MRS. CLINTON: Thank you, sir. Let me answer your last question and then go on to your more general point. The plan does not include incarcerated persons. Even though every citizen will have a health security card and be entitled to the comprehensive benefits package, during their term of incarceration they will be treated by whatever the correctional systems health care plan is.

The reasons for that have to do with everything from security, transportation, access -- there's a long list of reasons. We struggled with that very hard.

But, based on advice from both city and state governments that actually run these institutions, we determined it was not in either the institutions' nor the patients' interests during incarceration for them to continue as a member of whatever health plan.

They certainly would renew their membership once they were out. Now, that does not relieve the state, nor the health care system, from dealing with their health care problems, and particularly for any public health problems like tuberculosis and some of the things that we're dealing with right now.

I am particularly concerned about the points you make concerning underserved populations and minority providers. And we've done several things to try to protect against either the populations or the providers being discriminated against or being excluded.

For one thing, we are taking the Medicaid system and integrating it into the alliance and health plan system. We will no longer identify Medicaid recipients. When someone shows up at your clinic or your emergency room, they will not be identified as someone whose reimbursement is being provided through a government stream.

We will also have requirements for treating entire populations by the health plans if they choose to bid on the services that a population defined in an alliance will need.

We anticipate -- and there was an article recently that went in and talked to some minority providers in some of our inner cities -- that there will be linkages created that have never been created before between both private

practitioners, community health centers, and other community clinics, because, for the first time, there will be reimbursement available. There will be an incentive for large institutions who aren't in that downtown area to want to take care of those patients.

And then finally, with respect to managed care, I really view managed care in much more basic terms. I view it as making sure everybody has a doctor. And it has gotten a bad name in some circles because of, frankly, some of the unsavory and inappropriate techniques tried in order to wring costs out of the system at the expense of the patient.

But last week I visited probably the poorest congressional district in America -- in the south Bronx. And I visited a satellite clinic that is part of a managed care system for Medicaid recipients.

The patients I talked to were thrilled because, when left on their own in a fee-for-service network where there were no providers in the south Bronx, where they couldn't get transportation to anybody else, they used the emergency room. They did not have a doctor.

Now they come to the clinic under managed care in the Medicaid system there. They get more -- from their perspective -- more visits, more access, a 24-hour telephone line where they can always get a doctor on the line.

So if we just take a step back and look at it from a ground up perspective, it has great potential to enhance services to underserved populations.

DR. KOOP: I would like to add one word in support of what the First Lady said about correctional institutions. Judging by my eight years' experience as Surgeon General, with the Federal Bureau of Prisons that's the way to go. And experiments have been done in the past which were disastrous when you moved outside that system.

DR. WARSHAW: Mrs. Clinton, I'm Joseph Warshaw, a pediatrician from New Haven. There are certain groups in the population -- children with special needs, the mentally retarded, the handicapped -- for whom the competition model in the health alliances may not provide the most appropriate services.

What assurances will the plan have within it that will assure those populations the kinds of care that would provide the highest quality of service, not necessarily the least expensive?

MRS. CLINTON: Well, we are not only going to provide a comprehensive benefits package to which every child is entitled, but we are going to continue some of the special services that children need -- both those who are Medicaid eligible and those who are not but who have been receiving what are sometimes referred to as "wraparound services" because of mental retardation or physical disability of some kind.

So we have worked very hard on this with a number of advocates and experts in this area. And we think we can hold the health plans accountable. Again, I would ask you to look at the system now.

We have good plans and bad plans. We have good insurance policies and bad insurance policies. We have good doctors and bad doctors. I mean, we have the full range of everything out there now. We are not going to change human nature overnight.

It is going to be very important to hold these health plans accountable, and for consumer groups and advocacy groups with particular concerns to make sure that people are getting those services. So we are providing them. And we're going to make sure they're available. But we're going to have to make sure they actually get delivered. And that will be one of the roles of the alliance, which will be to monitor such groups.

A PARTICIPANT: Mrs. Clinton, I compliment you on your availability to the American Public to tell them, from yourself, about the health care reform proposal, and your willingness to access to the public so that they may ask questions and bring to you their concerns.

I'm a medical educator, and I'm concerned about preparing physicians and other health care providers to serve in the areas of this nation that not only is there an economic disincentive to enter practice, but also, there is a geographic disincentive.

You've traveled this great nation, and you know that there are areas that are not very densely populated where services are hard to get. And you've also traveled the inner cities, such as the south Bronx. And you know the scarcity of physicians who want to enter that area.

And I guess my question is -- as a medical educator, as dean of one of the finest medical schools in this country -- I would like to know what your message to me is about how to lead our young people into these areas.

MRS. CLINTON: I thank you for your concern and commitment on these issues. We are trying to build in incentives to do just what you're talking about, ranging from loan forgiveness, and additional funds for supporting facilities in underserved areas -- both rural and urban -- so that we can honestly tell young physicians that there's going to be support out there.

We are working very hard to set up a series of investments in informatics -- something Dr. Koop is very interested in -- and in technological advances, so that it's not just the financial disincentives that often keep physicians from these areas; it is also the sense of isolation from professional colleagues.

And we know we have to do better in order to provide those kinds of linkages. And that's something that Dr. Koop may want to comment on, because he has done a lot of work on that.

We also believe that, with respect to most underserved areas, we are going to have to rely on allied professionals as well. It may not be possible to staff every emergency clinic in rural Montana.

And Montana, for example, has adopted a law that permits EMTs and physician assistants to staff emergency rooms, because their view is that's a whole lot better than nothing when somebody is brought to one of those emergency rooms, and that it has actually proven very beneficial.

So we're going to ask for some changes in practice parameters for some allied professionals, because we share your concern that not only do we have barriers to overcome, but the sheer numbers -- especially with the specialist/

primary ratio being what it is -- will make it very difficult for the next years, until we get this thing up and going and get the right incentives in it to be able fully to answer the question the way I would like to. But I think we're on the right road to it.

PARTICIPANT: Well, as an educator, if I can be of any help, I'm offering my assistance.

MRS. CLINTON: Thank you very much. Would you tell me what that great medical school is so that I can find you. (Laughter)

PARTICIPANT: Yes. I'm proud to say it's the Uniformed Services University of the Health Sciences.

MRS. CLINTON: I know where it is. (Laughter and applause)

PARTICIPANT: The B.F. Edward-Aberr (phonetic) School of Medicine. And Mrs. Clinton, you might also like to know that I am the only woman dean of a medical school in this country -- the fourth ever.

MRS. CLINTON: You know, one thing about practice in the military services which has been very interesting to me is that both physicians and nurses have testified on numerous occasions that their range of practice parameter was so much broader in the military than it was once they got into civilian practice.

Not just nurses, but physicians as well have told me that all of a sudden they find themselves being restrained by hospital or staff rules. And certainly nurses feel terribly constrained after having gone from being very responsible in the military system to becoming much less able to make decisions. So I -- there's a lot we can learn there. I appreciate that.

PARTICIPANT: We also train physicians for the Public Health Service and graduate nurse practitioners, and our students have a tradition of going to some places where they are desperately needed that aren't very popular.

MRS. CLINTON: Thank you.

DR. KOOP: I'm not going to speak about informatics, as the First Lady suggested I might. But I don't think anybody in this room travels more than I do. And in those travels I try to meet as many medical students as I can. And I'm constantly pleased and amazed at how many more altruistic youngsters are coming into medicine.

And what I find that they see in this plan is that, having had the desire to go to a previously underserved area, but feeling they couldn't do it because they couldn't be paid enough, they now see an economic return that makes that kind of a life possible. Dr. Abdellah --

DR. ABDELLAH: I represent the Graduate School of Nursing at the University of the Health Sciences -- the President's own university. (Laughter) Mrs. Clinton, I am a nurse. We are preparing nurse practitioners to function in primary care centers, and also in underserved populations.

We know -- and this has been well documented --that nurses can provide quality care and in an economic way. We are pleased that the health care report does recognize the importance of the contribution of nurse practitioners.

My question is, Mrs. Clinton, can you assure us that the support for the education of nurse practitioners will be forthcoming, and that the practice barriers at the state level can be removed? Thank you.

MRS. CLINTON: Well, that is certainly the intention of the plan. I will say that we're going to have to fight for that. That is not going to be easy to maintain for both, what I would consider, unfair reasons, and for some legitimate questions.

And this is an area where the Institute might very well help us, because we need some unbiased opinion out there, because we're going to have quite an argument, I would predict, as to how far we should preempt state practice barriers and whether nurses will be able to perform the full range of functions for which many of them are now being trained. But we intend to pursue that vigorously.

DR. KOOP: I would like to put some statistics in here. I think the backbone of the plan that the First Lady

is talking about is really primary care physicians. And we are woefully understaffed in those on a national basis.

And if we were to turn out from our medical schools 50 percent of each class as primary care physicians from here on, it would take us 22 years until half of the physicians in the country were practicing primary care And that means that what Dr. Abdellah has said requires some kind of stopgap mechanism for people like nurse practitioners, physician assistants, and so on.

But I have one warning. If both of these groups are striving to take care of the entire problem, we have to be able to reassess this about 10 years down the pike so we don't end up with an oversupply of both and one of the worst turf battles we could ever have. (Laughter)

Yes, sir.

DR. HERDER (phonetic): I'm Dr. Larry Herder of New York and Florida, and a member of another health profession, the dental profession, and we applaud you for your interest in this total picture, and what a great job in communication. Your lovely smile indicates the fact that the axiom that you cannot have total health without good dental health. (Laughter)

DR. KOOP: You might tell them who coined that phrase. (Laughter)

DR. HERDER: You betcha. Our concern is, what was the rationale of not having in the basic benefits package dental care for adults. We've been struggling for 30 years to help a whole segment of the population -- let's say under Medicare, and Medicaid, really -- to achieve good dental health. Can you help me with that?

MRS. CLINTON: Yes. And it is something that we are planning to add to the package within the next eight years -- or seven years, by the year 2000. It was largely a question of cost.

We were able to fund children's dental care, which we thought was very important. As you know, dentists were not included in Medicare originally. And so the costing on extending dental care to everyone prevented us from including

it for everyone from the very beginning.

But it will be part of the legislation, that adult dental care will be available, as well as additional mental health benefits, by the year 2000. And that's the way we were -- those are some decisions we had to make based on actuarial decision making. It's been interesting dealing with actuaries on health care. (Laughter)

They don't believe in prevention. They think if you let people go to the doctors early, they'll just keep going to the doctors, even if they solve problems that might be more expensive in the -- the only data we've got, which is not really good, is that Hawaii, with its universal coverage system, has a higher per capita doctor/visit ratio than the rest of us, and lower costs.

But that's not convincing because everybody knows Hawaii doesn't count for comparisons because it's an island. You know, so there's all kinds of -- (laughter) -- and the dental issue got caught up in there somewhere, so --(laughter).

DR. HERDER: Well, wait just for one more second. We appreciate your interest in the fee-for-service system as a potential part. I come from a little county in New York called Broome County, where we have something called Medmax and Dentmax, which, utilizing the best capabilities of the fee-for-service system, is now delivering care for Medicaid patients.

We have saved, among 1,200 Medicaid patients, $1 million in prevented fees from them going to the emergency room for what we can handle in our own office.

MRS. CLINTON: That's what will happen all over the country if we can get this done right. Thank you.

DR. KOOP: There's one aspect of this that I think we haven't talked about. And, in the exclusion for the next seven or eight years of dental problems in adults, we have to remember that there are dental complications of diseases such as diabetes that do have to be covered meanwhile.

MRS. CLINTON: Right. And I believe those are covered. Medically necessary -- what's the -- there's a

phrase for that. I'll check on that, Dr. Koop. But I think that there is a coverage for those kinds of dental problems.

DR. HERDER: Yes. It is covered, but it can get lost in the shuffle because of dentistry.

MRS. CLINTON: Right.

DR. WATTS-LUBEK (phonetic): My name is Ruth Watts-Lubek. I'm from another island called Manhattan. (Laughter) I'm a nurse-midwife, and we met last week, Mrs. Clinton, at the fundraiser for Mayor Dinkins (phonetic).

But I've been involved for 18 years in giving birth back to families, primarily through free-standing birth centers, which we have proven works at all socioeconomic levels, including in the south Bronx, where we have done a demonstration which Dr. Lee will be seeing next month, and also with rural, low-income families, as well as among the affluent.

There is a birth center here in Bethesda which serves middle-class families. But, if utilized by only 50 percent of child-bearing families in this country, such centers could save $4 billion annually, because the birth center care for normal childbirth comes in at about half of the costs of in-hospital normal childbirth.

Expansion of such community-based services will require both construction and training monies. How will the plan accommodate to needs like this?

MRS. CLINTON: Well, we think that there will be a demand for birth centers. Again, this is related to how your services will be fit in with broader networks, and the role that nurse-midwives are permitted and encouraged to play in this system.

I don't know, though. I don't know the answer to whether there, specifically, is any funding available. I don't think there is. I think that is something that is probably not available in the plan at this time. I will look into that.

DR. WATTS-LUBEK: Thank you.

MRS. CLINTON: Oh, Dr. Lee just corrected me. It is in the plan. Thank you, Dr. Lee. Okay. Nurse-midwifery training and some funding for capacity expansion.

DR. KOOP: Over here.

A PARTICIPANT: Mrs. Clinton, although budgetary restraints will not allow, as you said, comprehensive dental care for adult patients at this time, I think I beseech you to reconsider at least giving emergency dental care for adult patients, because we feel that the greatest amount of suffering and dissemination of disease come from the underprivileged, who cannot receive emergency care at this time -- dental care.

MRS. CLINTON: I will check on that. I think we do have emergency care covered. I will check on that again.

PARTICIPANT: Thank you.

DR. BOWMAN (phonetic): I'm Dr. Marjorie Bowman from Winston-Salem, North Carolina. I'm a family physician. And I thank you first of all for tackling this difficult subject. And I have multiple questions, but I'll limit myself to one.

And that is that, as you recognize, the bureaucracy of our current system is great. The paperwork is great. But I also note that in the new plan there are new bureaucracies built into the plan. And I would like to hear what you think about whether or not we would really be simplifying or if we'll be moving from one bureaucracy to others.

MRS. CLINTON: Well, from my perspective, we're going to be eliminating a number of the bureaucracies that we currently have to contend with. The 1,500 insurance companies will not survive. There will be some, but most will not. That will save an enormous amount of time, effort, and money in paperwork and bureaucracy.

The way we have tried to structure this is to take away from both private and public sector bureaucracies the need and right to micromanage independent decision making by physicians, hospitals, and other providers. Now, the trade-off is that we set some kind of boundaries. Namely, that we set some kind of budget.

And some have said, "Well, you know, that's a very uncertain prospect, to be working within a budget." But your hospitals work within budgets, and you bust them all the time because you can't realistically predict what you're going to be spending on uncompensated care and other things that will no longer be part of the day-to-day worries that you will have.

The health alliances are consumer- and employer-driven organizations that are largely going to be collecting the funds and then, at your individual direction by the consumer, transmitting those to the health alliance that you choose. And that can change from year to year.

So I think that there is certainly an argument that what we're doing will be limiting bureaucracy. And it's one of our goals to continue to be extremely vigilant about that -- to limit it as much as possible. And it's just something that we're going to have to be watching all the time. But there is no doubt in my mind, we will significantly streamline the system over what we currently have.

DR. BOWMAN: But there will be a new national health board, a new graduate medical education board, a new board related to academic health centers, et cetera. And I perceive that those will engender bureaucracies related to them as well.

MRS. CLINTON: Well, that may be. But, you know, if we have a benefits package that's guaranteed, there has to be some entity that will make the decision about what benefits will be upgraded and included in years to come. Now, we could leave that to the Congress. I don't think that's a good idea. (Laughter)

This will take the politics out of it. But think now. We are replacing with one board, literally, hundreds of decision-making boards, all of them staffed, called insurance company executives and claims agents. I mean, we are replacing this huge infrastructure.

And it is a little bewildering to think that when we look out at how decisions are made now, that we will not be limiting bureaucracy. And yes, we do want some kind of advisory board for academic health centers to get together to make some decisions about quality and to make some decisions

about the direction of graduate medical education.

That seems to me to be a very cheap and unbureaucratic way to help organize decision making. So we'll watch it, and we'll see how it develops, and we want as many of you to take a hard look at it as possible. But we've tried to be as focused as we can about the missions that these entities are to preform.

DR. KOOP: If you ask short questions, you might get as many as two in. (Laughter)

A PARTICIPANT: Mrs. Clinton, your leadership is simply inspiring. Thank you very much. I wanted to focus for a moment on one other aspect of education. I'm the dean of the medical school at Columbia University. One of the things that's enabled us to educate medical students, and I would submit that one of the -- American medicine at its finest is the finest. The thing is to get it to everybody.

But one of the things that enables us to do it is the fact that we've been able to educate medical students. And as the needs change, we can change those needs. But there has to be support of the education through the medical schools themselves.

I know you have streams of money. I guess one of the concerns is that some of that money be designated for the education of the medical students, which heretofore has been done by cross-subsidization of clinical practice and also a lot of voluntary teaching. I wonder if you could comment on that?

MRS. CLINTON: I believe that in the designated streams, we do designate funding for medical education, as well as for other roles we want academic health centers to play.

PARTICIPANT: I think one of the fine points to make is that the educational part of an academic health center -- the medical schools, the nursing schools -- have to have those educational monies to make sure education gets done in the ambulatory care setting or anywhere else we think it should be done.

MRS. CLINTON: I absolutely agree with that. And

based on the many conversations we've had with you and others who have been kind enough to share your time with us, we have drafted legislation that we think will do that. And, obviously, we want you to carefully read it and make sure it's in accord with what we think we're doing together on this.

PARTICIPANT: Since Dr. Koop said I could have a second question, I'll make it very quick. (Laughter)

DR. KOOP: Herb, I didn't say that.

PARTICIPANT: Thank you for helping destigmatize mental illness.

DR. WOLHAMEL (phonetic): I'm Stephanie Wolhamel from Cambridge, Massachusetts, and I'm not going to ask about the details, which are really dazzling in their elegance, but about your poor decision to embrace managed competition, which at best -- at best -- is untried in terms of cost containment, and also your decision to turn your back on the single-payer system that many of us in the room have advocated and has a proven track record not only in covering the population, but in controlling costs and simplifying bureaucracy.

MRS. CLINTON: Well, I appreciate that. And I also appreciate greatly the extraordinary work you and your colleagues have done over the past decade to raise a lot of these issues that weren't raised before. And if it had not been for your painstaking comparisons of Mass General and Toronto General, a lot of these distinctions would not be well known.

In the legislation, we are providing that any state that wishes to be a single-payer state may choose to do so. Now, this is a decision that I'm sure will be controversial in some quarters. But it seems to us an appropriate role for the states, who will be given a lot of decision making authority in this area, to be able to choose.

And as the speaker has pointed out, there are a number of physicians, the New England Journal, other very distinguished observers of the medical scene, as well as practitioners, who believe totally in the single-payer system. There are many who believe it is totally wrong for

this country.

And we, in attempting to figure out how to create a system that would build on what we have -- to preserve what works and to fix what's broken with it -- have opted to create a system which, in general, would provide accountable health plans that would be competing on the basis of cost and quality.

But we want to be sure that the legislation provides for single-payer. And I anticipate, in going back to Dr. Shine's remarks, that there will be some states that will choose to have a single-payer system. And so, during the next 10 years as this system evolves, we will be able to make some legitimate comparisons.

We will have an opportunity to dispel myths, both pro and con, of both approaches -- or all approaches, because there will probably be more than two that you can describe. And I think that is the realistic and appropriate step for us to take at this time.

And I will look forward to seeing which states choose to go in that direction, and to watch closely the kind of support they engender and the kind of results they have.

This will be an area that we will have to fight very hard to keep in the legislation. Those of you who are single-payer advocates will really have to work hard to keep this option in this legislation, because right now there is not anywhere near a majority in either house to do anything beyond that with single-payer. But we have to try to preserve that option. And that's what we're going to do.

DR. KOOP: We'll take the last question from here.

DR. FRANK: I'm Ellen Frank (phonetic) from the University of Pittsburgh School of Medicine, and I do treatment outcomes research.

I would like to return to the last theme of your prepared remarks, and that is to ask what provision there is in the plan for shortening the time lag between the publication of a treatment outcome finding and its adoption in general practice. My understanding is that on average now, that's about 10 years.

MRS. CLINTON: Well, we don't have any sort of magic remedy for that. (Laughter) But you are absolutely right, that it is a significant problem.

We think, though, that through devices such as quality report cards, through the kind of peer accountability we think that the networks will engender, through the kind of small-scale, comparative research that Dr. Weinberg and Dr. Koop have been doing -- we really think we will have better mechanisms for getting information out, and there will be a return to the physician or the provider for doing it.

Now, I'll just give you one example that was brought to my attention in Minneapolis. One of the fine clinics in Minnesota developed a procedure -- radiological procedure for the detection of breast lumps, the mammo test.

They're having a difficult time beginning to introduce it and utilize it, even within their area, because there is, frankly, no incentive for surgeons to make referrals to radiologists so that a noninvasive procedure can be used, even in the numbers necessary to provide the kind of information that you're talking about.

In better organized networks of care, we won't have that kind of either/or situation in quite as stark a way as there is now. So information coming from basic research and applied research and clinical trials will have a more receptive audience, because it will not be so clearly viewed as a threat, very frankly, to the reimbursement patterns that currently exist to continue what has been done.

And I think we're talking about big changes in attitude to support big changes in practice styles. But we've got some mechanisms that we hope will push that. Any ideas you would have, we would certainly welcome to try to enhance that transition period.

DR. FRANK: Well, thank you for that opportunity, and thank you for all of your hard work. It's much appreciated. (Applause)

DR. KOOP: At the risk of being anticlimactic --(laughter) -- there is one question that I would like the First Lady to have the opportunity to answer, and it was posed to me by a number of you last night, and I'd like to

put it to her just as bluntly as you put it to me.

The plan is so complicated. There is so much to expect. There is so much possible opposition from Congress and from lobbies. If you don't have a simple fall-back position, isn't there a chance that we could lose it all?

MRS. CLINTON: Well, there's always that chance. But my view is that we have to believe we're going to succeed at this effort. The details will change. There will be a lot of good advice -- from you in this room and others --that will be legitimately aimed at improving what we are trying to do, that we will be very open to.

But I don't think you bring about change in the kind of atmosphere in which we live without enormous persistence and commitment to the final outcome. And from my perspective, there are certain absolutely nonnegotiable conditions -- like universal coverage and comprehensive benefits and enhanced quality and the things we've talked about.

And if we stick to those, and particularly if you become partners in this reform effort -- and when I say that, I don't mean that you will agree with everything that's in it, but you will stand behind and support what we're doing, and speak out for it -- I am very confident of the outcome.

And I wish we lived in an earlier time. I wish that this were the Social Security instead of the Health Security battle and that the legislation could be 32 pages long and the President could just go around saying, "Here's the deal. It's a new deal. You just put your money in and we'll take care of you when you're old." (Laughter)

But we don't live in those times. We live in an information overload time where everything is second-guessed and skepticism abounds, and where, as a result, we do have to present as many details as possible. But the details should not obscure our fundamental goal, which is to secure health security to every American, and to do it in a way that enhances their access and quality of care.

And if we stick with that, I think we're going to get it done. And, I don't think about fall-back positions.

I think about getting the job done. (Applause)

(End of tape.)

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THE REUTER TRANSCRIPT REPORT
HEARING OF THE HOUSE ENERGY AND COMMERCE COMMITTEE
SUBJECT: THE CLINTON HEALTH CARE PROPOSAL
CHAIRED BY: REPRESENTATIVE JOHN DINGELL (D-MI)

WITNESS:
FIRST LADY HILLARY CLINTON

2123 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON DC

TUESDAY, SEPTEMBER 28, 1993

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

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

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

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

Second, in order to enable the broadest possible participation of members today, it is the intention of the chair to observe the rules of the committee strictly because Mrs. Clinton's time with us today is most limited. I know members will be fair to their colleagues who are waiting patiently for an opportunity to question Mrs. Clinton by limiting their dialogue with the witness to the allocated time.

Finally, and consistent with committee rule 4(c), members present at the time the hearing was called to order will be recognized in order of seniority, alternating, as is the custom, between the majority and the minority. In light of the fact that we have two subcommittees who will be working on this legislation, the chair will treat the chairwoman and the ranking minority member of the commerce subcommittee, Mrs. Collins and Mr. Stearns, as having seniority immediately following that of Mr. Waxman and Mr. Bliley respectively. The rule also provides that members not present at the hearing when it was called to order will be recognized in order of their appearance, and staff will be making careful note of the arrival of members for this purpose.

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

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

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

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

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

Health care reform is not a new idea nor a revolutionary concept. But while most Americans favor reform, we have failed as a nation to make much progress when it comes to providing health security for every citizen. Sadly, health reform in this country is less a story of the typical American ``can do'' attitude than a story of procrastination and parochialism and all too often greed, fraud, waste and abuse.

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

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

the politics of the day and scares about socialized medicine.

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

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

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

For the past 12 years, this committee has fought to extend health care benefits to every American. For years, this committee has tried to root-out fraud and abuse in the health care system. For years, this committee has been ahead of its time.

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

Thank you very much, Mr. Chairman.

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

taking the leadership on it, and he'd be very pleased that you would mention him today, as indeed am I.

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

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

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

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

So I know it was my father's dream as well, and others around this country, that we finally have guaranteed access to care for all Americans. That's really what the core of the president's proposal is all about. And some of us who have worked in this area for a long time have felt that we needed a president who was willing to take the bold leadership to deal with this difficult issue. I used to think that would be enough. Now I know that what we needed more was also a first lady like yourself to give us the expertise and guidance you have given us in preparing this plan before us.

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

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

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

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

would substitute for the system that we currently have.

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

We looked very closely at that and we are continuing to work with those who advocate that position, particularly the Senate Republicans who have advocated an individual mandate. But we have a number of questions about it. One is that we worry that it would undermine the existing employer/employee system in which on a voluntary basis, as a matter of either collective bargaining or employer choice for competitive purposes, employers have responded over the last decades in increasing numbers to provide health insurance. And that employer/employee system has served as the basis for insuring more than 90 percent of the people in this country who have private insurance. And we would worry that shifting the burden wholly over to the individual would result in many employers who currently insure ceasing to do so, or maybe only insuring their high-wage workers and not their low-wage workers. And we would worry that if we subsidized individuals below a certain income level that there would be pressure on employers to keep wages below the subsidy level so that they would continue to be paid for by the government. So we have a number of problems with the individual approach.

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

REP. WAXMAN: Thank you very much.

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

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

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

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

REP. DINGELL: Without objection, so ordered.

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

Mrs. Clinton, like many others, we are currently working with a draft of the president's health reform proposal. To enable members to more fully understand this very complicated plan, I would ask that you make available to the committee the task force quantitative working papers concerning financing, premium caps, actuarial analysis of benefits, job impact, and the national health expenditure data.

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

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

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

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

MRS. CLINTON: Mr. Bliley, that's an excellent question. I really appreciate your asking that, because this is one of the crucial issues that

we have confronted. And let me start -- and I hope the chairman may give us just a little bit of leeway on time, because it's such a critical inquiry.

Let me start by saying that we anticipate realizing some substantial one-time only savings over the next several years. For example, we believe that insurance market reform, particularly in the non-group and small group market, will result in substantial savings. We believe that moving toward a single form system will result in substantial savings. We can outline in more detail and will gladly do so the kinds of changes that we anticipate beginning to bring down our base level of expenditures.

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

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

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

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

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

:he way we deliver health care more efficiently.

REP. BLILEY: Thank you.

Thank you, Mr. Chairman.

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

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

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

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

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

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

REP. COLLINS: There is a community health center in my district called the -- I can't think of the name of it right now, but it's a health center just outside of downtown Chicago, and it was closed for a long period of time and has been reopened. All the people in that health center -- in that neighborhood use that health center for primary care for children and everything else. And so I wondered if that is the kind of center -- Martin Luther King Health Center -- the kind of center that would be sort of an essential provider center, and more about that would be helpful to me.

MRS. CLINTON: Yes, that is what we anticipate, that community health centers that serve underserved populations in both urban and rural areas will be considered essential providers, and they will become part of larger networks that will serve the entire population, but they will have

elationships with hospitals and clinics and others so that the people who se the community health centers as the primary care givers will therefore be ble to be referred on to a specialist or to a more complicated kind of care hat they might need; whereas now, for too many people who use our community ealth centers, they may go to the community health center for primary care, ut because they are uninsured or underinsured, they have no real recourse xcept the emergency room, which is their entry into the additional health ervices that they may need. So we do intend for those linkages to be eveloped.

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

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

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

MRS. CLINTON: Well, what you're describing is what's happening right now, that insurance companies are very often overriding doctors' opinions and making decisions based on insurance coverage instead of clinical judgment that the doctor would like to bring to bear. That is happening right now. We believe that moving toward the system that we've envisioned, there will be less of that, and in fact, doctors will, we hope, regain some of the autonomy and authority that they have had to give up. But the antitrust laws will still guard against monopolistic practices.

Now we do, though, want to make some changes in antitrust to permit doctors and hospitals to have the same kind of opportunity to organizeBC
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You know, we want to have alternatives to insurance company-governed plans. We want to have the Catholic Hospital Association or the Mayo Clinic

or the local medical school to have the same kind of opportunity to join together with physicians to present services to the communities that will be covered, and we hope that we can strike the right balance in the laws to permit that.

REP. COLLINS: Thank you very much.

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

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

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

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

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

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

First of all, there is such a wide disparity of costs of health care right now in this country. And there has been a great deal of research done to try to determine whether there are significant differences in quality or access between regions or communities that provide care at a higher price or a lower price. What we have found in looking at all of the available research is that there is no discernible difference in quality between a lot of the high-priced care and more moderately-priced care that is available in the country.

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

If you look at just this one simple booklet, which outlines how much it costs at every hospital in Pennsylvania to perform this surgery, you will find that the cost ranges from $21,000 to $84,000. Then if you look at

quality indicators, including the number of patients who died and who were expected to die given the severity of their illness, you will find that there is no correlation between the high cost and better outcomes. In fact, the lowest cost of the operation in one hospital has some of the best results.

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

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

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

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

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

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

REP. STEARNS: Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

MRS. CLINTON: Yes, congressman.

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

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

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

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

REP. SHARP: Thank you.

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

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

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

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

But the question that's coming up time and time again -- on the radio, on television, the press -- is the financing. And I know you've been asked similar questions before. But there was one broadcaster this morning -- Charles Osgood -- said that if you thought you could save -- if you'd spend $300 billion more in the next ten years and still be able to cut $400 billion out of it, he has a car that will run only on water that he'll be happy to

sell you. And that's the kind of a sale you have to be able to make, because the public is very, very concerned about that particular issue.

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

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

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

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

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

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

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

REP. MOORHEAD: Thank you.

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

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

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

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

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

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

First of all, we think the fact that everyone would be insured will be a very big improvement in rural areas, because if we can begin to

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

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

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

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

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

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

REP. SYNAR: Thank you.

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

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

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

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

I notice in the president's book that you use the number of 37 million Americans who do not have health insurance. Interestingly, nowhere else is that number as high as it is in the president's plan. The Census Bureau said that 32 million are uninsured at some point in time, and 16 million as of 1987 had no insurance for the entire year. The Agency for Health Care Policy said that 24.5 million had no insurance for an entire year, and 23.3 million were uninsured for part of the year. The Harvard School of Public Health in 1992 said that 21 million were without health insurance for an entire year, and the Congressional Research Service says that 35.4 million lack insurance at a given point in time.

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

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

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

The most recent work that was just completed was done by Families USA looking at every one of the statistics that you have cited, plus trying to determine how to make it an understandable figure for people. They have pointed out that what we are now in the process of seeing because of increasing layoffs and people losing jobs and downsizing in the economy that accelerated in the last two-year period, and that may in part count for the difference between the 35 million and 37 million, is there are people who are

losing their insurance now every month, who unlike in the past are not being reemployed and, therefore, regaining insurance. And their figure is that 2.25 million lose insurance every month. Some may get it back in a month; some may get it back in a year. But based on their projections, they believe that, by this year next -- by this time next year, in the absence of our doing anything, we will be closer to 40 million uninsured. And I'll be happy to lay all that out and give you all of the statistics and the cites behind that as to how we have calculated it.

REP. BARTON: Thank you. And as a subset of that, we'd like to have, of the numbers that don't have insurance how many of them don't have it because they don't want it, or, conversely, how many of them desperately want it and flat can't get it. Because the Heritage Foundation and some of those groups have indicated that the number of Americans that don't have health insurance that do want it and just simply cannot get it for any reason is a much smaller number, somewhere between 10 million and 16 million.

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

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

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

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

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

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

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

three. Or if your appointment is going to be at the beginning of the month, they'll just put you off a few more weeks so that they could do this sneaky, back-door rationing.

Now, I know you're opposed to it and have heard you speak in favor of it, but I wonder if we could look at two other ideas in addition to the plan that could help us stop this kind of back-door approach. One of them would be to say that when you have a closed panel, a health maintenance organization, that panel would also have to give people the right to go outside the panel and get what they want by paying a little bit more. That would be one proposal. And the second would be in the area of technology, where we know that new products are fueling the cost increases so dramatically, whether we could look at a way to give the companies an incentive to provide up front information that would show why their product is superior to what's actually out there.

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

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

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

Thank you, Mr. Chairman.

MRS. CLINTON: Thank you.

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

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

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

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

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

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

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

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

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

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

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

Now, in our conversation -- and this is something that we will want to continue and that I'm sure this committee will want to engage in as

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

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

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

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

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

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

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

MRS. CLINTON: Well, Congressman, let me start by recognizing the extraordinary work that this committee, and particularly the subcommittee chaired by Mr. Waxman, has done over the years in trying to provide a medical safety net for millions of Americans through the Medicaid program.

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

We think by eliminating the Medicaid program and integrating those

cipients, we will end up giving better care to the recipients over the long n; we will, we hope, realize the kind of savings we think will come from .ving more Medicaid recipients in primary and preventive health care :tworks, the kind of reorganization that we anticipate; and we believe that : will eliminate a lot of the gross discrimination that currently exists ;ainst Medicaid recipients.

REP. SLATTERY: Okay, thank you.

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

MRS. CLINTON: No.

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

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

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

MRS. CLINTON: But under the direction of the state. I mean, it could be an intermediary kind of fiscal and negotiating collection function would be performed, but the ultimate responsibility would have to rest at the alliance level.

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

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

think can be delivered more efficiently at less cost, and we will lay those out for you.

REP. SLATTERY: Do you know by when?

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

REP. SLATTERY: Okay. Thank you.

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

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

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

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

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

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

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

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

MRS. CLINTON: Yes.

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

MRS. CLINTON: Yes.

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

MRS. CLINTON: Not necessarily, Congressman, for the following reasons. Unlike what has happened up until now, where choice has been

creasingly limited because doctors have been told who they can practice th if they expect to be reimbursed by this insurance company policy, we are ing to end that kind of discrimination against doctors. Doctors will be le to join more than one plan, and every doctor in a region will be in what ll be a fee-for-service network in addition to any other plan that the octor is in. So there will be many more options for doctors as well as for onsumers.

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

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

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

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

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

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

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

support these academic medical centers is so that they will be available for young men like the one you just mentioned so that that will be an option.

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

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

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

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

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

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

REP. HASTERT: Thank you very much.

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

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

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

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

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

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

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

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

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

here's a lot of difference that can be made in there.

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

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

REP. ROWLAND: Thank you.

Thank you, Mr. Chairman.

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

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

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

I have just three questions. One, during these very difficult times, why not cut health care costs before adding new health care benefits? And my second question would be: What aspects of tort reform would you embrace? And my third question would have to do with the illegal aliens. Though I come from Connecticut, we do have a major problem in Connecticut -- in Danbury, Connecticut, in particular -- with illegal aliens. And my question to you would be: How will they be dealt with in your proposal? They represent, obviously, an additional cost. They will have no insurance card, not being an American citizen obviously. And they also represent an additional burden to our overall system.

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

If we reduce the rate of increase in Medicare but we don't provide

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

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

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

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

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

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

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

At the same time, when anyone in this country gets sick, they're going to come to our hospitals. If there is an outbreak of tuberculosis, we're going to treat all of those who might be involved in it, whether or not they are citizens. So there will continue to be costs in the system that will

ive to be addressed in order to deal with the emergency and public health eeds of illegal aliens. But we want to draw the line as to who is entitled o have that health security card, and that should be only our citizens and egal residents.

REP. FRANKS: Thank you.

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

REP. THOMAS J. MANTON: Thank you, Mr. Chairman. Madam First Lady, t the outset, let me say we are honored to have you here today, and I think ou and your president, our great president for bringing to fruition, opefully very soon, the long-held ideal of universal health care. I had the leasure this Sunday of spending several hours with the president in my ometown, in the borough and county of Queens in New York, where he had a ort of a mini-town hall in a diner. Somehow diners are important in our ocial life in Queens and also in our political lives. And we heard from eople -- horror stories about the pre-existing condition limitation, about eople who, because they are in a small pool in small businesses, pay xtraordinarily high premiums. And one of my constituents who was there who as a college- educated woman who had had a kidney transplant had to mpoverish herself and not be employed so that she could qualify for medical are and not be above the so-called poverty line. We recognize that this is ery, very irrational.

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

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

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

And in a community like the one you represent, where families like to try to stay together and help each other out, there is just no help. I mean, I have visited so many homes and hospitals and community centers that just ask me, why are we so penny wise and pound foolish? I was in a hospital, St. Agnes Hospital, in Philadelphia earlier this year and they tried to run an adult day care center so that the families in the neighborhood who wanted to stay in the neighborhood, but had older relatives, could send their family members to the hospital during the day while everybody was out working. But the cost was about $35, $40 a day. And many of the families, which themselves

were uninsured, hard-working families, couldn't even afford that and could get no care or no compensation.

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

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

MORE

REP. MANTON: Thank you.

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

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

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

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

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

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

I'd like you to respond to your concerns about what happens to those businesses, how we deal with them. I know that there will be savings on the worker's comp side, maybe on the automobile side that might accrue to their benefit, even in their own personal health care premiums if they go

down, but it seems inevitable that when you impose a mandate such as this on employment, you have to have a downward pressure on employment. There have to be hundreds of thousands of decisions about should I expand my workforce beyond 50 or not? Should I bring on a part-time employee, a temporary employee? All of those decisions have to be reweighed in consideration of the cost of providing health care, and I'd like your comments on that.

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

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

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

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

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

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

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

Now, with respect to what will happen, if you look at Hawaii, which has during this entire time that it's had an employer mandate had an

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

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

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

REP. GREENWOOD: Thank you.

Thank you, Mr. Chairman.

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

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

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

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

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

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

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

I would like to ask you about the section of the plan which deals

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

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

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

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

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

I don't know if any of you heard, as I did the other day, on National Public Radio, the physician from Mayo Clinic who was talking in great detail about a drug that had been developed for deworming animals that was determined to have some beneficial use for colon cancer in human beings. And this physician at Mayo worked closely, hand in hand, with a drug manufacturer to make sure all of the testing was done so that it could be used for human beings. When it came on the market, the drug manufacturer started charging $6 a pill when you had basically the same drug being charged at 6 cents a pill for use in animals. And this physician at Mayo said, you know, this has got to stop.

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

What we've tried to do is to strike a balance in which more money

s going into the pharmaceuticals through the prescription drug benefit, hrough additional research dollars. But somebody, somebody has to have some ay of saying you cannot charge this much. And what the national board will o is not regulate prices but will publish information about what it onsiders to be a fair price for a drug based on its cost of development. And f we have any better ideas about how to sustain the good development of rugs, have the drug manufacturers and the biomed research companies get a air return, but somehow put a brake on what are the unfair and in many espects totally unjustifiable costs that are still being asked in the harmaceutical industry for us as the public and individuals to pay, we're pen to that. But we believe strongly there has to be some method for trying o get a handle on these prices.

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

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

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

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

Mrs. Clinton, your work especially with preventive care has been particularly outstanding, and we want to thank you for that. Erskine Bowles, speaking during the day after you addressed all of us in the health university, talked about some losers that would come about in terms of the payroll payment, and he said those companies particularly that can lose would be those that have a lot of young workers that have aggressively tried to ratchet down, if you will, health care costs, and those companies, especially those that have real good wellness programs, aggressive anti-smoking campaigns, exercise on the premises, that sort of thing.

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

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

But the reason we think it's fair to ask them to do that is

ecause if you look at the entire population, between 63 and 65 percent of nericans will pay the same or less for better benefits; about 20 or 22 ercent will pay a little bit more for better benefits; and then we're left ith this group that is young and they have benefited from what's called xperience rating because they are young.

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

And I have told some of the young people who -- you know, we have lot of young people around the White House, in case you haven't noticed, nd some of them have come up to me and they've said, ``Now, you mean I'm oing to have to pay more?'' And I've said, ``Well, yes, because we have this ld-fashioned idea that young people and old people and sick people and well eople all ought to be insured because you all will get old and none of you now whether tomorrow you could be sick or lying in the emergency room ecause of a motorcycle accident.'' And so we think that the basic principles f fairness mean that everybody has to be in the system and that some young eople now who pay less will pay a little bit more, but that is an investment hat will pay off for them as they get older and have children and do what he rest of us do.

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

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

REP. : The time of the gentleman has expired.

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

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

is dead. (Laughter.)

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

REP. : Mike. I mean mike.

REP. KREIDLER: Thank you, Mr. Chairman.

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

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

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

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

REP. KREIDLER: Great. Thank you. I was also encouraged to see how closely the -- in another respect that the president's plan parallels our state plan. But one difference is that our state plan does not require all health care coverage to be purchased through health alliances. Our plan has an exemption for large firms as the president's plan does, but it also allows

smaller employers to buy coverage directly from plans without going through the alliance. Why do you feel that all but the largest purchasers should obtain coverage through alliances?

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

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

REP. KREIDLER: Thank you, Mr. Clinton.

Thank you, Mr. Chairman.

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

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

REP. : Thank you very much.

I recognize the gentlewoman from Pennsylvania.

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

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

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

As you know, there are many insurance policies now that do not cover diagnostic services like Pap smears and mammograms, which means that

the woman bears the entire cost if she should obtain such a service. What we have done is to absolutely include them in the comprehensive benefits package. Mammograms and Pap smears are covered services. That means that you can never be denied insurance coverage for those particular diagnostic tests.

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

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

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

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

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

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

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

REP. MARGOLIES-MEZVINSKY: I suspect this next answer may have something to do with a report card, but will there be a compliance element

ıvolved here also? I feel that it isn't enough for an insurer of any sort to ıst have this service available.

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

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

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

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

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

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

REP. MARGOLIES-MEZVINSKY: Thank you very much.

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

The chair recognizes now the gentlewoman from Arkansas, Ms. Lambert.

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

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

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

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

The other, I hear a tremendous amount from my small rural ɔspitals, the disadvantage that they're put at because of the certain CLIA ɜp) regulations and others. I'm hoping that there are certain CLIA (sp) ɜgulation reforms that will certainly level the playing field hopefully, or t least put these hospitals in a position where they can be capable of ompeting with the larger urban hospitals.

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

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

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

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

Secondly, with respect to small rural hospitals and CLIA (sp), we look forward to working with this committee, which pioneered the kinds of protections that CLIA (sp) put into law to make sure that where adjustments and reforms might be called for, they can be made in a thoughtful way. And I

now that the committee will welcome your specific suggestions based on the eal-life experiences because I, like you, have heard that sometimes when we ry to do the right thing we have unintended consequences have been articularly difficult in rural areas so that, for example, hospitals and linics no longer feel free even to do a strep test for strep throat because hey feel like they have to send it off and then it takes two days, and you ould have beaten the strep infection if you had just been able to do it on ite. So those are some of the practical considerations that I think this ommittee will be very sensitive to.

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

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

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

REP. LAMBERT: Thank you.

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

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

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

The chair announces that the time that Mrs. Clinton had available to us expired 15 minutes ago, and so we express again to you our thanks for your kindness in that particular. Without objections, all members will be

ermitted to insert opening statements in the Record. The chair advises that ir time here has expired and there will be no time for further questions at nis time, but if members choose, Mrs. Clinton has indicated that she and her taff would respond to questions which we would not only make available to ne members if they -- the response which we would not only make available to ne members, but would insert in the Record.

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

MRS. CLINTON: Thank you, Mr. Chairman.

REP. DINGELL: Committee stands adjourned to the call of the hair. (Sounds gavel.)

END

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

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 tim s 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 becau e 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 i 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 syst . 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 proble 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 be 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 co t 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 -- th n 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 he

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 progra 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 th 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 plan . 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 -- 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