Strom Thurmond (R-SC)

Questions not submitted to ASL.

really is competitive.

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

MRS. CLINTON: Yes, sir.

SEN. THURMOND: Thank you, Mr. Chairman.

SEN. KENNEDY: Thank you very much.

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

Senator Mikulski.

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

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

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

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

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

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

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

Could you comment on that?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEN. KENNEDY: Very good.

Senator Hatch.

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

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

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

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

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

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

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

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

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

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

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

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

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

Orrin Hatch (R-UT)

QUESTION:

Walk us through exactly how the global budget will work, explaining how the costs are going to be restrained without reduction in quality of care, choice, access, or technical innovation.

ANSWER:

We do not have global budgets in this plan. We do have enforceable caps on premiums for plans covering the guaranteed benefits. This is an important distinction.

Global budget signifies a limit on total health care spending, including copays and deductibles, spending for non-covered services, and any other health care expenses individuals may incur by electing to pay for care privately, outside of their health plan. It is a much broader concept than that included in our bill.

A premium cap, by contrast, constrains the rate of growth in the price of health plans. In the Health Security Act, these caps are a backstop -- we are confident that competition in a reformed market will bring down costs dramatically.

In the unlikely event the caps were triggered - here is what would happen:

Every noncomplying plan in a noncomplying alliance is subject to a reduction in its premiums to insure that total alliance spending is within the allowed target.

An alliance is considered to be noncomplying if the weighted average accepted bid exceeds the per capita target. A plan is considered to be noncomplying if its final accepted bid exceeds the per capita target for that alliance for that year.

The amount of the reduction is equal to the plan's proportion of the total excess spending that would be generated by all the noncomplying plans in the region.

In addition, each plan that is subject to the reduction reduces its payment rates to providers by a comparable percentage. This can be adjusted to offset any anticipated increase in volume that might result from lowering the rates.

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

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

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

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

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

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

SEN. HATCH: Well, thank you.

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

SEN. KENNEDY: Thank you very much.

Senator Bingaman.

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

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

record of leadership on this issue.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you, Mr. Chairman.

SEN. KENNEDY: Senator Durenberger?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEN. DURENBURGER: Thank you.

SEN. KENNEDY: Senator Wellstone.

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

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

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

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

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

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

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

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

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

MORE

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

36thadd

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

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

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

Senator Wofford?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEN. WOFFORD: Thank you.

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

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

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

Nancy Kassebaum (R-KS)

QUESTION:

How will experimental procedures like transplants be covered?

ANSWER:

The National Institutes of Health supports clinical trials and other clinical research, which assist providers and third party payers in determining which clinical treatments are effective. The cost of investigational treatment is currently supported by research funds and by third payers who may cover the cost of routine care associated with investigational treatment.

NIH also supports efforts to evaluate treatment and prevention efforts through development of prevention and treatment guidelines and by sponsoring consensus conferences. The results of these activities can be used by the proposed National Health Board in updating the Comprehensive Benefits.

Experimental treatments for a life-threatening disease can be covered at the discretion of the health plan. However, even if the experimental treatment itself is not covered by the plan, the benefit package includes coverage for routine care during treatment, if such care would have been provided even if the individual were not receiving an investigational treatment. All plans, together with their providers, will determine what is medically necessary and appropriate treatment on a case-by-case basis.

The National Board will be charged with monitoring advances in medical technology and will be able to revise the guaranteed benefits package over time to reflect these advances. Consequently, a procedure that is considered untested and experimental today may at some point become incorporated into standard, accepted medical practice. In such a case, the Board could direct all plans to include such a procedure in their covered benefits.

doesn't cover costly procedure -- experimental procedure.

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

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

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

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

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

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

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

SEN. KASSEBAUM: Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

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

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

SEN. DODD: I thank you for that answer.

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

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

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

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

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

The committee stands in recess.

MRS. CLINTON: Thank you, Mr. Chairman.

- END -

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30-Sep-1993 08:18am

TO: (See Below)

FROM: Jeffrey L. Eller
Office of Media Affairs

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

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

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

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

Did I leave anything out, Bill?

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

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

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

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

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

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

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

Mr. Goodling.

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

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

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

Thank you.

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

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

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

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

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

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

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

Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

price for insurance.

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

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

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

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

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

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

Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

REP. CLAY: Thank you.

REP. FORD: Mr. Petri.

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

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

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

TAB REF # 12

Tom Petri (R-WI)

Questions not submitted to ASL.

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

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

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

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

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

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

REP. PETRI: Thank you.

REP. FORD: Mr. Murphy?

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

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

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

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

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

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

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

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

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

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

REP. MURPHY: Thank you.

Thank you, Mr. Chairman.

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

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

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

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

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

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

REP. FORD: Ms. Roukema.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REP. ROUKEMA: Yes. Correct.

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

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

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

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

REP. ROUKEMA: Thank you.

Thank you. That's a very comprehensive response.

REP. FORD: Mr. Williams.

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

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

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

REP. WILLIAMS: We enjoyed having you.

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

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

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

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

William Goodling (R-PA)

QUESTION:

To what extent will these subsidies (to the unemployed and early retirees) be funded from the Medicare and Medicaid programs? What kind of formula will the national health board use to allocate the subsidies to the regional alliances? And, if it isn't enough money, how is it paid for?

ANSWER:

There will be no direct stream of funding flowing from current programs to new health care reform programs. Savings will be achieved through a balanced reduction of both private and public sector rates of growth, through improved systems and efficiency, and the tobacco tax.

Discounts will be provided based upon the number of individuals and employers an alliance reports to be in need of assistance.

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

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

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

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

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

REP. WILLIAMS: Thank you.

REP. FORD: Thank you.

Mr. Goodling?

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

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

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

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

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

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

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

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

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

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

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

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

We now recognize Mr. Owens.

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

TAB REF # 14

Tom Sawyer (D-OH)

QUESTION:

We know you've taken care of dealing with independent students. full-time students up to the age of 23, I believe. But with the changing demographics of American campus, with the enormous gray areas in different kinds of employment, I include full-time independent students beyond that age, stipend-supported teaching assistants, work-study program participants and even National Service Program employees, do we have a clear definition of, in circumstances like that, who is the employer and who is the employee and how people in these kinds of circumstances are covered under the health care program?

ANSWER:

Stipend-Supported Teaching Assistants and Work-Study

- Students working in stipend-supported teaching positions or in work-study arrangements would have their health insurance premiums paid for in the manner as other full- or part-time employees.
  - o If the employer is a college or university, the institution would be responsible for paying the "employer" portion of the premiums.
  - o If the employer is an off-campus business, it would pay the relevant premium.
  - o In both cases, the student would be responsible for the "employee" share.
  - o It is important to note howeve, that in many cases the student will be working only part-time and therefore the employer share will be pro-rated based on the number of hours the student is working.
  - o In addition, depending on the student's income, he or she may be eligible for low-income subsidies.

National Community Service

- Students participating in the National and Community Service (NCS) program will receive full health benefits. The majority of the premium (85%) will be paid through NCS grants to the participating organizations. The balance (15%) will be paid by matching funds from the participating organizations.

Tom Sawyer (D-OH)

Response forthcoming from Education.

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

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

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

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

REP. FORD: Mr. Sawyer.

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

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

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

REP. SAWYER: Thank you.

REP. FORD: Mr. Gunderson.