent the President from putting his spouse on the federal payroll, it does not preclude his spouse from aiding the President in the performance of his duties.

In sum, the government musters a strong argument in support of its interpretation of "full-time officer or employee" under FACA as including the President's spouse—whether or not a "First Lady." But it is by no means overwhelming. Indeed, the government is uncomfortable at having to choose

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whether Mrs. Clinton should be thought of as an officer or employee. The government's discomfort is quite understandable. Mrs. Clinton has not in any sense been appointed or elected to office, and, assuming she is an officer under Title 1, due to the duties delegated to her under 3 U.S.C. § 105(e), how, one might ask, could she be removed? All officers and employees of the United States, except the Vice President, can be removed, at least for cause, through the ultimate authority of the President. We suppose the President could withdraw any or all authority delegated to his spouse, but then he would be left without the official assistance of any family member. The very provision authorizing the delegation to the spouse provides for a delegation to another member of the President's family only "[i]f the President *does not have a spouse.*" 3 U.S.C. § 105(e) (emphasis added). That language seems to present the President with rather extreme alternatives.

What is more, section 105(e) would seem to apply whether or not the President's spouse held another job that an officer or employee of the government could not possibly hold. Suppose, for instance, that the President's spouse was counsel to a major law firm and spent a good portion of his or her time practicing law. Presumably, the spouse would still be authorized to provide assistance to the President under section 105(e) and would, thereby, also be an officer or employee of the government. The government suggests that this hypothetical does not create a problem under FACA, because a spouse in that situation, whether or not an officer or employee, would not be full-time and so would not qualify for the exemption. But that answer may be too facile. How would we determine how much or what kind of outside activity was inconsistent with full-time status?

Suffice it to say that the question whether Mrs. Clinton's membership on the Task Force triggers FACA is not an easy one.[3] The government argues, therefore, that we should

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[3] It is not clear how FACA applies if only one member of an advisory committee is not a full-time government officer or employee. How does the government carry out its obligation to ensure

construe the statute not to apply here, because otherwise we would face a serious constitutional issue. The Supreme Court has noted many times that "where an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress." *Public Citizen v. Department of Justice*, 491 U.S. 440, 466 (1989) (quoting *Edward J. DeBartolo Corp. v. Florida Gulf Coast Building & Construction Trades Council*, 485 U.S. 568, 575 (1988)). Only a few years ago the Court employed that very maxim of statutory construction to avoid applying FACA to the ABA committee that advised the Attorney General on the qualifications of prospective federal judicial nominees. *See id.* The government there argued that applying FACA would impair the effectiveness of the committee's deliberations (by exposing them to public examination), and thus would interfere with the advice that the committee provided to the Attorney General and ultimately, it was assumed, to the President. Such interference would encroach on the President's appointment power—his sole responsibility to nominate federal judges.[4] In order to escape that constitutional question, the Court held that the ABA committee was not "utilized" by the President because it was established and run by a private organization, even though the Act covers advisory committees established *or* utilized by the executive branch. *See id.* at 455–65. The Court adopted, we think it is fair to say, an extremely strained construction of the word "utilized" in order to avoid the constitutional question. The gravity of the constitutional

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that the committee is "fairly" balanced in terms of the points of view represented?

[4] Ironically, the ABA committee's role in advising administrations as to the qualifications of putative judges has over the years become more of an impediment (reflecting certain ABA institutional and, perhaps, political interests) than an aid to Presidents. R. Marcus & S. Torry, *ABA Judicial Evaluation Again Under Fire*, WASH. POST, May 7, 1989, A6; M. Thornton, *The ABA's Judgments on Judges*, WASH. POST, Sept. 25, 1987, A23.

issue was revealed by the three concurring justices who were unable to accept the Court's statutory construction and believed that FACA was unconstitutional as applied to the ABA committee. *Id.* at 467–89 (Kennedy, J., concurring).

It is, of course, necessary before considering the maxim of statutory construction to determine whether the government's constitutional argument in this case is a powerful one. In other words, are we truly faced, as the Court thought it was in *Public Citizen*, with a grave question of constitutional law? The government relies primarily on the claim that an explicit presidential power is implicated. Article II of the Constitution provides that the President "shall from time to time give to the Congress Information of the State of the Union, and recommend to their Consideration such Measures as he shall judge necessary and expedient." U.S. CONST. art. II, § 3, cl.1. According to the government, this clause gives the President the sole discretion to decide what measures to propose to Congress, and it leaves no room for congressional interference. To exercise this power, the government claims, the President also must have the constitutional right to receive confidential advice on proposed legislation.

Under the government's theory, FACA would interfere with the President's unbounded discretion to propose legislation. President Clinton formed the Task Force specifically to recommend legislation dealing with health care reform. FACA's requirement of public meetings would inhibit both candid discussion within the Task Force and its presentation of advice to the President. Challenging the district court's ruling, the government argues that this encroachment occurs regardless of whether the Task Force is engaged in information-gathering or internal deliberation. In either situation, the glare of publicity would inhibit the free flow of frank advice and would handicap the President's ability to develop legislation.

Appellees point out that the concurring opinion in *Public Citizen* commanded the votes of only three justices and rely,

instead, on the Court's opinion in *Morrison v. Olson*, 487 U.S. 654 (1988).[5] *Morrison* upheld the Ethics in Government Act's creation of an independent counsel because it did not prevent the President "from accomplishing [his] constitutionally assigned functions," *id.* at 695 (quoting *Nixon v. Administrator of General Services*, 433 U.S. 425, 443 (1977)), even though the counsel was largely immune from the executive branch's operational control (she was appointed by a panel of judges and was removable only for good cause). Applying FACA to the Task Force, according to appellees, has a rather minor impact on the institution of the presidency compared to the much greater encroachment on the President's core executive function sanctioned in *Morrison*.

Nevertheless, the government maintains that *Morrison* is not directly on point. Picking up on Justice Kennedy's concurrence in *Public Citizen*, the government contends that the *Morrison* Court's imprecise balancing test, which is apparently less favorable to the President, does not apply when a textual grant of presidential authority is implicated. In distinguishing *Morrison*, Justice Kennedy said:

> Thus, for example, the relevant aspect of our decision in *Morrison* involved the President's power to remove Executive Officers, a power we had recognized is not conferred by any explicit provision of the text of the Constitution (as is the appointment power) but rather is inferred to be a necessary part of the grant of the "Executive Power."

Public Citizen, 491 U.S. at 484 (Kennedy, J., concurring).[6] But because *Public Citizen* involved the President's textually

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[5] Justice Kennedy, who was recused in *Morrison*, was joined by Chief Justice Rehnquist and Justice O'Connor in *Public Citizen*. Justice Scalia, who dissented in *Morrison*, was, in turn, recused in *Public Citizen*.

[6] *But see Bowsher v. Synar*, 478 U.S. 714, 721–27 (1986) (removal power more important than appointment power in controlling subordinate officials).

granted power to appoint federal judges, the concurrence would have struck FACA down:

> Where a power has been committed to a particular Branch of the Government in the text of the Constitution, the balance already has been struck by the Constitution itself.

Id. at 486. The government argues that here, as in *Public Citizen*, but unlike in *Morrison*, we have an explicit textual delegation to the President to propose legislation.

We perceive several weaknesses in the government's position. First, the government ignores the *Morrison* Court's consideration of the President's Article II, section 3 responsibility to "take Care that the Laws be faithfully executed." *See Morrison*, 487 U.S. at 692–93. The Court specifically recognized that the statute before it encroached upon or burdened that responsibility, but concluded that the burden was not great enough to be unconstitutional.

> This is not a case in which the power to remove an executive official has been *completely* stripped from the President, thus providing no means for the President to ensure the "faithful execution" of the laws.... We do not think this limitation as it presently stands *sufficiently* deprives the President of control over the independent counsel to interfere *impermissibly* with his constitutional obligations to ensure the faithful execution of the laws.

Id. (emphasis added) (footnote omitted). *Morrison v. Olson*, thus, cannot be easily disposed of in accordance with the government's (and Justice Kennedy's) suggested distinction.

The President's constitutional duty to take care that the laws be faithfully executed, moreover, seems far greater in importance than his authority to recommend legislation. The Framers intended the Take Care Clause to be an affirmative duty on the President and the President alone. In contrast, the Recommendation Clause is less an obligation than a right. The President has the undisputed authority to recommend legislation, but he need not exercise that authority with

respect to any particular subject or, for that matter, any subject.[7] Only the President can ensure that the laws be faithfully executed, but anyone in the country can propose legislation.

The government's focus on the Recommendation Clause seems somewhat artificial. Discussions on policy—whether they take place in executive branch groups or in pure FACA advisory committees—to some extent always implicate proposed legislation. Whenever an executive branch group considers policy initiatives, it discusses interchangeably new legislation, executive orders, or other administrative directives. Thus, virtually anytime an advisory group meets to discuss a problem, it will implicate the Recommendation Clause, from which all executive branch authority to recommend legislation derives. Accordingly, if the application of FACA to groups advising the President or anyone else in the executive branch were constitutionally problematic, insofar as those groups were advising on proposed legislation, FACA would be problematic with regard to virtually all policy advice. Under that reasoning FACA would be constitutionally suspect on its face—an argument the government declined to make.

We do think that the government's alternative, albeit implicit, argument is more persuasive. Application of FACA to

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[7] To be sure, during the Constitutional Convention in Philadelphia, the Framers changed the language of the clause from "may recommend" to "*shall* recommend." As James Madison recorded in his notes of the convention for August 24, 1787:

> On motion of Mr. Govr Morris, "he may" was struck out, & "and" inserted before "recommend" in the clause 2d. sect 2d art: X in order to make it the duty of the President to recommend, & thence prevent umbrage or cavil at his doing it.

J. MADISON, NOTES OF DEBATES IN THE FEDERAL CONVENTION OF 1787, 464 (G. Hunt & J. Scott, eds. 1987). Gouverneur Morris' amendment suggests that the clause was intended to squelch any congressional objections to the President's *right* to recommend legislation—hence the prevention of "umbrage or cavil." *See* J. Sidak, *The Recommendation Clause*, 77 GEO. L.J. 2079, 2082 (1989).

the Task Force clearly would interfere with the President's capacity to solicit direct advice on *any* subject related to his duties from a group of private citizens, separate from or together with his closest governmental associates. That advice might be sought on a broad range of issues in an informal or formal fashion. Presidents have created advisory groups composed of private citizens (sometimes in conjunction with government officials) to meet periodically and advise them (hence the phrase "kitchen cabinets") on matters such as the conduct of a war.[8] Presidents have even created formal "cabinet committees" composed in part of private citizens.[9] This case is no different. Here, the President has formed a committee of his closest advisers—cabinet secretaries, White House advisers, and his wife—to advise him on a domestic issue he considers of the utmost priority.

[8] For example, President Johnson often sought advice from Clark Clifford and Justice Fortas, "two old and trusted friends from outside the Executive Branch," along with government officials on matters concerning the Vietnam War. *See, e.g.*, L. JOHNSON, THE VANTAGE POINT: PERSPECTIVES OF THE PRESIDENCY 1963–1969 at 235–37 (1971)

[9] President Ford, in 1975, convened a "cabinet committee" composed of the Secretary of State, the Secretary of Commerce, the Secretary of Labor, the President of the AFL–CIO, and the President of the Chamber of Commerce to formulate the government's policy toward the International Labor Organization. President Carter continued the same body. *See, e.g., Committee Fails to Agree on U.S. ILO Membership*, WASH. POST, Oct. 13, 1977, A24. Neither President apparently acknowledged FACA's application. *See, e.g.*, GENERAL SERVICES ADMINISTRATION, FEDERAL ADVISORY COMMITTEES: FOURTH ANNUAL REPORT OF THE PRESIDENT COVERING CALENDAR YEAR 1975 at 54–55 (1976) (no mention of ILO committee in list of presidential advisory committees); *see also* GENERAL SERVICES ADMINISTRATION, FEDERAL ADVISORY COMMITTEES: FIFTH ANNUAL REPORT OF THE PRESIDENT COVERING CALENDAR YEAR 1976 at 55–56 (1977) (same). In 1980, however, President Carter continued that structure, but explicitly recognized FACA's coverage (after the issue that gave rise to the committee—whether the United States should withdraw from the ILO—had been resolved). *See* Exec. Order No. 12,216, 45 Fed. Reg. 41,619 (1980).

Applying FACA to the Task Force does not raise constitutional problems simply because the Task Force is involved in proposing legislation. Instead, difficulties arise because of the Task Force's operational proximity to the President himself—that is, because the Task Force provides advice and recommendations directly to the President. The Supreme Court has recognized that a President has a great need to receive advice confidentially:

> [There is a] valid need for protection of communications between high Government officials and those who advise and assist them in the performance of their manifold duties; the importance of this confidentiality is too plain to require further discussion. Human experience teaches that those who expect public dissemination of their remarks may well temper candor with a concern for appearances and for their own interests to the detriment of the decisionmaking process. Whatever the nature of the privilege of confidentiality of Presidential communications in the exercise of Art. II powers, the privilege can be said to derive from the supremacy of each branch within its own assigned area of constitutional duties.

United States v. Nixon, 418 U.S. 683, 705–06 (1974) (footnotes omitted); *see also Nixon v. Administrator of Gen. Servs.*, 433 U.S. 425, 441–49 (1977). *Nixon v. Administrator of General Services* further explains that the President is entitled to confidentiality in the performance of his "responsibilities" and "his office," and "'in the process of shaping policies and making decisions.'" 433 U.S. at 449 (quoting *United States v. Nixon*, 418 U.S. at 708). Article II not only gives the President the ability to consult with his advisers confidentially, but also, as a corollary, it gives him the flexibility to organize his advisers and seek advice from them as he wishes. In *Meyer v. Bush*, 981 F.2d at 1293–97, for example, we held that the President could create a Task Force composed of cabinet secretaries and other close advisers to study regulatory reform without having to comply with FOIA. In this regard, FACA's requirement that an advisory committee must be "fairly balanced in terms of the view represented"

would—if enforceable and applied to groups of presidential advisers—restrict the President's ability to seek advice from whom and in the fashion he chooses.

The ability to discuss matters confidentially is surely an important condition to the exercise of executive power. Without it, the President's performance of any of his duties—textually explicit or implicit in Article II's grant of executive power—would be made more difficult. In designing the Constitution, the Framers vested the executive power in one man for the very reason that he might maintain secrecy in executive operations. As Alexander Hamilton wrote in the Federalist Papers:

> *Decision, activity, secrecy, and dispatch* will generally characterise [sic] the proceedings of one man, in a much more eminent degree, than the proceedings of any greater number; and in proportion as the number is increased, these qualities will be diminished.

THE FEDERALIST No. 70, at 472 (J. Cooke, ed., 1961) (emphasis added). The Framers thus understood that secrecy was related to the executive's ability to decide and to act quickly—a quality lacking in the government established by the Articles of Confederation. If a President cannot deliberate in confidence, it is hard to imagine how he can decide and act quickly.

This Article II right to confidential communications attaches not only to direct communications with the President, but also to discussions between his senior advisers. Certainly Department Secretaries and White House aides must be able to hold confidential meetings to discuss advice they secretly will render to the President. Congress, in another context, has recognized that the President's right to confidential communications extends to meetings between his top advisers. For example, FOIA, 5 U.S.C. § 552, exempts "the President's immediate personal staff or units in the Executive Office whose sole function is to advise and assist the President." *See Kissinger v. Reporters Comm. for Freedom of the Press*, 445 U.S. 136, 156 (1980) (quoting H.R. REP. No. 1380, 93d

Cong., 2d Sess. 14 (1974)); *Meyer v. Bush*, 981 F.2d at 1291–92.

A statute interfering with a President's ability to seek advice directly from private citizens as a group, intermixed, or not, with government officials, therefore raises Article II concerns. This is all the more so when the sole ground for asserting that the statute applies is that the President's own spouse, a member of the Task Force, is not a government official. For if the President seeks advice from those closest to him, whether in or out of government, the President's spouse, typically, would be regarded as among those closest advisers.

As we have indicated, we do not place much significance on the government's claim that this sort of interference is qualitatively, in constitutional terms, more troublesome insofar as it relates to advice the President seeks concerning the exercise of an enumerated power. If we were to go on to decide the constitutionality question, we would be obliged to ask whether, in *Morrison v. Olson* terms, this asserted application of FACA "impermissibly" burdens executive power. *Morrison* tells us to balance how much the interference with the President's executive power prevents the President "from accomplishing his constitutionally assigned functions," *Morrison*, 487 U.S. at 695, against the "overriding need to promote objectives within the constitutional authority of Congress." *Nixon v. Administrator of Gen. Servs.*, 433 U.S. at 443. We readily confess that this balancing test is not one that, as judges, we can apply with confidence. This is all the more reason to view the constitutional issue soberly. We are satisfied that the application of FACA to the Task Force seriously burdens executive power. And our reading of *Morrison* does not lead us easily to a conclusion that the burden placed is a permissible one.

The court below correctly recognized the constitutional difficulties that FACA's application to the Task Force created. The court, therefore, ruled the Act partially unconstitutional, insofar as it was applied to the meetings in which the Task Force actually advised the President. When the Task

Force was engaged in "information-gathering and information-reporting," however, the court thought that the President's constitutional interests were not so seriously implicated.

We believe it is the Task Force's operational *proximity* to the President, and not its exact function at any given moment, that implicates executive powers and therefore forces consideration of the *Morrison* test. The President's confidentiality interest is strong regardless of the particular role the Task Force is playing on any given day. Indeed, the two functions naturally interrelate and can only be divided artificially. If public disclosure of the real information-gathering process is required, the confidentiality of the advice-giving function inevitably would be compromised. If you know what information people seek, you can usually determine why they seek it. A group directly reporting and advising the President must have confidentiality at each stage in the formulation of advice to him. As we said in *Meyer*, "[p]roximity to the President, in the sense of continuing interaction, is surely in part what Congress had in mind when it exempted [from FOIA] the President's 'immediate personal staff.' " 981 F.2d at 1293 (citation omitted). And, as we recognized in *Soucie v. David*, 448 F.2d 1067 (D.C. Cir. 1971), FOIA's exemption may be constitutionally required to protect the President's executive powers. In any event, the district judge decided to truncate the statute in light of constitutional concerns only because it determined that FACA applied to the Task Force.

We think the district court should have acted otherwise. Prudent use of the maxim of statutory construction allows us to avoid the difficult constitutional issue posed by this case. The question whether the President's spouse is "a full-time officer or employee" of the government is close enough for us properly to construe FACA not to apply to the Task Force merely because Mrs. Clinton is a member. We follow the Supreme Court's lead, if not its strict precedent, in recognizing that [if the Act] were "[r]ead unqualifiedly, it would extend FACA's requirements to any group of two or more persons, or at least any formal organization, from which the President or an executive agency seeks advice." *Public Citizen*, 491 U.S. at 452 (footnote omitted). Because it be-

lieved that Congress could not have intended such a result, the *Public Citizen* majority read "utilize" to exclude the ABA committee. If the Supreme Court correctly construed the statute not to cover the advice the Attorney General receives, on behalf of the President, from the ABA, the statutory construction issue we face should be resolved *a fortiori* in favor of the government.

We, therefore, read the phrase "full-time officer or employee of the government" in FACA to apply to Mrs. Clinton. In doing so, we express no view as to her status under any other statute.[10]

IV.

The district court, having concluded that the Task Force was a FACA advisory committee, dismissed under Rule 12(b)(6) appellees' claim that the working group was also covered by FACA. The court thought that under *National Anti-Hunger Coalition v. Executive Committee*, 557 F. Supp. 524 (D.D.C.), *aff'd*, 711 F.2d 1071 (D.C. Cir. 1983) ("*Anti-Hunger*"), subgroups of a FACA committee should be regarded as staff of the advisory committee and not as advisory committees themselves. *See Anti-Hunger*, 557 F. Supp. at 529. Based on Mr. Magaziner's affidavit, the district court determined that the working group merely gathered information to be passed on to the Task Force. Appellees cross-appeal the district court's ruling and its corollary refusal to permit further discovery into the status and operations of the working group.

The government challenges our jurisdiction to consider the cross-appeal because the district court's rulings on the working group are neither independent final judgments, nor covered by the preliminary injunction against the Task Force which is before us on an interlocutory appeal pursuant to 28

[10] We do not need to consider whether Mrs. Clinton's presence on the Task Force violates the Hatch Act, 5 U.S.C. § 7324(a), the Anti-Deficiency Act, 31 U.S.C. § 1342, or any conflict of interest statutes.

U.S.C. § 1292(a). We have said that our jurisdiction over an interlocutory appeal, however, is considerably broader:

> [R]eview quite properly extends to all matters *inextricably bound up with the remedial decision* .... [T]he scope of review may extend further to allow disposition of all matters appropriately raised by the record, including entry of final judgment. Jurisdiction of the interlocutory appeal is in large measure jurisdiction to deal with all aspects of the case that have been sufficiently illuminated to enable decision by the court of appeals without further trial court development.

Wagner v. Taylor, 836 F.2d 578, 585 (D.C. Cir. 1987) (emphasis added) (quoting *Energy Action Educational Found. v. Andrus*, 654 F.2d 735, 745 n. 54 (D.C. Cir. 1980), *rev'd on other grounds*, 454 U.S. 151 (1981)); *see also* 16 C. WRIGHT, A. MILLER, E. COOPER & E. GRESSMAN, FEDERAL PRACTICE & PROCEDURE § 3921, at 17–20 (1977). The district court's final disposition of the claim against the working group was "bound up" with its reasons for granting the injunction against the Task Force. Once it is determined that the Task Force is not covered by FACA, the implicit analytical premises of the district court's decision as to the working group are removed. Moreover, had the district court determined, as have we, that the claim against the Task Force was invalid and then also dismissed the claim against the working group, the latter unquestionably would be appealable as well. Under these circumstances, we think it is appropriate to consider the cross-appeal.[11]

[11] The lower court dismissed appellees' claim under Rule 12(b)(6) because it found that appellees had failed to state a claim upon which relief could be granted. Mem. Op. at 15. It also noted that it could have dismissed appellees' claims under FED. R. CIV. P. 56, because appellees had failed to state that further discovery was necessary before summary judgment could be granted. *Id.* at 15 n.11. As we will discuss, the legal basis for the Rule 12(b)(6) ruling, or a Rule 56 ruling, was incorrect. Furthermore, contrary to the district court's decision, Rule 56 does not require a party to state in its discovery motion that discovery is necessary before a court may

As it argued below, the government claims that the working group is not in contact with the President and is not, therefore, "utilized" by him. That seems to us a strange argument. There are two exceptions to FACA's inclusion of all presidential advisory groups: (i) where the advisory committee is independently established and operated by a private organization, *see Public Citizen*, 491 U.S. at 457–59; and (ii) where the group is composed wholly of full-time government officials. *See* 5 U.S.C. App. 1, § 3(2)(iii). We have construed the second exception here to extend to a cabinet committee that includes the First Lady. The government now presses upon us a third exception, one for advisory committees that do *not* meet face-to-face with the President. The government's argument, however, conflicts with the serious constitutional concerns we have recognized concerning the Task Force. The statute cannot be properly interpreted as applying only to those advisory committees, established in the Executive Office of the President, that present the most delicate constitutional problems.[12] Otherwise, the government's argument effectively would render almost all presidential advisory committees free from FACA. Committees in direct contact with the President implicate the President's executive power and hence cannot be covered by FACA, while committees not directly in contact are not "utilized." In

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rule on summary judgment. Indeed, a party's filing of a discovery motion would seem implicitly to assert just that. But under Rule 12(b)(6), once the Magaziner affidavit was filed and considered the district judge was obliged to permit reasonable discovery as to the facts set forth in the affidavit. *See First Chicago Int'l v. United Exchange Co.*, 836 F.2d 1375, 1380 (D.C. Cir. 1988).

[12] The government, only at oral argument, and rather tentatively, suggested that application of FACA to *any* advisory groups established and utilized by the President, because they advise someone in the Executive Office of the President, raises constitutional problems. We do not think we should entertain a constitutional argument of such enormous significance made in so glancing a fashion. After all, it could be thought to come close to an argument that the government disavowed—that FACA is unconstitutional on its face.

any event, the statutory language does not remotely support the government. Not only does FACA define an advisory committee as a task force or "any subcommittee or other subgroup thereof," 5 U.S.C. App. 1, § 3(2), but it also specifies that an advisory committee is a group that is either *established* or *utilized* by the President. *See id.* Certainly the President can establish an advisory group that he does not meet with face-to-face. In *Public Citizen* the Court did not suggest that FACA could be avoided merely because the ABA committee communicated with the Justice Department rather than with the President.

The district court accepted a variation of the government's argument by concluding that the working group was not really a subgroup of the Task Force within the meaning of FACA, but rather only staff to the Task Force. The court relied, as we noted, on the *Anti-Hunger* case, in which we affirmed Judge Gesell's decision to similarly treat subordinate working groups operating under the Executive Committee of the Private Sector Survey. Although we affirmed the decision, we did not explicitly approve the judge's reasoning relating to the supposed staff groups; rather, we rejected an effort to challenge his decision based on new information not in the record. *See National Anti-Hunger Coalition v. Executive Committee*, 711 F.2d 1071, 1075 (D.C. Cir. 1983). In any event, *Anti-Hunger* presented crucially different facts. That case involved the Executive Committee of the Private Sector Survey, formed by President Reagan to obtain management and cost control advice from the private sector. The Executive Committee, composed of 150 private citizens, had a subcommittee composed of 30 members and also had 36 task forces that performed the preliminary work of the survey. *Anti-Hunger*, 557 F. Supp. at 525–26. The government conceded, in that litigation, that the Executive Committee and the subcommittee were both FACA committees and it was only thereafter that the district court determined that the task forces were not FACA committees, but staff.

Our conclusion that the Task Force is a committee wholly composed of government officials makes this case entirely different. In contrast to the situation here, in *Anti-Hunger*

the top levels of the *outside* advisory groups were covered by FACA—both the executive committee of 150 and the subcommittee of 30. In that scenario, there is less reason to focus on subordinate advisers or consultants who are presumably under the control of the superior groups. It is the superior groups, after all, that will give the advice to the government, and which, in accordance with the statute, must be "reasonably" balanced. But when the Task Force itself is considered part of the government—due to the government officials exemption—we must consider more closely FACA's relevance to the working group. For it is the working group now that is the point of contact between the public and the government. The district court's conclusion that the working group could be disregarded as staff depended on its determination that the Task Force was covered by FACA. Our disagreement with the district court on the latter issue therefore compels a different analysis of the working group's status.

Alternatively, the government argues that the working group is not, as a matter of law, a FACA advisory committee because it is not expected to offer consensus advice. In making this argument, the government relies on a regulation issued by the General Services Administration:

> The following are examples of advisory meetings or groups not covered by the Act or this subpart; . . . (i) Any meeting initiated by a Federal official(s) with more than one individual for the purpose of obtaining the advice of individual attendees and not for the purpose of utilizing the group to obtain consensus advice or recommendations. However, agencies should be aware that such a group would be covered by the Act when an agency accepts the group's deliberations as a source of consensus advice or recommendations.

41 C.F.R. § 101–6.1004(i) (1992).

As we have so often noted, we do not defer to an agency's construction of a statute interpreted by more than one agency, *see, e.g., FLRA v. Department of Treasury*, 884 F.2d 1446, 1451 (D.C. Cir. 1989), let alone one applicable to all agencies, *see Reporters Comm. for Freedom of the Press v. Department*

of Justice, 816 F.2d 730, 734 (D.C. Cir. 1987), *rev'd on other grounds*, 489 U.S. 749 (1989). Nevertheless, we think the government's regulation expresses a concept similar to one that we find embedded in the statute. It is not so much that a group is not a FACA advisory committee unless it gives "consensus" advice. To be sure, many committees are convened with that expectation. *See, e.g.*, The Commission on the Future of Worker–Management Relations, 58 Fed. Reg. 27,311 (1993). Others, however, are established presumably with the full expectation that the positions to be taken and the advice to be offered may well be sharply divided. *See, e.g.*, The Presidential Commission or the Assignment of Women in the Armed Forces, 57 Fed. Reg. 49,394 (1992). And since one of the purposes of FACA is to achieve some balance, and thereby diverse views on advisory committees, it would be passing strange if FACA only applied to those committees that would offer consensus recommendations.

The point, it seems to us, is that a group is a FACA advisory committee when it is asked to render advice or recommendations, *as a group*, and not as a collection of individuals. The group's activities are expected to, and appear to, benefit from the interaction among the members both internally and externally. Advisory committees not only provide ideas to the government, they also often bestow political legitimacy on that advice. As the House Committee that investigated advisory committees before FACA's passage stated: "The work product of a committee composed of distinguished and knowledgeable individuals appointed by the President to advise him is presumed to have value and should be considered." H.R. REP. No. 1731, 91st Cong., 2d Sess. 12 (1970).

Advisory committees are not just mechanisms for transmitting policy advice on a particular subject matter to the government. These committees also possess a kind of political legitimacy as representative bodies. Membership on a committee is often highly prized and sought after because it carries recognition and even prestige. When the executive branch endorses its advice and seeks to promote the policy course suggested by the committee, the executive branch

draws upon the committee's political legitimacy. Congress' effort to ensure that these committees are balanced in terms of viewpoint recognizes their usefulness for political (and patronage) purposes. But committees bestow these various benefits only insofar as their members act as a group. The whole, in other words, must be greater than the sum of the parts.

Thus, an important factor in determining the presence of an advisory committee becomes the formality and structure of the group. Judge Gesell, in another district court case, *Nader v. Baroody*, 396 F. Supp. 1231 (D.D.C. 1975), seems to have approached the same notion by focusing on the word "established" in FACA. *Nader* involved meetings between an assistant to the President and a changing slate of federal officials and private sector groups. *See id.* The groups met for the express purpose of exchanging views on a variety of subjects. In exempting these meetings from FACA, the court noted that "the committees were not formally organized and there is little or no continuity." *Id.* at 1234.

Since form is a factor, it would appear that the government has a good deal of control over whether a group constitutes a FACA advisory committee. Perhaps, for that reason, it is a rare case when a court holds that a particular group is a FACA advisory committee over the objection of the executive branch. In order to implicate FACA, the President, or his subordinates, must create an advisory group that has, in large measure, an organized structure, a fixed membership, and a specific purpose. The government suggests that the working groups, composed as they are of a crowd of 340 virtually anonymous persons, do not bear the characteristics of the paradigm FACA advisory committee. That may well be so. The working groups, as a whole, seem more like a horde than a committee. On the other hand, the groups have been created ("established") with a good deal of formality and perhaps are better understood as a number of advisory committees. We simply cannot determine how to classify the working groups based on the record before us.

Finally, the government claims that all of the members of the working groups are full-time officers or employees of the

government, and, for that reason alone, the working groups are not FACA advisory committees. The three-hundred members drawn from the agencies, the Executive Office of the President, and from the congressional staffs are concededly within that category. The working group also includes, however, 40 "special government employees." The government claims that these individuals are also "full-time" government employees, even though they have been employed by an agency or the Executive Office of the President for less than 130 days in a year, some without compensation. The record does not reflect where these persons come from, nor does it show how many hours they work. We are, moreover, unsure whether FACA's definition of "full-time" extends to a person who works for the government for less than 130 days out of a year. The government directs us to the conflict of interest provisions of Title 18, which define a "special Government employee" as:

> an officer or employee of the executive or legislative branch of the United States Government ... who is retained, designated, appointed, or employed to perform, with or without compensation, for not to exceed [130] days during any period of [365] consecutive days, *temporary duties either on a full-time or intermittent basis.*

18 U.S.C. § 202(a) (1988) (emphasis added). The government argues that section 202 clearly implies that a temporary employee can be "full-time." Intermittent (or non-full-time) applies, according to the government, to those who work less than a full day.

We do not believe section 202(a) helps the government. Just as we did not read 5 U.S.C. §§ 2104, 2105 to govern the question of whether Mrs. Clinton is a federal officer or employee, we do not think that Title 18's definitions should necessarily control FACA. We must construe FACA in light of its purpose to regulate the growth and operation of advisory committees. FACA would be rather easy to avoid if an agency could simply appoint 10 private citizens as special government employees for two days, and then have the committee receive the section 3(2) exemption as a body

composed of full-time government employees. Moreover, section 202 contrasts "full-time" with "intermittent," and so "full-time" seems to mean no more than not "intermittent." There is no reason to think that not "intermittent" for section 202 purposes has any bearing on whether the employee is "full-time" for FACA purposes. Whether the special government employees are full-time, however, is, in part, a factual issue that was not developed below due to the lack of discovery.

A third class of persons are described as consultants. According to the government, the consultants attend meetings on an intermittent basis, with or without compensation, and have no "supervisory role or decision-making authority." Drawn from the ranks of the medical profession, the academy, and from business, they only provide information and opinion. These consultants raise a different question from that presented by the other two classes of working group employees. The key issue, it seems to us, is not whether these consultants are "full-time" government employees under section 3(2), but whether they can be considered members of the working group at all. When an advisory committee of wholly government officials brings in a "consultant" for a one-time meeting, FACA is not triggered because the consultant is not really a member of the advisory committee. In that situation, the relationship between the temporary consultant and committee is very similar to the one between the White House officials and various private sector representatives exempted from FACA in *Nader*. We are confident that Congress did not intend FACA to extend to episodic meetings between government officials and a consultant. To do so would achieve the absurd result *Public Citizen* warned against: reading FACA to cover every instance when the President (or an agency) informally seeks advice from two or more private citizens.

But a consultant may still be properly described as a member of an advisory committee if his involvement and role are functionally indistinguishable from those of the other members. Whether they exercise any supervisory or decisionmaking authority is irrelevant. If a "consultant" regularly attends and fully participates in working group meetings as

if he were a "member," he should be regarded as a member. Then his status as a private citizen would disqualify the working group from the section 3(2) exemption for meetings of full-time government officials.

* * * *

When we examine a particular group or committee to determine whether FACA applies, we must bear in mind that a range of variations exist in terms of the purpose, structure, and personnel of the group. Perhaps it is best characterized as a continuum. At one end one can visualize a formal group of a limited number of private citizens who are brought together to give publicized advice as a group. That model would seem covered by the statute regardless of other fortuities such as whether the members are called "consultants." At the other end of the continuum is an unstructured arrangement in which the government seeks advice from what is only a collection of individuals who do not significantly interact with each other. That model, we think, does not trigger FACA.

We simply have insufficient material in the record to determine the character of the working group and its members. We understand why the district court, believing the Task Force covered by FACA, thought it unnecessary and inappropriate to put the working group under further scrutiny. But, as we have indicated, because we differ with the district court concerning the Task Force, we believe further proceedings, including expedited discovery, are necessary before the district court can confidently decide whether the working group is a FACA committee.

Accordingly, we reverse the district court and lift the preliminary injunction on the operations of the Task Force. The Task Force need not comply with the requirements of FACA because it is a committee composed wholly of full-time government officials. We also reverse the district court's dismissal of appellees' claims as to the working group under Rule 12(b)(6). We remand for further proceedings, including expedited discovery, regarding the working group.

So ordered.

BUCKLEY, *Circuit Judge, concurring in the judgment:* I admit at the outset the persuasive force of the majority's opinion—a force derived, I think, from a comparison of the most obvious facts of this case with those of *Public Citizen v. United States Department of Justice*, 491 U.S. 441 (1989). *Public Citizen* interpreted the word "utilized" so as to exclude the Justice Department's use of a committee of the American Bar Association whose only mission was to advise on appointments to the federal judiciary. In concluding that Congress did not intend to subject the ABA Committee on the Judiciary to FACA's requirements, the Court acknowledged that what "tip[ped] the balance decisively against FACA's application," *id.* at 465, was the "cardinal principle" that where "a serious doubt of constitutionality is raised, . . . the Court will first ascertain whether a construction of the statute is fairly possible by which the question may be avoided." *Id.* at 465–66. Here, to achieve a similar end, we are asked only to stretch the phrase "officer or employee of the Federal Government" far enough to include a person who is greeted like a head of state, guarded by the Secret Service, and funded from the public fisc. On first appearances, *Public Citizen* would seem to support both the majority's result and the reasoning used to reach it.

If this case is to be distinguished from *Public Citizen*, it is not because of a lack of gravity in the constitutional issues it presents. In *United States v. Nixon*, 418 U.S. 683 (1974) ("*Nixon I*"), and *Nixon v. Administrator of General Services*, 433 U.S. 425 (1977) ("*Nixon II*"), the Supreme Court recognized a constitutionally grounded doctrine of executive privilege which holds that Presidential communications are presumptively privileged against disclosure:

> Human experience teaches that those who expect public dissemination of their remarks may well temper candor with a concern for appearances and for their own interests to the detriment of the decisionmaking process. . . .
>
> . . . .
>
> A President . . . must be free to explore alternatives in the process of shaping policies and making decisions and

> to do so in a way many would be unwilling to express except privately. These are the considerations justifying a presumptive privilege for Presidential communications. The privilege is fundamental to the operation of Government and inextricably rooted in the separation of powers under the Constitution.

Nixon I, 418 U.S. at 705, 708. The Court found that this privilege extends

> to communications in performance of a President's responsibilities . . . and made in the process of shaping policies and making decisions.

Nixon II, 433 U.S. at 449 (quoting *Nixon I*, 418 U.S. at 708, 711, 713) (internal quotation marks, brackets, and citations omitted). And it set forth standards for evaluating intrusions on privileged communications:

> [I]n determining whether the Act disrupts the proper balance between the coordinate branches, the proper inquiry focuses on the extent to which it prevents the Executive Branch from accomplishing its constitutionally assigned functions. Only where the potential for disruption is present must we then determine whether that impact is justified by an overriding need to promote objectives within the constitutional authority of Congress.

Id. at 443 (citations to *Nixon I* omitted).

We confront in this case a task force consisting of the President's closest advisors that was established to address a paramount political priority. Because it included his wife—by all accounts, a person whose policy advice he has relied on throughout his public life—the Task Force on National Health Care Reform arguably was bound by law to conduct its proceedings in public. Given these circumstances, the considerations animating the Presidential privilege, like the President's claim of privilege itself, are before us in pointed fashion. My colleagues, sensing the weight of these issues, hold that we may avoid addressing them through "prudent

use" of *Public Citizen's* "maxim of statutory construction." Maj. Op. at p. 23, I cannot agree.

I begin with the axiom that in interpreting a statute, a court must ascertain the will of the enacting Congress. Here I admit to detecting something of an implicit argument in the Government's pleadings before this court. To the extent that it may be discerned, this argument begins with an assumption that *Public Citizen* 's result could not have been reached through genuine interpretation—interpretation that is consistent with the will of Congress—and ends with the conclusion that *Public Citizen* authorizes courts to avoid constitutional issues by ascribing implausible meanings to the most unambiguous language. The suggestion, I admit, is tempting. But it is also barred by the very decision on which the Government places its principal reliance. *Public Citizen* states explicitly that courts "cannot press statutory construction to the point of disingenuous evasion, even to avoid a constitutional question." 491 U.S. at 467 (internal quotation marks and citation omitted).

The weakness of the position that FACA may be interpreted to exclude the Task Force is suggested by the Government's vacillation on the question of Mrs. Clinton's status. Before the district court, the Government argued that the Task Force was not subject to FACA because Mrs. Clinton was the functional equivalent of a federal employee. In its opening brief here, it argued that she was either an officer or an employee without saying which. On reply, it said explicitly that Mrs. Clinton was an "officer." And at argument, it retreated to ambiguity and again refused to categorize her. In fact, the Government's only consistent position has been that FACA is not subject to those statutory definitions of "officer" and "employee" that most logically apply to it.

FACA appears in the appendix to Title 5 of the United States Code. Sections 2104 and 2105 of Title 5 contain the following definitions:

Id. at 452 & n.8, 452–54. Taken literally, FACA's definition would have endowed the President with Midas ears capable of turning any continuing source of consensus opinion into a FACA committee. In such a world, the physicians jointly consulted to protect the President's health, the editorial board of the President's favorite newspaper, and two dietitians jointly planning the President's meals could all be classified as "Presidential advisory committees" subject to regulation. Because "the literal reading of [utilize] would 'compel an odd result,' " the Court "search[ed] for other evidence of congressional intent to lend the term its proper scope." *Id.* at 454 (citation omitted). Third, on examining FACA's origins and legislative history, the Court concluded that while "it seems to us a close question whether FACA should be construed to apply to the ABA Committee, . . . we are fairly confident it should not." *Id.* at 465.

The Court reached this last conclusion in significant part on the basis of the following passage from the FACA Conference Report: "The Act does not apply to persons or organizations which have contractual relationships with Federal agencies *nor to advisory committees not directly established by or for such agencies.*" *Id.* at 462 (emphasis added by *Public Citizen*). The Court also noted that the relationship between the ABA Committee and the Justice Department had not fallen within the scope of President Kennedy's Executive Order No. 11007, from which FACA was derived. *Id.* at 462–63. From this, the Court concluded that "[t]he phrase 'or utilized' therefore appears to have been added simply to clarify that FACA applies to advisory committees established by the Federal Government in a generous sense of that term," *id.* at 462; and that "[r]ead in this way, . . . the word 'utilize' does not describe the Justice Department's use of the ABA Committee," *id.* at 463.

In applying what the majority, Maj. Op. at p. 8, has laconically (and accurately) described as a "rather sweeping" statutory definition of "advisory committee" to the unique relationship between the Justice Department and the ABA Committee, the Court concluded that it was more probable than not that Congress did not intend that FACA apply to

such privately organized groups. Nevertheless, because it considered the question close in light of the broad sweep of the definition, literally interpreted, it applied its venerable rule of statutory construction to tip the balance away from one that would have presented "formidable constitutional difficulties." *Id.* at 466.

In this case, we deal not with woolly terms but with the meaning of two words in common legal usage, "officer" and "employee." Far from creating absurdity, literal interpretations of these terms are necessary in order to give effect to the congressional policy of drawing sharp distinctions between individuals outside the Government and those within it. And in contrast with *Public Citizen*, in which no statutory definition of "utilize" was available and great weight was placed on legislative history, definitions of both "officer" and "employee" have been enacted into law by Congress. In this case, none of the considerations animating *Public Citizen* are remotely presented; and because we do not deal with ambiguous terms, there is no "balance" to be tipped by resort to legal maxims. Despite appearances, *Public Citizen* has little to do with the case we decide today.

Finally, to conclude my statutory analysis, I note that the *Nixon I* Court engaged in a patently straightforward interpretation of Federal Rule of Criminal Procedure 17(c), 418 U.S. at 697–702, even though it recognized that "[i]f we sustain[ ] this challenge, there [will] be no occasion to reach the claim of privilege asserted." *Id.* at 698. Needless to say, the considerations counseling avoidance of difficult constitutional issues were never more pressing than on the facts of *Nixon I*. Because I can find no credible argument to the contrary, and because I cannot bring myself to strain the meaning of "officer" or "employee" to produce one, I would hold that the Task Force was not exempt from the public disclosure requirements of FACA; and having done so, I would address the constitutional implications of that holding.

As I pointed out earlier, the Supreme Court has acknowledged a Presidential right to confidentiality that "is fundamental to the operation of Government and inextricably root-

ed in the separation of powers under the Constitution." *Nixon I*, 418 U.S. at 708. Although the privilege is not absolute, the Court has only twice found that it must yield to competing constitutional interests, such as "the primary constitutional duty of the Judicial Branch to do justice in criminal prosecutions," *id.* at 707; and in each case, it has protected the confidentiality of Presidential communications from unwarranted disclosure.

In *Nixon I*, in which President Nixon sought to enjoin the subpoenaing of certain of his papers, the Court found it necessary to

> weigh the importance of the general principle of confidentiality of Presidential communications in performance of the President's responsibilities against the inroads of such a privilege on the fair administration of criminal justice.

Id. at 711–12. It concluded that the President's "generalized interest in confidentiality . . . cannot prevail over the fundamental demands of due process of law in the fair administration of criminal justice." *Id.* at 713. Accordingly, it ordered the examination *in camera* of the papers subject to an instruction that the district court be scrupulous in "protect[ing] against any release or publication of material not found by the court [to be] probably admissible in evidence and relevant to the issues of the trial for which it is sought." *Id.* at 714.

Nixon II involved a balancing of the President's interest in the confidentiality of his communications against other national interests. In that case, former President Nixon asserted the Presidential privilege in a challenge to the constitutionality of the Presidential Recordings and Materials Preservation Act, which placed his papers in the custody of the Administrator of General Services. *See* 433 U.S. at 429–30. The Supreme Court found that the statute was constitutional because of the Nixon papers' historical importance and their possible significance as aids to the legislative process, and because of "the safeguards built into the Act to prevent disclosure of [confidential] materials and the minimal nature

of the intrusion into the confidentiality of the Presidency." *Id.* at 454. Those safeguards included the requirement that "any party's opportunity to assert any ... constitutionally based right or privilege" be protected. *Id.* at 450 (quoting section 104 of the Act). The Court concluded "that the screening process contemplated by the Act [, which was to be conducted by Executive Branch archivists,] ... will not constitute a more severe intrusion into Presidential confidentiality than the *in camera* inspection by the District Court approved in [*Nixon I*]." *Id.* at 455.

In these two cases, the Court permitted only the most limited intrusions on the privilege. FACA, by contrast, would have required that the Task Force operate in the full glare of provisions requiring public meetings and disclosure of records. It is hard to imagine conditions better calculated to suppress the "candid, objective, and even blunt or harsh opinions," *Nixon I*, 418 U.S. at 708, that the President was entitled to receive from the twelve advisors he had appointed to his Task Force. Because none of Congress's purposes in enacting FACA are of a gravity that would justify overriding the Presidential privilege in this case, I would conclude that FACA is unconstitutional as applied to the Task Force.

For the foregoing reasons, I concur only in the majority's conclusion, in Part III of its opinion, that FACA's public disclosure provisions may not be applied to the Task Force. With respect to Part IV, I agree that the district court must develop further facts before it can determine whether the Working Group, or any division thereof, qualified as an advisory committee under FACA.

§ 2104. Officer

(a) *For the purpose of this title*, "officer", except as otherwise provided by this section or when specifically modified, means a justice or judge of the United States and an individual who is—

(1) required by law to be appointed in the civil service by one of the following acting in an official capacity—

(A) the President;

(B) a court of the United States;

(C) the head of an Executive agency; or

(D) the Secretary of a military department;

(2) engaged in the performance of a Federal function under authority of law or an Executive act; and

(3) subject to the supervision of an authority named by paragraph (1) of this section, or the Judicial Conference of the United States, while engaged in the performance of the duties of his office....

§ 2105. Employee

(a) *For the purpose of this title*, "employee", except as otherwise provided by this section or when specifically modified, means an officer and an individual who is—

(1) appointed in the civil service by one of the following acting in an official capacity—

(A) the President;

(B) a Member or Members of Congress, or the Congress;

(C) a member of a uniformed service;

(D) an individual who is an employee under this section;

(E) the head of a Government controlled corporation; or

(F) an adjutant general designated by the Secretary concerned under section 709(c) of title 32;

> (2) engaged in the performance of a Federal function under authority of law or an Executive act; and
>
> (3) subject to the supervision of an individual named by paragraph (1) of this subsection while engaged in the performance of the duties of his position....

5 U.S.C. §§ 2104, 2105 (emphasis added).

The common denominator of these provisions is the requirement that both officers and employees be "appointed in the civil service." In the Executive Branch, the civil service consists of (1) positions requiring Senate confirmation, (2) the "Senior Executive Service," (3) the "competitive service," and (4) "positions which are specifically excepted from the competitive service by or under statute." 5 U.S.C. § 2102(a). Mrs. Clinton does not wear any of these labels. *See, e.g.*, 5 U.S.C. § 3132(a)(2) (defining "Senior Executive Service position"). The Government's (and the majority's) strategy, then, is to argue that she need not satisfy the section 2104 and 2105 definitions because they do not apply to FACA. Specifically, because FACA has been codified in an appendix to Title 5, not in the title proper, the Government contends that the sections do not govern the meaning of "officer" and "employee" as used in the definition of "advisory committee." For several reasons, I disagree.

First, there is the plain meaning of the statutory language. An appendix to a title of the United States Code necessarily qualifies as a part of that title. If it did not, then the appendix would be part of no title whatever and would be an appendix to the Code as a whole. Yet FACA appears in the Code under the banner, "Title 5, Appendix." Because sections 2104 and 2105 state plainly that they apply "[f]or the purpose of" Title 5, and because FACA is a part of that title, the definitions apply to FACA.

Second, Congress surely knew that FACA would be codified under Title 5. The same statute that adopted sections 2104 and 2105 also stipulated that Title 5 be captioned: "Government Organization and Employees." Pub. L. No. 89–554, 80 Stat. 378, 408–09 (1966). A glance at the captions of

the remaining 49 titles in the Code confirms that Title 5 is the only one under which FACA could have been codified.

Third, there are the practical considerations. The Ethics in Government Act, codified alongside FACA in Title 5's appendix, requires financial disclosures from "each officer or employee in the executive branch" who meets certain criteria. Ethics in Government Act of 1978, 5 U.S.C. App. 3, §§ 101(a), 101(f)(3) (1991 Supp.). FACA imposes open-meeting and other requirements on committees not "composed wholly of full-time officers or employees of the Federal Government." 5 U.S.C. App. 1, § 3(2) (1988). And, although each of those statutes contains a sizable definitional section, neither defines either "officer" or "employee." *See* 5 U.S.C. App. 1, § 3 (1988); 5 U.S.C. App. 3, § 109 (1991 Supp.). The Government tells us that those terms are intentionally left undefined even though Congress took the trouble, in those statutes, to define terms that are of far less significance. *See, e.g.*, 5 U.S.C. App. 1, § 3(4) (1988) ("The term 'Presidential advisory committee' means an advisory committee which advises the President"); 5 U.S.C. App. 3, § 109(3) (1991 Supp.) (" 'designated agency ethics official' means an officer or employee who is designated to administer the provisions of this title within an agency"). But without definitions of "officer" and "employee," neither statute could be sensibly administered. The better explanation for the absence of these definitions is that their repetition in FACA and the Ethics in Government Act would have been redundant.

Finally, there is the apparent reasoning behind FACA's location in Title 5's appendix. The United States Code is published pursuant to 1 U.S.C. §§ 201–13 (1988). That law requires the codification of new laws in annual Code supplements and permits the publication of an entirely new Code every five years. *See id.* § 202. Thus, the current United States Code and supplement contain all laws of the United States that are "general and permanent in their nature." *Id.* § 204(a). As of 1988, ten of the fifty U.S.C. titles contained an appendix. *See* 5, 10, 11, 18, 26, 28, 40, 46, 49, 50 U.S.C. (1988). Some statutes have been placed in appendices because, while considered more than temporary, they are viewed as less than permanent additions to the Code. *See* 40 U.S.C. App. (Appalachian Regional Development Act of 1965).

Other statutes have been relegated to appendices because they were not enacted directly by Congress. *See* 11 U.S.C. App. (Bankruptcy Rules and Official Forms as promulgated by Supreme Court pursuant to 28 U.S.C. § 2075). With respect to Title 5, Congress has divided it into three parts: "The Agencies Generally" (Part I), "Civil Service Functions and Responsibilities" (Part II), and "Employees" (Part III). *See* Pub. L. No. 89–554, 80 Stat. 378 (1966), *as amended by* Pub. L. No. 96–54, § 2(a)(1), 93 Stat. 381 (1979). An appendix to Title 5, then, is the natural place to codify statutes that relate to "Government Organization and Employees" but do not pertain to "The Agencies Generally," "Civil Service Functions and Responsibilities," or "Employees." As of 1988, five acts, including FACA, had been codified in Title 5's appendix. None of these fits within any of the three pigeonholes into which the main body of the title has been divided.

As against all of this—the statute's plain language, the imputed knowledge of its draftsmen, the practical need for Title 5's definitions to apply to its appendix, and the apparent reasons for FACA's placement there—the Government can offer a bare shred of legislative history. It points out that the Senate version of FACA explicitly incorporated the Title 5 definitions of "officer" and "employee," but that these were dropped at conference. The question, of course, is whether the conferees discarded the definitions because they were redundant (as FACA was destined for codification under Title 5), or because they wished the definitions not to apply to FACA.

The evidence on this issue consists of statements from the reports of the Senate Committee on Government Operations and the House–Senate Conference Committee. Referring to the section of the Senate bill that incorporated definitions to be found in the main body of Title 5, namely, those for "agency" (5 U.S.C. § 551(1)), "officer" (5 U.S.C. § 2104), and "employee" (5 U.S.C. § 2105), the Senate Report stated only that these three definitions had "been chosen to give the broadest interpretation to the coverage commensurate with generally accepted principles of law." S. Rep. No. 1098, 92d Cong., 2d Sess. 8 (1972). The Conference Committee Report

merely noted that "[t]he conference substitute deletes the Senate amendment definitions of 'officer' and 'employee.' " H.R. Conf. Rep. No. 1403, 92d Cong., 2d Sess. 9 (1972). The definition of "agency," however, was retained.

The Government infers, from the deletion of two of the Senate definitions and the retention of the third, that the conferees found the definitions of "officer" and "employee" inapplicable to FACA. There is a far more plausible explanation. As sections 2104 ("officer") and 2105 ("employee") were applicable to all statutes codified under Title 5, they were superfluous. The definition of "agency," by contrast, appears under the heading, "For the purpose of this *subchapter*—," 5 U.S.C. § 551 (emphasis added), and therefore would not apply to FACA unless specifically incorporated into that Act.

Even if we could disregard the definitions found in Title 5, we would still be compelled to attach meanings to the words "officer" and "employee" that Congress might reasonably have had in mind. To this end, I have examined other sources for definitions of these terms. At the outset, I dismiss the possibility that Mrs. Clinton might be considered an employee. In these proceedings, the Government has not attempted to argue that Mrs. Clinton is an employee for purposes of FACA—no doubt because her services are unpaid. *Cf.* Black's Law Dictionary 471 (5th ed. 1979) (defining employee as "[o]ne who works for an employer; a person working for salary or wages"). And while the majority does assert that Mrs. Clinton "could still be regarded as an 'employee' " under FACA, Maj. Op. at p. 10, it too lacks an argument in support of the proposition. In particular, it ignores the fact that, while subsections (a) and (b) of 3 U.S.C. § 105 explicitly "authorize[ ]" the President "to appoint and fix the pay of [White House] employees," subsection 105(e), the statutory acknowledgment of the First Lady's role, is carefully phrased so as *not* to authorize her appointment as an employee or any remuneration for her services. An "unpaid employee" is an oxymoron. although an "unpaid officer" is not. FACA's strictures can be avoided, then, only if it can credibly be argued that Mrs. Clinton is an officer of the Federal Government. I can find no such argument.

To begin with the beginning, the Constitution imposes certain requirements on those who are to serve as officers of the United States. Such persons must be appointed by the President with the consent of the Senate unless Congress, by law, has vested the power of appointment "in the President alone, in the Courts of Law, or in the Heads of Departments," U.S. Const. art. II, § 2, cl. 2. Furthermore, all officers must take an oath to support the Constitution. *Id.*, art. VI, cl. 3. Congress has enacted laws to implement these requirements. *See, e.g.*, 5 U.S.C. § 3331 (officers of the United States required to swear an oath); 5 U.S.C. § 2906 (officers' oath to be "preserved"); 5 U.S.C. § 2902 ("officer[s] appointed by the President" must have commissions made out and sealed by the Secretary of State); 5 U.S.C. §§ 3333, 7311 (anyone who accepts either "office or employment in the Government of the United States" required to swear their loyalty by affidavit). We have received no indication that any of these requirements have been met with regard to Mrs. Clinton.

More generally, an officer implies an office, and an office implies duties. Title 1 of the United States Code defines "officer" by reference to an "office" with "duties"—" 'officer' includes any person authorized by law to perform the duties of the office." 1 U.S.C. § 1. And the Supreme Court has interpreted "officer" similarly with reference to the Constitution. In *Burnap v. United States*, 252 U.S. 512, 516 (1920), the Court reasoned: "Whether the incumbent is an officer or an employee is determined by the manner in which Congress has specifically provided for the creation of the several positions, their duties and appointment thereto." *Burnap* held that a "landscape architect" was an employee, not an officer, because "[t]here [was] no statute which creates an office of landscape architect . . . nor any which defines the duties of the position," *id.* at 517, and because "[t]here [was] no statute which provides specifically by whom the landscape architect . . . shall be appointed." *Id.*

The undoubted value of the services that the wives of Presidents have rendered their husbands and their country notwithstanding, it cannot be said that they have occupied an office with duties. The provision of the U.S. Code on which

the majority relies, 3 U.S.C. § 105(e), is carefully phrased so as *not* to name a position or prescribe duties a President's spouse is to fulfill. In fact, section 105(e), strictly speaking, does not even *authorize* a First Lady to assist the President; rather it authorizes federal employees to assist the First Lady, and, in the course of doing so, *acknowledges* the assistance that First Ladies commonly render their spouses. In sum, Mrs. Clinton carries none of the indicia of a federal officer. She has neither been appointed to nor confirmed in the position of "First Lady," she has taken no oath of office, and she neither holds a statutory office nor performs statutory duties.

Having searched the U.S. Code and the Government's briefs in vain for definitions of "officer" that might give aid and comfort to the Government, I conclude that under any fair interpretation of the term, Mrs. Clinton is not an officer of the United States. But to complete this tour through the statute books, I note that section 105(e) does not, as the Government and the majority contend, require a finding that Congress has acknowledged that a President's spouse performs the duties of an officer. Another direct congressional statement on the subject of the First Lady's duties appears in the Anti-Nepotism Act. That Act declares that public officials (expressly including "the President") may not employ relatives (expressly including a "wife") in "a civilian position in the agency in which he is serving or over which he exercises jurisdiction or control." 5 U.S.C. § 3110(a), (b). The use of the definite article in the phrase "*the* agency in which he is serving" appears to imply that every "public official" belongs to some agency and that their relatives may not be employed in that agency, whatever it happens to be. Moreover, as a matter of policy and consistency, the restrictions on the President under the Anti-Nepotism Act must be viewed to be as broad as the Executive Branch: It is inconceivable that Congress, in combatting nepotism, intended to forbid Mrs. Clinton's service as Attorney General while permitting her appointment as National Security Advisor. Viewed purely as a matter of congressional intent, the argument that the Anti-Nepotism Act applies only to the Depart-

ments and not to the White House, *see* Maj. Op. at p. 12, is a weak one. As a result, any gravitational pull exerted in the direction of congressional acceptance of a President's spouse as a "*de facto* officer" attributable to section 105(e) is overwhelmed by the opposite force exerted by the Anti–Nepotism Act.

One final consideration. Although we may assume that, when drafting FACA, Congress gave no thought to the possibility that a President might appoint his spouse to an advisory committee, we may not assume that it failed to contemplate the relationship between FACA and the legal obligations and sanctions imposed on officers and employees of the Federal Government.

As one reviews the affidavit filed with the district court by Ira Magaziner, Senior Advisor to the President for Policy Development, one is struck by the fact that *every* member of the Task Force and Interdepartmental Working Group, but one, was subject to one or more of the statutes that Congress has enacted to ensure the proper conduct of members of the Federal Government—the "insiders," as the Government describes those who qualify as "full-time officers and employees" within the meaning of FACA. These laws impose burdensome ethics requirements. *See, e.g.*, Ethics in Government Act of 1978, 5 U.S.C. App. 3, § 101(f)(3) (1991 Supp.) (applying financial disclosure requirements on all higher paid "officers and employees" in the Executive Branch); *id.* §§ 501(a)(1), 505(2) (1991 Supp.) (applying outside income limitations on all higher paid officers and employees except "special government employees"); 18 U.S.C. § 205 (1991 Supp.) (prohibiting any "officer or employee" from representing outsiders in "matters affecting the Government"); *id.* § 207 (prohibiting anyone who formerly was an "officer or employee" from participating in certain governmental proceedings and decisions after leaving government employment); *id.* § 208 (prohibiting an "officer or employee" from "participat[ing] personally" in a matter affecting "a financial interest"); 5 U.S.C. § 7324 (1988) (prohibiting an "employee in an Executive agency" from taking "an active part" in political campaigns). And even though the Government argues that the Interdepartmental Working Group was not an

advisory committee within the meaning of FACA, Mr. Magaziner nevertheless took pains to stress the fact that every member of and consultant to the Group—whether a regular or special government employee, whether working full time or part, for pay or without—was required to file a financial disclosure statement and to comply with other requirements of these laws. *See* Magaziner Affidavit, Gov't App. at 41–43.

These requirements, then, appear as a signal distinction between what would normally be considered to be "inside" and "outside" members of advisory committees. In fact, this distinction—the legal obligations and sanctions imposed on officers and employees of the Government as opposed to private citizens—undoubtedly provides a substantial part of the justification for the very different requirements imposed by FACA on committees that are composed exclusively of federal officers and employees and those that are not. In enacting FACA, Congress found that "[o]ne of the great dangers in the unregulated use of advisory committees is that special interest groups may use their membership on such bodies to promote their private concerns." H.R. Rep. No. 1017, 92 Cong., 2d Sess. 6 (1972). Because committees not composed exclusively of federal officers and employees have members who are not required to foreswear their private associations and insulate themselves against potential conflicts of interest, FACA requires, as an alternative check, that their deliberations be conducted in the open.

When the majority states that we "need [not] consider whether Mrs. Clinton's presence on the Task Force violates . . . any conflict of interest statutes," Maj. Op. at p. 24 n.10, it indicates that we have not been presented with claims under these statutes that call for adjudication. The question remains, however, whether Congress, if it had ever considered that the President's spouse might be appointed an official member of a Presidential advisory committee, would have labelled her an "officer or employee" within the meaning of FACA. To put it another way, could Congress have intended that Mrs. Clinton, alone of the twelve members of the Task Force and 340 members of the Working Group, would be

entirely exempt from the reach of ethics laws that Congress has imposed on the President himself? I think not.

In visiting these sundry provisions, I doubt I have said very much with which my brethren in the majority would disagree. Our disagreement centers, I think, not on Congress's intent in enacting the relevant statutes, but on the lens through which we must view that intent in this particular case. The majority argues (1) that construing the phrase, "officers and employees," to exclude Mrs. Clinton would give rise to weighty constitutional issues, Maj. Op. at p. 22; (2) that the *Public Citizen* Court avoided deciding similar issues by embracing "an extremely strained construction of the word 'utilized,' " Maj. Op. at p. 14; (3) that "[i]t is reasonable . . . to construe section 105(e) as treating the President's spouse as a *de facto* officer or employee," Maj. Op. at p. 11; and hence (4) that the phrase "full-time officer or employee of the government" must *a fortiori* be read to apply to Mrs. Clinton, Maj. Op. at p. 24. I remain unconvinced.

First, I do not think that section 105(e) can reasonably be read to create an officer or employee, either *de facto* or otherwise; and even if it could, I do not think we could avail ourselves of such a reading in this case. I noted above that section 105(e) has been carefully phrased so as *not* to recognize an office, an officer, or an employee. But equally important, I know of no case in which the Supreme Court has saved one provision from constitutional difficulty by liberally construing another, entirely unrelated provision. In *Public Citizen* itself, as well as in *every* case cited in *Public Citizen* in which the Court avoided a constitutional challenge, the Court sidestepped the constitutional claims presented through an interpretation of the statute under attack. See *Public Citizen*, 491 U.S. at 465–66 (citing cases); *see also id.* at 465, 467 (avoiding a constitutional challenge to FACA by construing FACA § 3(2)); *see also, e.g., Edward J. DeBartolo Corp. v. Florida Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 575, 588 (1988) (avoiding a constitutional challenge to the National Labor Relations Act by construing NLRA § 8(b)(4)); *St. Martin Evangelical Lutheran Church v. South Dakota*, 451 U.S. 772, 780–81, 788 (1981) (avoiding a

constitutional challenge to the Federal Unemployment Tax Act by construing FUTA § 3309(b)). Because it is FACA that is under attack, I think that any additional degree of interpretive freedom we enjoy in construing FACA cannot be extended to a statute authorizing expenditures for White House staff.

Second, I cannot believe that *Public Citizen* establishes the rule my colleagues tacitly embrace. In reaching their holding, the majority implicitly distinguishes between "extremely strained construction," which, under their reading, *Public Citizen* permits or even requires, and "disingenuous evasion," which it explicitly forbids. *Compare* Maj. Op. at p. 14 *with* 491 U.S. at 467. The rule the majority appears to adopt, then, is that judges must strain (but may not evade) the plain meaning of a statute before they may entertain an "as-applied" constitutional challenge. If my colleagues are right, the line between "extremely strained construction" and "disingenuous evasion" will determine the outcome in *every* case involving an as-applied challenge presenting "formidable constitutional difficulties." *Public Citizen*, 491 U.S. at 466. While I suspect my colleagues may have some sympathy (as I do) with Justice Kennedy's position that the Supreme Court majority in *Public Citizen* had stretched its interpretation of FACA "beyond the point at which such a construction remains '*fairly* possible,' " *id.* at 481 (Kennedy, J., concurring in judgment) (emphasis in original), I cannot believe the Court intended to establish a rule *requiring* such constructions in cases posing serious constitutional questions.

A review of its reasoning demonstrates that *Public Citizen* neither explicitly nor implicitly sanctions "strained" statutory interpretation. Its holding—that the ABA Committee was not "utilized" by the President within the meaning of FACA—was based principally on three considerations. The first of these was that, in the Court's memorable phrase, " 'utilize' is a woolly verb," *id.* at 452, which necessarily requires judicial definition. Second, it recognized that a "dictionary reading [of the word "utilize" in] FACA's definition of 'advisory committee' " would lead to a statute of "almost unfettered breadth" and produce "absurd results."