Jim Slattery (D-KS)

QUESTION:

What programmatic changes will you be proposing in the Medicare program?

ANSWER:

We have proposed a series of provisions that can achieve significant Medicare savings when linked to cost reduction efforts in the private sector.

For Medicare, we are proposing $124 billion in savings by the year 2000, 23 percent of which would be gained by extending expiring authorities such as Medicare secondary payer provisions, the part B premium, and reductions in the hospital market basket which expire after FY 1998. Another 27 percent of Medicare savings would be achieved through elimination of subsidies that will be unnecessary after health care reform, such as a reduction in indirect medical education payments, reducing the Medicare disproportionate share hospital adjustment, and lowering the Medicare secondary payer threshold for disabled workers.

The remainder of provisions involve a broad spectrum of Medicare program activities. I can assure you that they are designed to achieve savings without adverse impact on vulnerable populations, such as those in rural areas.

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

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

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

REP. SLATTERY: Do you know by when?

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

REP. SLATTERY: Okay. Thank you.

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

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

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

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

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

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

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

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

MRS. CLINTON: Yes.

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

MRS. CLINTON: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REP. HASTERT: Thank you very much.

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

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

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

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

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

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

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

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

In very carefully comparing the cost of Medicare in areas that

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

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

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

REP. ROWLAND: Thank you.

Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REP. FRANKS: Thank you.

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

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

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

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

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

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

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

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

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

these services in a more cost-effective way.

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REP. MANTON: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

be those that have a lot of young workers that have aggressively tried 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 because if you look at the entire population, between 63 and 65 percent of Americans will pay the same or less for better benefits; about 20 or 22 percent will pay a little bit more for better benefits; and then we're left with this group that is young and they have benefited from what's called experience rating because they are young.

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

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

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

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

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

REP. : The time of the gentleman has expired.

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

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

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

REP. : Mike. I mean mike.

REP. KREIDLER: Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

REP. KREIDLER: Thank you, Mr. Clinton.

Thank you, Mr. Chairman.

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

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

REP. : Thank you very much.

I recognize the gentlewoman from Pennsylvania.

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

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

MRS. CLINTON: Well, I'm so glad you asked that, because there has been so much misinformation and misunderstanding about this feature.

And I am happy to have the opportunity, Congresswoman, to clarify that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REP. MARGOLIES-MEZVINSKY: Thank you very much.

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

The chair recognizes now the gentlewoman from Arkansas, Ms.

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

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

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

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

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

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

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

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

REP. LAMBERT: Thank you.

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

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

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

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

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

MRS. CLINTON: Thank you, Mr. Chairman.

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

Chair. (Sounds gavel.)

END

EXECUTIVE OFFICE OF THE PRESIDENT

30-Sep-1993 08:08am

TO: (See Below)

FROM: Jeffrey L. Eller
Office of Media Affairs

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

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

Internal Transcript -- Not for external distribution

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

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

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

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

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

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

Nancy.

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

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

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

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

But Mr. Chairman, I agree.

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

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

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

Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

themselves without health care coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEN. KENNEDY: Thank you.

Senator Kassebaum?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MRS. CLINTON: Right.

SEN. KASSEBAUM: The governor?

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

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

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

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

SEN. KASSEBAUM: Thank you.

SEN. KENNEDY: Senator Pell?

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

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

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

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

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

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

SEN. PELL: Thank you.

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

SEN. KENNEDY: It will be inserted.

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

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

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

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

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

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

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

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

SEN. PELL: Thank you very much.

MRS. CLINTON: Thank you, senator.

SEN. KENNEDY: Senator Jeffords.

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

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

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

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

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

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

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

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

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

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

Now a question -- I don't --

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

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

best possible resolution for the American people.

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

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

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

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

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

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

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

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

SEN. JEFFORDS: An all-payer rate system.

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

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

MRS. CLINTON: Thank you very much, Senator.

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

Senator Metzenbaum?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEN. KENNEDY: Senator Coats?

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

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

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

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

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

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

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

political process to be included.

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

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

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

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

MRS. CLINTON: Senator, those are--

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

MRS. CLINTON: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Senate Labor & Human Resources Committee:

HRC Testimony. 9/28/93

SEN. KENNEDY: Thank you very much.

Senator Dodd?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEN. DODD: Thank you very much.

Thank you, Mr. Chairman.

SEN. KENNEDY: Thank you very much.

Senator Gregg.

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

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

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

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

hard to realize.

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

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

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

So I don't see where those fit.

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

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

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

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

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

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

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

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

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

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

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

But in the event of some unforeseen circumstance where a state

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

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

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

SEN. GREGG: Thank you.

SEN. KENNEDY: Senator Simon.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

provided.

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

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

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

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

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

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

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