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TAB REF # 15

Steve Gunderson (R-WI)

QUESTION:

Explain the role of the Department of Labor in regulating the health care delivery system (in contrast with that of HCFA or HHS).

ANSWER:

The Department of Labor (DOL) has primary responsibility for regulating corporate alliances and self-insured health plans; ensuring compliance with the employer mandate in the regional alliances; and implementing and monitoring uniform claims dispute procedures for all health plans. DOL and HHS will work together to establish standards for State/regional alliance financial and management systems, and to coordinate audits of the regional alliances. DOL and HHS will also work jointly in the areas of workers compensation and work force development.

Corporate Alliances

DOL has overall responsibility for the regulation of corporate alliances, and for terminating corporate alliances that fall below the size requirements, exceed restrictions on premium increases, or otherwise fail substantially to meet applicable requirements.

For group health plans maintained by corporate alliances, DOL establishes rules for computing premiums. DOL also continues to enforce ERISA's fiduciary standards and relevant reporting and disclosure provisions, as well as new reporting and disclosure rules promulgated by DOL under the Health Security Act.

DOL regulates self-insured corporate alliance health plans; assures that they continue to meet financial reserve requirements; and, in the event of insolvency, administers self-insured corporate alliance health plans through a court-ordered trusteeship. DOL also administers an insolvency fund for self-insured corporate alliance health plans to assure continued payment for guaranteed benefits until the plan is either restored from trusteeship or terminated and its participants transferred to regional alliance plans.

Regional Alliances

DOL consults with HHS, which establishes standards for State and regional alliance financial and management systems. Both agencies coordinate audits of regional alliances. HHS conducts

financial and performance audits of the regional alliances; DOL performs audits of the regional alliances as necessary to enforce the employer mandate.

Employers

The States have the primary responsibility for ensuring that employers participating in the regional alliances are meeting their contribution obligations. DOL will serve in an oversight capacity and assist States as needed in enforcing the employer mandate in regional alliances. Should this be necessary, DOL will assess civil monetary penalties against a regional alliance employer in the case of continued failure to pay (as defined in DOL rules).

DOL has primary responsibility in assuring that corporate alliance employers make premium contributions on behalf of their employees. In appropriate cases, DOL has discretion to commence collection activities directly against employers for delinquent contributions.

Plans

DOL develops and monitors uniform claims dispute procedures for all health plans, including an alternative dispute resolution program (with mediation and administrative law judge hearing), and a procedure for hearing appeals before an administrative board appointed by DOL. In addition, DOL continues to enforce ERISA's fiduciary standards and relevant reporting and disclosure provisions with respect to certain supplemental benefit plans (i.e. plans providing benefits not offered under the comprehensive benefit package).

Other Responsibilities

DOL and HHS jointly develop protocols for the treatment of work-related injuries covered by workers' compensation, conduct demonstration projects on the treatment of work-related injuries and illnesses, and staff a commission that will report to the President regarding the feasibility of full integration of workers' compensation into the new health care system. DOL is independently responsible for developing rules for health plans and workers compensation carriers regarding the use of standard forms and provision of data on quality. DOL is also required to study and report to Congress on the impact of the workers compensation provisions in the Act on workers compensation premiums.

DOL and HHS jointly operate a National Institute for Health Care Workforce Development, which will focus on the supply of health care workers and the need for education, training and career development. In addition, DOL has independent responsibility for retraining and job bank programs.

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performs audits of the regional alliances as necessary to enforce the employer mandate.

Employers

DOL assures that corporate alliance employers make premium contributions and monitors the States' enforcement of the employer mandate in regional alliances. DOL assesses civil monetary penalties against a regional alliance employer in the case of continued failure to pay (as defined in DOL rules). In appropriate cases, DOL has discretion to commence collection activities directly against employers for delinquent contributions. DOL also develops a grievance procedure for employers and alliances aggrieved by audits.

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authority as last resort

REP. STEVE GUNDERSON (R-WI): Thank you, Mr. Chairman.
Mrs. Clinton, I think I've figured out a way to extend two minutes into a long Q&A period.

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

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

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

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

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

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

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

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

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

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

REP. FORD: Mr. Payne?

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

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

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

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

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

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

help support those institutions in those areas.

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

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

REP. FORD: Mrs. Unsoeld.

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

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

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

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

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

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

MRS. CLINTON: Yes, we will.

REP. FORD: Mr. Armey.

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

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

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

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

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

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

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

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

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

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

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

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

REP. ARMEY: Thank you.
MRS. CLINTON: Thank you.
REP. FORD: Ms. Mink.
REP. PATSY T. MINSK (D-HA): Thank you very much, Mr. Chairman.

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

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

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

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

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

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

and out of it.

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

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

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

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

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

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

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

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

REP. MINK: Thank you.

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

Mr. Andrews?

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

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

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

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

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

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

MRS. CLINTON: Yes, sir.

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

MRS. CLINTON: Yes, annually.

REP. ANDREWS: Thank you very much.

MRS. CLINTON: Thank you.

REP. FORD: Mr. Fawell?

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

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

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

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

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

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

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

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

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

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

REP. FAWELL: Thank you.

REP. : Thank you.

Mr. Reed.

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

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

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

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

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

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

MRS. CLINTON: Yes, sir.

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

REP. FORD: Mr. Roemer?

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

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

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

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

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

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

Eliot Engel (D-NY)

QUESTION:

With the maintenance-of-effort requirements in the plan, can you assure us that generous States like New York will not end up subsidizing other States?

ANSWER:

Overall State spending will be based on historical spending patterns and existing matching formulas in the short term. However, the Health Security Act will create an Advisory Commission on Regional Variations in Health Expenditures, which will recommend methods for eliminating variations in health spending by 2002. These recommendations will be submitted to the National Health Board, and then to Congress for legislative action.

The Health Security Act charges the Advisory Commission with examining regional variations in: (1) Federal and State premium payments and financing for wrap-around services on behalf of cash recipients; and (2) State maintenance-of-effort payments on behalf of non-cash recipients. The Commission will be required to consider ways to eliminate variations due to practice patterns and variations due to historical differences in provider reimbursement and the amount, duration and scope of covered Medicaid benefits in different States.

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

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

REP. ROEMER: Thank you very much.

MRS. CLINTON: Thank you.

REP. ROEMER: Nice to see you again.

REP. FORD: Mr. Engel.

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

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

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

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

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

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

REP. ENGEL: Thank you very much.

REP. : Mr. Scott.

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

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

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

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

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

MRS. CLINTON: Yes, sir.

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

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

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

Thank you.

REP. : Mr. Ballenger?

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

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

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

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

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

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

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

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

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

REP. BALLENGER: Thank you, ma'am.

REP. : Mr. Becerra.

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

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

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

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

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

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

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

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TAB REF # 17

Gene Green (D-TX)

QUESTION:

Will the medical screenings required for children under the elementary-secondary education reauthorization be covered by insurance under health care reform?

ANSWER:

The Elementary and Secondary Education Act as introduced requires that schools with 50 percent or more poor children ensure that all children in that school receive two health screenings at appropriate intervals.

Department of Education Chapter 1 funds may be used to pay for these services if no other funds are available.

Once health care reform is implemented, these health screenings would be included in the basic package of insurance benefits.

Chapter 1 funds could be used to coordinate and facilitate the provision of these services.

anyone who's in the country who needs it.
REP. : Mr. Green?
REP. GENE GREEN (D-TX): Thank you, Madam Chairman.
Mrs. Clinton, it's great to have you here, and after Pat Williams said about he's glad that the president chose you as his spouse, after almost 24 years, my wife has convinced me that she chose me as her spouse and it wasn't the other way around.
Let me ask a question, though, on how this relates, since we are the Education and Labor Committee and I'm on Labor Management, so we'll do this, but I also spend a lot of time on the education side of it. The administration has proposed as part of the elementary- secondary re-authorization that we use -- the schools also provide health care screenings for children. And I was wondering if the security health plan would provide that, or would we have to also dip in our education funds that we're struggling to use. And I would hope it would be an umbrella plan when we talk about it. Health care includes, you know, obviously screenings and preventive care that I know you've talked about on a great deal of -- a great many occasions.
MRS. CLINTON: You know, I'm afraid I'm not familiar with what the provisions in the education bill currently are with respect to that, but I'll be happy to look into that. And we do, in the health care reform, propose some public health outreach kinds of initiatives, including bringing services to schools where we think that students may be more easily accessed. But I'll have to give you a specific answer about the relationship with the education bill, Congressman. I just don't know the answer to that.
REP. GREEN: Okay. Thank you.
Thank you, Madam Chairman. REP. : Mr. Barrett?
REP. BILL BARRETT (R-NE): Thank you, Madam Chair.
I, too, Mrs. Clinton, like the previous speakers, thank you for your sharing of your time and your talent before this full committee. I guess, like Mr. Murphy -- his question triggered, in my thinking -- I come from a very large rural district, where the small hospitals are closing and the doctors are caught with the bureaucratic Medicare/Medicaid and going to greener pastures in the urban areas and so forth. But I also have another unique problem in that my district is elderly, percentage-wise very elderly. And I guess the question is simply this: What happens in your plan if the insurance companies elect not to bid for the alliance's business? In other words, why would companies want to if they had to take everyone? Has that been a concern for you and your task force?
MRS. CLINTON: Yes, Congressman, and we are particularly concerned about rural areas where there are not sufficient providers now. But in looking at what has proven successful in providing rural health care delivery, we think we have built in a number of those features, starting with providing an adequate funding base in your district now. Because what is often found in rural areas is not only a heavier-than-usual Medicare load, but a heavier-than-usual uninsured population. Oftentimes, agricultural areas

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TAB REF #18

Bill Barrett (R-NE)

Questions not submitted to ASL. See responses to Payne (TAB REF # 5) for possible duplication.

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

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

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

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

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

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

MRS. CLINTON: Yes, please.

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

REP. BARRETT: Thank you, Mr. Chairman.

REP. FORD: Ms. Woolsey.

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

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

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

choose to participate.

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

REP. WOOLSEY: Thank you.

REP. FORD: Mr. Romero-Barcelo.

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

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

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

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

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

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

Thank you.

MRS. CLINTON: Thank you very much.

REP. FORD: Mr. de Lugo?
DEL. RON DE LUGO (D-Virgin Islands): Thank you very much, Mr. Chairman.
Mrs. Clinton, I want to thank you very much for the help you gave us in getting into the -- this health care plan. This is the most social legislation of our lifetime, and for the first time when a president of the United States says "all Americans" it will include all Americans. I want to thank you again that you put all of us in the territories in the plan -- 4-1/2 million of us. It's going to mean a lot to us.
I wondered, has thought been given to possible technical assistance as we try to come into this plan?
MRS. CLINTON: Yes. And I appreciate your comments as well, because we mean what we say when say American citizen, and Americans should be treated the same no matter where they are. But we also recognize that there may need to be some technical assistance provided in order to ensure that what this legislation will ultimately contain can actually be delivered effectively. And we will provide that as well.
DEL. DE LUGO: Thank you.
REP. FORD: Mr. Faleomavaega?
DEL ENI F.H. FALEOMAVAEGA (D-American Samoa): Thank you, Mr. Chairman.
I suppose for want of a better term, Madam First Lady, I would like to also echo the sentiments that have been expressed by my colleagues, again extending our appreciation for the dynamic leadership that you've demonstrated in providing for our nation's health care needs. It may well be said that the soul and the spirit of our nation's health care system will be attributed highly to your leadership, Madam First Lady, and I want to commend you for that.
I think our previous colleague from the territory of Guam, a retired Marine general, said a very sentimental statement to me the other day. He said, "We are equal in war for those of us from the territories, but not in peace." And all we're suggesting here is perhaps not to forget the 4-1/2 million citizens who die in our -- in the wars that we fought and make sure that they are also provided for.
The problem that I'm faced with, and it troubles me sometimes, too -- you know, those of us -- I'm sure the president, the politicians here in the Congress, our state governors -- when something happens to you, you get first-class treatment. Recently, our governor had to be medevaced from Samoa to the state of Hawaii, which is about 2,500 miles distance. How do we provide for a system where the average American cannot afford this kind of a first-class treatment given to those of us supposedly because of the capacities that we serve as public servants? How can we provide a sense of equity for those who simply do not have that luxury? Can you help me with that?
MRS. CLINTON: Well, I think we have to start by making sure everybody has access to comprehensive health care benefits, and then we have

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

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

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

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

DEL. FALEOMAVAEGA: Thank you, Madame First Lady.

Thank you, Mr. Chairman.

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

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

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

When I hear about that, what instantly goes through my

TAB REF # 19

Karen English (D-AZ)

Questions not submitted to ASL.

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

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

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

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

Pat, would you like to close it off now?

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

MRS. CLINTON: Thank you very much.

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

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

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

MRS. CLINTON: Thank you, Mr. Chairman.

- END -

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Senate Finance

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

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

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

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

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

If I have any misgiving, and it is your fault or your husband's fault or your administration's fault, it is a misgiving based upon history, and that's the cost estimates of what we hope we can save and what we hope the new entitlements will not cost. And the only reason I say that is, over the last quarter of a century, we have all been wrong. You have done more to attempt to quantify the cost as accurately as possible as I think can humanly be done, but I would still bet a dime to a dollar they're wrong, and maybe that's just 25 years of being burned.

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

We must get our friends and neighbors and our loved ones to get their flu shot this year and every year. And it's a good time for older Americans to probably get their Pneumonia shot too, which is also paid for by Medicare . Modern medicine has come such a long way from the plagues and the epidemics of the past. But now we really can reduce the impact of the flu, but only when we take responsibility for our own health and for the health of our loved ones and get vaccinated.

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

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

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

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

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

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

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

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

Bruce.

BRUCE VLADECK: Thank you, Phil.

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

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

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

In the past few weeks, Mr. Chairman, you and other distinguished members of this committee have raised tough and important questions about how best we can finance health care reform. This is, as we all know, a subject of great complexity, one that has been studied exhaustively, but which is still subject to a great many questions. We have to, in the coming weeks and months ahead, work closely together to understand as fully as we are able the kinds of issues that are raised by the reforms that are offered, not only by the president, but by the Republican senators represented here on this committee and others.

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

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

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

And we know all too well how paperwork, administration and bureaucracy cost us at least 10 cents of every health care dollar. And for

small businesses, administrative costs eat up one out of every three health care dollars. And finally, the Justice Department estimates that health care fraud, because of the kind of system we currently have, robs the American taxpayers and those who buy their own insurance of at least $80 billion a year.

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

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

There is no mystery, however, about how we pay for care. More than half of Americans' annual health care bill, and that includes both public and private funds, comes from employers and individuals, those who create the jobs, work hard, play by the rules and pay largely for our health care system. They pay for insurance premiums and they pay both through business and through individual payments. They pay through out-of-pocket expenses, and they pay taxes to cover the public programs that include Medicare, Medicaid, the veterans program, CHAMPUS, and other federal outlays such as uncompensated care payments.

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

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

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

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

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

han what they get today.

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

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

We believe this approach will provide the least disruption for people who have benefits who have fought hard for their health benefits and like how they get them now. And it is an idea that some would argue is a pretty old-fashioned one because it builds on the system we have. It was advocated, as you pointed out, Mr. Chairman, by President Nixon, introduced by Senator Packwood, and it will provide a familiar way for Americans to know they will be secure.

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

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

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

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

The second element in the financing plan is something Washington ars a lot about: trying to limit the growth of government spending. We all now, and you know better than most in this committee, that it is tough to top, let alone try to control, government spending. But we do think we can

low the rate of increase down. And we intend to do so not with a cap that is ot specified, but with specific, scorable, line-by-line savings proposals.

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

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

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

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

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

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

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

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

proud of and that Americans will feel good about.

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

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

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

And good morning, Mr. Leader.

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

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

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

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

SEN. MITCHELL: Thank you, Mr. Chairman.

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

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

We face a legislative challenge that will take all of the knowledge, the experience, and the cooperation that members of this committee have developed over many years of work. The need for affordable health care for all Americans is not a partisan issue. Health care is a fundamental human need and, I believe, a fundamental right of every citizen in a democratic society.

Our challenge is to provide access to affordable health care to every American. To achieve this goal, the attitudes, the habits, and the behavior of every health care consumer and provider must change. Rising health costs threaten the long-term fiscal health of the nation. They represent the single greatest contributor to the future growth of the federal budget deficit, a deficit which drains needed savings and investment from the

private sector. Yet despite the truly enormous national resources devoted to health care in our society, we have a system which doesn't serve all of our people.

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

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

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

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

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

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

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

I applaud the efforts of Senators Chafee and Dole and other members of the Republican health care task force. Their proposal contains many provisions which are similar to those found in the president's plan. There is substantial common ground on which to build. I look forward to a vigorous and well-informed debate on the significant differences which exist in the two plans as well.

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

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

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

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

SEN. MOYNIHAN: Nothing be added.

Senator Dole?

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

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

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

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

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

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

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

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

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

But I think finally I would say that whatever else happens, this issue is all about health care for American people. And I think we have to talk as honestly as we can to the American people -- no rosy scenarios, no smoke and mirrors, and no juggling of the books. That's true of us or anybody else, Republicans or the administration. Because there's no doubt about it, somebody has to sacrifice. And the thing that really interested me was President Clinton's sixth point he made, his sixth principle -- responsibility. I mean, my view is if we're going to delay responsibility for 10 years for individuals in some cases, we may never have responsibility. And it seems to me if we want people to better use the system and save money in the system, there's got to be some individual responsibility. We think that's present in probably both packages, but I think it's very important.

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

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

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

that, and we certainly appreciate your being here this morning.
Thank you, Mr. Chairman.

SEN. MOYNIHAN: Thank you, Senator Dole.

Mrs. Clinton would you like to -- ?

MRS. CLINTON: No, I just want to thank Senator Dole for the kind of leadership that you've shown on this issue and your willingness to work it through, just as you said. We do want to preserve what is best about the American health system and fix what is broken, and I think if we have in mind that that's the approach we want to take and we then really hold up to scrutiny anything we're going to do to see whether it advances that and advances, I think, the goals we all agree on of security and responsibility and quality and choice and simplicity and savings, I'm very confident that we're going to be able to come up with bipartisan support for a package that we'll all be able to advocate for. We may not all like 100 percent of what's in it, but in the natural course of putting it together, we will have made the right decision for the American people.

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

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

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

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

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

We believe -- and I don't think you can find any health economist or student of the health care system who would disagree -- that there are [illegible]nsiderable, substantial savings in the existing system that can be realized [illegible]oth on a one-time only basis and on a continuing basis. There are varying [illegible]stimates as to what those savings are. Dr. Koop says, for example, that

[Ba]sed on the work he has done with Dr. Jack Wynberg (sp) at Dartmouth and [ot]hers who have been studying health care expenditures that there may be as much as $200 billion of unnecessary costs within the health care system. And even if we take an estimate below that or above it, wherever it comes out, we know there are substantial one-time and continuing savings in the system.

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

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

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

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

And that is the kind of waste and inefficiency that permeates our health care system, and we believe very strongly that if we don't set the kind of very strong goals that we can achieve in both the public and the private sector, we will continue to reward this piecework, inefficient delivery system that does not guarantee quality at all. I think most of us on this committee would be more than pleased to get all of our health care from [the] Mayo Clinic, and we would get it at much less of a cost than if we went to [a]ny of the hospitals within a few miles of this building.

SEN. MOYNIHAN: Mrs. Clinton, I have to say to you the only thing

[th]at you -- the one option you have not considered sufficiently in this whole [pl]an is if we can just move every -- half the population to Minnesota, half [t]o Hawaii, our problems would be solved. (Laughter.)

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

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

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

(Off mike discussion.)

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

(Recess.)

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

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

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

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

SEN. PACKWOOD: Okay. Very quickly on abortion , and then I'll [mo]ve on to something else. Will the president's bill -- it includes [p]regnancy-related services -- will it include abortion?

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

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

MRS. CLINTON: Yes.

SEN. PACKWOOD: Okay. Now, you're the company, and you've got a 30-year plan. Somebody age 55 can retire, and they get $1,000 a month. And their health plan costs $300 a month to carry them. And the company's having to shrink. It's getting more productive. So it says to this person, ``Sally, Joe, listen, I'll make you a deal. I'll sweeten this offer and we'll give you $1,100 a month to retire.'' And Joe or Sally says, ``Well.'' ``And no change in your health plan.'' Sally or Joe says, ``Great.'' The government picks up $240 of the 300. How do you -- and, therefore, the company saves money. How do you estimate ahead of time what the volume of that is going to be?

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

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

MRS. CLINTON: Well, you know, as you pointed out rightly in your [o]pening statement, there is a lot of estimating that goes on with health [c]are, and there's no precision attached to it. But we have looked at both

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Bob Packwood (R-OR)

QUESTION:

How did you estimate the cost of the early retiree benefit?

ANSWER:

This benefit is now estimated at approximately $12 billion over the period 1995-2000. All non-workers, regardless of age, are eligible for subsidies on the eighty percent (or employer) share if their non-wage income is less than or equal to 250 percent of poverty. The $12 billion dollars noted here is the extra cost of subsidizing early-retirees beyond the regular subsidy to non-working families. In addition, government subsidies are offset somewhat by individuals aged 55-64 who work part-time or who have employed spouses. For example a 58 year old man who is working half time will have fifty percent of the employer share paid by his employer and fifty percent by the government. No government subsidy is necessary when a retiree has a full-time working spouse. These factors combine to limit the costs to the government of this provision.

ates of retirement and rates of retirement when benefits were offered like early retirement bonus packages and have used those figures in terms of the percentage of the workforce willing to go into retirement. Now, the company will, as you point out, still bear some of that responsibility. A number of early retirees go to work somewhere else or start their own small business. So there will continue to be contributions coming in that regard.

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

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

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

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

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

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

low which we won't pay for some. Do you think the nation ought to be moving in that direction?

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

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

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

SEN. PACKWOOD: Thank you, Mrs. Clinton.

Thank you, Mr. Chairman.

SEN. MOYNIHAN: Thank you, Senator Packwood.

Senator Baucus.

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

Mrs. Clinton, all of us commend and praise you and the president. I think it's clear that our country's on the verge of making a truly historic step which will not only benefit the people individually but give them health care that they do not now have at lower cost, but even in a more fundamental sense make American people feel even better about the country, ourselves as a people, because we will be joining the ranks of other nations where health care is essentially a right. It's something that all of us as citizens are entitled to. And you are trying to steer us in that direction, the president is trying to steer us in that direction, and we all are tremendously grateful and appreciative of the efforts you're taking. It's truly monumental, it's truly historic, and it's wonderful that we're doing this.

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

I think half of the counties in the state of Montana have no doctors who will deliver babies, and there are many counties with no doctors whatsoever. And it's -- I think it's eight counties. We have 56 counties. But eight just have no physicians whatsoever.

I know there are many provisions in your plan which very directly address rural health care, and when you were visiting Montana in April -- to Billings, Montana and to Great Falls, Montana -- we were all very impressed with your understanding and sense of the nature of the rural communities in the West when you coined a phrase, frankly, that's become very popular when you said ``Hey, this is not just ordinary rural America, this is hyper-rural,'' you said, ``this is mega- rural.'' And it is true. The rural

communities in the West are farther away than are rural communities, say, in the East. And could you just go over what you plan to do and what this plan contains that very directly addresses the concerns of many Americans who are isolated and who pay very high costs today because they're unable to enjoy the benefits of -- are unable to enjoy the benefits that people in the cities have?

MRS. CLINTON: Senator, I would happy to, and I am very grateful for the opportunity that I had to go with you to Montana. I care deeply about rural health care. The first thing I ever did when I found myself in 1979 being married to the governor of a state that was predominantly rural was to work on a task force to try to improve access to rural health care in Arkansas. But as I told you, there is rural health care, and then there is rural health care, and some of the difficulties that you face in Montana are even more dramatic than what we faced in Arkansas in trying to make sure access was real for our people.

We have given a lot of time and attention to this, and there are a number of ways that we believe it should be addressed.

The first is that there is a higher proportion of uninsured Americans in rural areas than there is in any other part of our country. That, combined with a higher than average proportion of the elderly, places the primary burden on financing health care in many rural areas on the backs of Medicare and the uninsured. Through universal coverage, we will be providing more resources for reimbursement in the rural areas by ensuring that there are no uninsured and that there are contributions made that will be available for reimbursing for care.

Secondly, we believe there should be what we call essential providers in both underserved rural and underserved urban areas that are targeted for additional funding because of the difficulty of being able to support emergency facilities or hospital facilities in many rural areas, even though we might now have a better-insured population to take advantage of those.

The third is we want to provide more physicians and nurses and other allied health care professionals in rural areas. And we have targeted assistance to physicians and nurses, particularly advanced practice nurses to go into rural areas in return for having educational loans paid back or even forgiven. We also want to be sure that other states do what Montana has done, which is to make it possible to keep emergency rooms open even though a doctor may not be there, by permitting the laws to permit that kind of enterprise where emergency technicians, physician assistants, and advanced practice nurses are available in rural areas that are otherwise totally inaccessible.

We also believe technology can play a major role in bringing state-of-the-art medical care to rural areas, and we have seen some remarkable examples of that. There are now some good models being used where over hundreds of miles an x-ray can be read being held in a doctor's office in a rural area at an urban medical center. And it can be done over existing equipment that is not very expensive right now. We want to provide incentives for moving in that direction.

So, those are some of the things that we think will enhance rural care, but I would just add, as you well know, Senator, that it is very difficult to imagine how, in many of our rural areas, there will ever be a sufficient level of competition that will realize the kind of efficiencies that we expect to see in urban and suburban areas. And I think we have to continue to be very sensitive to the needs in the rural communities to make

William Roth (R-DE)

Nature of Promise:
Pros and cons of Senator Roth's proposal to let small businesses buy into FEHBP.

ANSWER:

Although the American Health Security Act is more sweeping than Sen. Roth's proposal to allow small businesses to buy into FEHBP, the Act could be seen as implementing his proposal in the sense that small businesses would be "buying into" regional alliances modeled on the FEHBP. Through the alliances, employees of small business (and large) would choose from a menu of health plans ranging from HMOs to orthodox indemnity plans.

We would disagree that actually retaining and opening the FEHBP to the entire population of small business employees is a feasible approach. It would not avoid the administrative burdens associated with enrolling employees, updating records and payroll files, managing accounts, answering routine inquiries, and so on. These burdens are minimal for OPM today because that FEHBP involves relatively few large "employers" (the various agencies), all of whom handle their part of the administrative tasks internally at no cost to OPM.

We believe the purchasing cooperatives serving employers should be governed by local consumers and employers, not a central office in Washington.

ure that there is a base level of delivery of high-quality care available or every American no matter where that American lives.

SEN. BAUCUS: Thank you very much, Mrs. Clinton.

I might say, Mr. Chairman, it's my belief, after studying the plan, that health care in rural America will be better than the status quo, significantly better than the status quo.

MRS. CLINTON: Thank you, Senator.

SEN. MOYNIHAN: Thank you, Senator Baucus.

Senator Roth.

SEN. WILLIAM V. ROTH, JR. (R-DE): It's a great pleasure to welcome you here, Mrs. Clinton.

One of the great concerns, of course, is coverage of the uninsured. And, as you know, I've been very much interested in the possibilities of using the federal employee health benefit program as a means of providing coverage to millions of uninsured who are working for small business.

I'd point out that this has been a very successful program. For example, this year, its cost is only increasing 3 percent, well below the average. In fact, 40 percent are getting a decrease. They are adding preventive measures to it. So, it's a program that I think can be said that is working very well.

It was my idea that we would open this up to small business so that they could provide insurance at the same low prices, I think roughly $577 for the individual, $1,000 -- a little over $1,000 for a family. This has not been included as part of the plan. I would ask -- I would hope that ou would take a second look at it, as it does seem to me a means of roviding coverage. You've got a network that covers the rural areas as well s the urban. It would not require the creation of a new bureaucracy. And yet, we could give good coverage. So, I wonder if you would care to comment on that.

MRS. CLINTON: Senator, you're absolutely right that the kind of program that the federal employees health benefits program provides is the model for what we are attempting to do nationally. We have looked very closely at that. And as you know, the federal government pays a considerable portion of the share for the employee. And really, the idea of the alliance that underlies our program is again that all employers would, in effect, follow the model of the federal government and pool their resources to realize the same kind of gains that you point out this program has achieved.

We think that although it is a good model and one that we have learned a lot from, that in its current condition, it would not meet all of the needs we have to reach universal coverage. If you would like us to look further at whether given the same proportionate sharing, I think it's 70/30 now, that if all employers were willing to have a 70/30 split, how many employers could be covered and what the problems with access would be, we will give you a report on that. We have looked at that. I don't have all of that information with me.

But we do believe that using that as a model is what we have tried to do, and that many of the best features of that federal program will be in the national program that the president has proposed. But we'll be happy to provide you more specific information of the pluses and the minuses that we calculated after looking at it as the way that you had recommended ing available for buy-ins on the same basis.

SEN. ROTH: One of the advantages, as I mentioned, of course, is you don't have to create a new bureaucracy. And my understanding is that you

William Roth (R-DE)

QUESTION:

Can you give me some examples of how Medicare has cut costs without undermining quality?

ANSWER:

We have many examples of how technology, quality improvements and increased productivity can reduce costs.

Our experience under the Medicare hospital prospective payment system demonstrated that successful hospitals have utilized their bed and equipment capacity more efficiently, have employed labor in more creative and productive ways, have managed inventories of supplies and medications more economically and, most importantly, have worked with their medical staffs to identify and eliminate practices and procedures that are wasteful and detrimental to high quality care.

We have also seen, in the Medicare program and elsewhere, that the more heart surgery, cataract surgery, or AIDS treatment performed at a particular hospital, the lower the costs per case and the better the outcome. There are, in other words, significant and identifiable economies of scale in the treatment of many conditions.

We have long known that the better managed HMOs use fewer specialty referrals, laboratory tests, and invasive procedures and produce better care than typical fee-for-service practices.

e keeping the postal employees in its current form. So, there is some recedent for keeping this kind of a program.

I'd like to turn for a moment to the question of -- really a two-part question. I think we're all concerned about how we pay for it. And, certainly, a lot of the calls that I am getting from home are, what's going to happen to Medicare? There's a lot of -- a Mrs. Streets (sp), for example, is worried about what's going to happen to her proposal and so forth. I think that there are some serious questions in this area as to the savings. As I understand it, you expect to save something like 20 percent of the increased costs over the next five years. In the judgment of many people, that cannot be just made from eliminating waste, fraud and abuse, but would require very substantial cuts. What is the answer to this? Because Medicare obviously is of great importance to the senior citizen.

And this brings me to the second part of the question, because, as was said earlier, a lot of these estimates are really guesstimates. I mean, they're the best you can get, but there's no assurance of their accuracy. Would we be wise to try some demonstration programs before we move nationwide? We're talking about a seventh of the economy. We're talking about jobs, so that whatever we do will influence not only the quality and kind of health care, but the economy and growth of jobs.

Are we wise to put it in nationwide, or would it -- is there any merit to the idea of trying some of these proposals first on a demonstration basis?

MRS. CLINTON: Well, Senator, I think it's very important to be cautious and to be very careful, but I would respond by saying there are many examples around the country of high-quality care being given to Medicare recipients at much less of a cost than in other parts of the country. In effect, we have demonstration projects. We can point to a number of states and a number of communities where Medicare recipients are taken care of very well at one-half or one-third the cost of Medicare recipients in the exactly same situation but in another part of our country. And what we fear is that if we don't build on what we know works, which is changing the incentives in our health care system, better organizing the way health care is delivered, and persuading people that they will get high-quality care if their physicians and their hospitals are making the decisions instead of insurance companies and government bureaucrats, that we will only fall further and further behind the cost curve.

So I believe -- and I will be, again, very happy to share this information with you -- there are a number of examples all over the country of what works, which is why we feel confident, as does Senator Chafee in his proposal, that we can reduce the rate of increase in Medicare without undermining quality for Medicare recipients. I don't think you would find the president, I know you wouldn't find any of the senators on this committee supporting that rate of reduction if they thought it would in any way hurt my mother or any of your family members. But we have too many examples now of how it can be done better at lower cost with the same or better quality, and that's what we're counting on the rest of the country being able to do as well.

SEN. ROTH: Well, I would only add we do have a number of proposals. We have the Chafee, we have the Clinton plan. I guess my question is would it be wise to try those out first, because I don't think anything is exactly the same that's in operation at the current time.

MRS. CLINTON: I think both of them, Senator, recognize that until we get to universal coverage, we do not in any way control our health care

stiny, because we have too many decisions that are still made for the wrong easons. But I think both in the Senate Republican approach as well as the president's, it rests on very strong evidence that we can do this better and that we are not going to sacrifice quality or care for our citizens.

SEN. ROTH: Thank you, Mr. Chairman.

SEN. MOYNIHAN: Thank you, Senator Roth.

Senator Rockefeller, who is chairman of the Subcommittee on Medicare and Long-Term Care. Senator Rockefeller.

SEN. JOHN D. ROCKEFELLER IV (D-WV): Thank you, Mr. Chairman.

Mrs. Clinton, as you know, the president's plan includes a mandate on, in a sense, employers but also on individuals. Both have to have responsibility. The Republican plan has a mandate on individuals and not on employers. You touched on that in your statement, but I'd like to have you, if you would be willing to, to expand as to why it was that the administration chose that approach, question number one.

Question number two, the Republican proposal, which has a lot in it which is in common with the president's proposal, and I think there's not -- that cannot be said enough. Senator Dole has talked about starting down the road together. I think we're going to be travelling a long way together. But one of the things they have is a tax cap that limits the deductibility of health insurance to the average cost of one-third of the policies in the area, in whatever area that might be.
I would like to get you, if you would, Mrs. Clinton, to expand upon your views about that.

MRS. CLINTON: Thank you, senator. And I also appreciate all of our help and guidance and the visit to West Virginia that we had that put aces on all of these problems for us.

The approach that the president has chosen, to build on the employer-employee system or, as Senator Packwood says, the individual mandate in terms of making sure everybody who is employed contributes to their insurance, was chosen for several reasons:

First because it is the way most people currently get insurance. Over 90 percent of those who are insured are insured through an employer-employee relationship.

Secondly, because it is the most familiar and the way that most Americans are used to getting their insurance. We think it will be the least disruptive to both people's understanding of insurance and their acceptance of individual responsibility because it is what others are doing or have been doing. Thirdly, the employer-employee system gives us an existing way to make sure that payments are made and can be collected. We anticipate very little additional paperwork or difficulty for employers or employees because they would, as they currently do, whether it is FICA or Social Security, be looking at a table and then filling out their contribution which will be flowing to these alliances. For those who already are insured, they do the same, only they pay their insurance company. So we don't think that the difficulties that one would have in moving toward a system of universal coverage will be significant at all.

In contrast, although we very much applaud the Senate Republican approach of making sure we reach universal coverage and choosing an individual mandate as the route to get there, we have several worries that we will be working with the Senate Republicans on to make sure we fully nderstand their approach over the next several weeks.

Among those worries are that if we have a legislatively required individual mandate, we worry that the numbers of people who currently are

insured through their employment will decrease, because there will no longer be any reason for many employers who have struggled to ensure their workers, particularly those whose incomes are not significant, to feel that responsibility, because by failing to insure, the individuals will be mandated to have insurance, and individuals below a certain level of income will become the government's responsibility. They will fall into the subsidy pool.

It's very to predict how many or at what rate that would possibly increase the number of uninsured, but we worry that that would be one of the unintended consequences.

Secondly, unlike the existing employer-employee system, we have great concerns about how the administrative structure to track the individual contribution, to collect it, and to then connect it with health insurance would be set up.

In our efforts to try to work with Treasury, and OMB and others to create that individual subsidy system, it struck us as extremely complicated and bureaucratic, and also maybe more intrusive, because instead of the employer-employee transaction, with the money coming in, individuals would have to perhaps show their income tax returns, they'd have to have their income tracked because they would either be up or below the subsidy level at certain periods or certain years. So we believe it would be much more difficult to administer the individual mandate system.

And finally, we worry that there would be some incentive to keep wages lower so that individuals would remain in the subsidy pool as opposed to being covered by their employer, with whatever contribution might be available, which would result in, perhaps, a further splitting of the kind of care that's available between those who can afford and have some kind of employer contribution and those who do not.

So those are some of the reasons that we have preferred the employer-employee system, and we think with the addition of discounts for small business, with a subsidy system that works through that relationship which would be, we believe much easier to administer, we have taken care of the biggest problems that an employer-employee approach have.

And I know my time is up, but let me just try to briefly answer your second question--

SEN. MOYNIHAN: Mrs. Clinton, may I say Senator Rockefeller's time is up. Your time is never up. (Laughter.)

MRS. CLINTON: Thank you, Mr. Chairman.

Well then, on my time, Senator, I will answer your question, the second one you posed.

We also looked very hard at the proposal that is common in managed competition approaches to controlling health care costs, of imposing a tax cap and limiting deductibility. And we believe that eventually that should be a feature in our system. But we have a lot of difficulty with starting it at the beginning of reform because currently there are millions, and our estimate is at least 35 million working Americans plus their dependents, who currently have health care benefits that would be taxed if either the approach of taxing at the average cost of one-third the policies in the area, or the approach that some of the managed competition advocates propose, which is taxing at the lowest cost plan in the area, were to go into effect.

We would then be in a position in the administration and the Congress of telling millions of Americans, a very, very big percentage, that health care reform means for you right now a big tax increase. I don't think

at's the initial message that any of us want to deliver, when we know
ere's already more money being spent in this system than we need to spend, and when we know that millions of those same Americans have seen their wages held flat, have not realized any kind of increase in their wages comparable with what their productivity or wage increases in other sectors should have brought them, because their compensation has been in effect made up of health care benefits.

So what we believe instead is that we should wait until we have our health care reform in place, the comprehensive benefits package is secure, and then we say with fair notice to these Americans, at a certain date, you will be taxed for any expenditure above that.

And in addition to the problem of the tax issue, is trying to administer a tax cap that is based on either a lowest cost plan in a region, or the average cost of the lower one-third of the plans, is extremely complicated.

When we went to the Treasury people to talk to them, how they would do that, they were just beside themselves, because you would have to track that cost, plus you would have to track the individual's payment, plus you would have to have some kind of tax proof as to what that was, and the complexity and administrative bureaucracy necessary to administer that is substantial.

So for those two reasons, we decided we would wait until the system was up and going, give everybody fair notice, and then tax at a level that was more uniform around the country.

SEN. ROCKEFELLER: Thank you, Mr. Chairman.

SEN. MOYNIHAN: Thank you, Senator Rockefeller.

Could I just express appreciation for the sensitivity you have own to the question of complexity of administration. That is the continuous oncern of this committee with the Treasury Department, what the form looks like. And also, to say that it would be just about 50 years ago that Robert K. Murton (sp), at Columbia University, who is still thriving, wrote his essay on the unanticipated consequences of social action, and I was pleased to see you use that phrase, and we will be thinking about unanticipated consequences all through this, which is a necessary way to go about it. Because you think about it doesn't mean you can't come up with some answers.

Senator Danforth.

SEN. DANFORTH: Mrs. Clinton, I want to ask you a general question of philosophy, and then if I have time, follow up on whether or not this can be accomplished in fact. My question is whether you would agree with me that somehow there should be some way of telling people that they cannot have the medical care that they might want for themselves or their family, and we'll give you some examples.

The so-called Baby K case that's been publicized recently, a baby born with a condition called anincephaly (ph), the brain is missing, the baby can't think, the baby can't feel, the baby has been kept alive, I think for 11 months, well over $1,000 a day because the mother says I want the baby kept alive; the siamese twin case in I think Pennsylvania, one baby died, the other has a one percent chance of survival. The more prevalent case, the low birth weight baby, the baby under one pound, the likelihood is only 15 percent of these babies will be functional, enormous cost of keeping them alive, average of $150,000 each.

On the other edge of life, a case I heard of yesterday, a 92 ar-old man who received a pacemaker, and then everything in between. The se of somebody who's dying who wants to be kept alive for another three onths, six months at a very high cost.

Philosophically, before we get to the mechanism question, should somebody at some level be in a position to say no?

MRS. CLINTON: Senator, I think there should be a discussion in this country about what is appropriate care and that a lot of these very hard decisions that you have just outlined should be made with more thought and more concern about both the human and the economic cost. So I would agree that for both moral and ethical reasons, as well as economic ones, there has to be the kind of very difficult conversation that you are suggesting.

I have thought a lot about this and I have had a lot of time to think about it both on a personal level, when I was in the hospital with my father, and spending literally all day every day talking to doctors and nurses about the very kinds of cases that you are outlining. And I have had a lot of time to think about it in this position that I am in.

And I think that there is more of a likelihood that we can actually have that conversation once we establish health security and a more rational system of making decisions about providing care to people. And I would just give you an example that struck me recently.

The hospital administrator of a very large hospital came to me as a part of a group visiting, as a delegation brought in by the member of Congress, and he said that he had recently asked one of his cardiac surgeons why the cardiac surgeon had admitted a 92-year-old man for a quadruple bypass. And the cardiac surgeon had said, ``Well, because he was referred to me by the cardiologist who refers me all of my cases, and I didn't want to say no because he might send his cases to another cardiac surgeon.'' And the hospital administrator said, ``Well, do you think it was medically appropriate for you to accept this surgery?'' And he said, ``No, it wasn't appropriate or necessary, but that's the way the system works.''

SEN. DANFORTH: I think that there's maybe a harder question, and that is the question of the person or the person's family who simply wants the treatment no matter what the cost. And there is a treatment that's available, for example, to keep this baby going who can't think. And -- I mean, I guess the threshold question is: Under any circumstances, should there be somebody out there or something somewhere at some level that says, ``No, I mean, it's possible to do this; it's possible to perform whatever this procedure is, but even though you want it, the answer to you is, no, you can't have it''?

MRS. CLINTON: I think that, if we do this health care reform right and we create the kind of security we're talking about so that people will know that they're not being denied treatment for any reason other than it is not appropriate, it will not enhance or save the quality of life, we will have a much better chance of having that kind of conversation, and physicians will, once again, have much more latitude and discretion in advising families in an honest manner about what the real costs are. So I think we will get to that point, but I think, in order to get to there and to bring the country along with us, we have to make some of these other changes first to establish the kind of climate in which those conversations can take place.

SEN. MOYNIHAN: Thank you, Senator Danforth.

Senator Breaux?

SEN. JOHN BREAUX (D-LA): Thank you very much, Mr. Chairman.

Thank you, Mrs. Clinton, and welcome to the committee. I think that what you and the president have done on this health care debate is truly remarkable in at least two significant ways. I certainly hope that what you all have accomplished becomes a pattern or a blueprint perhaps for future

legislative action on major and controversial legislative proposals. I think it's remarkable, first, in outlining very clearly the goals of this very complicated effort -- universal access to health care; comprehensive, standardized package; and quality health care for everybody. I think you all have done a real remarkable job in spelling that out -- what we want and what the goal is.

The second area I think that is truly remarkable is the way this process has been put together. We can learn a lot from that. You have had -- and the president has had private meetings with Republican senators, private meetings with Democratic senators, and private meetings with both of us together in the same room.

You have done the same thing, I think, also on the House side. So I think it's truly remarkable as to what has been accomplished so far.

I think that as we move towards reaching those goals, however, we have to decide which path we're going to take. I think there are two options. One is the path of improving the marketplace, changing the rules so that competition can work better than it does right now because right now doesn't work very well. The second path we can take is more government regulation, more government bureaucracy, either at a state level or a local level or at the federal level. And I think that it's difficult if we try and mix the two. I think that when you try and add some regulatory rules and regulations to a system that's saying we're going to improve the competition system, it gets very difficult to make sure how much we add without messing up competition. And that's my concern as we move down this path.

I had introduced, and we've discussed this a number of times, in the last Congress the bill that was called managed competition, with a number of co-sponsors, which was, I think, a more pure competition without the regulatory regimes. I want to work very closely with this administration on marrying these concepts, and hopefully, we'll be able to do that.

My question this morning is I'm concerned that by adding some regulatory requirements to the proposal, and by adding what I think are disincentives to changing the way people buy health care, that we make it difficult to reach the goals and make competition less possible.

The point I have in the short time I have is, as I understand the proposal, is that after the law is enacted for 24 months, two years, we are hoping to make some rather dramatic reductions in the cost of health care in this country. If we do not, the premium caps kick in. I am concerned that 24 months is not nearly enough time to allow the competition to really work, particularly in areas that don't have any competition now, and I'm concerned that there are disincentives that have been added that really make it even more difficult. And the disincentives are the complete employer deduction regardless of the price of the plan. I think that's a real disincentive to purchasing the least costly plan. Not taxing the employee benefits if they are in excess of that plan for either 10 years or to the year 2000 I think is a disincentive. Quite frankly, I think the prescription drugs being made available without requiring Medicare recipients to change their habits by joining an alliance is a particular problem area. I think all these are areas that we can work on to try and reach some compromise, and I guess my question would be: Is there any possibility or any thought about trying to delay or spread out the time in which the premium caps would kick in in order to give the competition the time to be put into place and actually start showing some results? I mean, I think it's 1996, or what about the year 2000, or is there some type of phase-in that can be considered?

MRS. CLINTON: Senator, we would certainly work with you to

nsider exactly those issues. We are trying to do two things simultaneously, .d I certainly understand how trying to do two things simultaneously sometimes creates perhaps some question as to how you can get both done. But we are trying to create incentives through the market and through enhanced competition to reorganize our health care system so that services are delivered more efficiently at high quality. At the same time, we have to recognize we start from very different stages of development in different parts of the country with incredibly different practice styles used by physicians that have increased costs dramatically in those regions.

So, what we are looking for -- and we will work very closely with you because I share your concern -- we want the competitive market forces to work, but when you create a new system in which the costs in some areas of our country are three times what they are in others, and where, if there isn't any feeling on the part of the providers that there is some budgetary discipline waiting out there for them, I worry that you will not create the kind of incentives for the changes in practice styles to occur that will create exactly what you and I want, which is a much more competitive, market-driven, high-quality health care system.

Now, whether we can get to where we need in two years or over a longer period of time, we are very open to talking with you about that. But to go back to the example I talked with Senator Danforth about, this hospital administrator told me this story about this inappropriate care in the context of saying to me that he appreciated having some kind of premium cap out there as a backstop because, he said, otherwise it will be very difficult for me as a hospital administrator to go to this cardiac surgeon or for his colleagues go to him and say, ``Remember we got together last year and we made these cisions about what we were going to be doing this year and how we were ɔing to be providing care, and this is why we need to do it because we've got this budget backstop up there that might possibly reduce our income if we don't do it right?''

And so, on psychological as well as economic grounds, some form of discipline in a marketplace that, frankly, has had none, in which blank checks have been written by both the government and private insurers until very recently, seems to us a feature that needs to be there as a backup. But how we get there, when it's triggered, under what circumstances, we're very open to that. We want to get to the same place, and we very much want to work with you on that.

SEN. MOYNIHAN: Thank you, Senator Breaux.

Senator Chafee?

SEN. JOHN H. CHAFEE (R-RI): Thank you, Mr. Chairman.

Mrs. Clinton, I want to join in welcoming you here and pay tribute to your tireless efforts in this area. I'm absolutely certain that health care would not have the prominence it has now but for your personal involvement, and I think we're all grateful to you. You've been wonderful.

I just would like to point out one thing in connection with your conversation with Senator Rockefeller and the points he raised.

Your plan does have an individual mandate to the extent of the 20 percent.

MRS. CLINTON: Yes, sir.

SEN. CHAFEE: In other words, the individual is responsible for paying a portion of his or her -- the employee -- insurance . Whereas ours kes the individual 100 percent, yours makes him 20 percent. So it's a ifference of degree --

MRS. CLINTON: That's right.

SEN. CHAFEE: -- more than the total difference.

The other point is, sort of referring back to what you were talking with Senator Breaux about, regarding the taxation of benefits over a certain level. In our plan we go into that; your plan you defer that, but as I understand it, it is your intention that down the road that would occur.

MRS. CLINTON: Yes.

SEN. CHAFEE: There would be a level -- call it the reasonable level of benefits. Anything above that would be taxable to the employee and non-deductible by the employer.

MRS. CLINTON: That's absolutely right, senator.

SEN. CHAFEE: The thrust of the various bills, as I see it, is to provide coverage for those who are not covered now. And this is costly, but it's worth it, we believe. However, in one instance it seems to me that the administration has embarked on providing coverage by the government for those who are already covered. And this I have great difficulty with, and I'm referring to page 13 of the plan summary, in dealing with retirees. And I'll briefly read it: ``Americans who retire before 65 and were employed for at least the amount of time used as a standard to qualify for Social Security purchase health coverage through their regional alliance and pay only the employee share of the premium for their health plan. The federal government pays the 80 percent of the employer's share.''

And it seems to me that this is a very, very expensive undertaking. What you're doing is saying that an employee who is retired whose employer currently is providing all or a substantial portion of his or her insurance will no longer have to do that -- employer: the government will do it. And I see that being very costly. And furthermore, we get into this point you've made with Senator Moynihan, our chairman, unanticipated consequences of social action. Many more employers, I believe, will choose to have their employees go this route. I mean, what a bonanza. The government is going to step in and pay this 80 percent. Could you explain why you chose that?

MRS. CLINTON: Yes, senator, and I want to start, though, by thanking you for your leadership on this issue and your incredible willingness to educate and to talk with us about the approaches that you've taken and that you have worked on for many years. I'm very personally grateful to you.

This is a policy decision that is certainly one that we will be debating and discussing. And it comes out of several sources of concern.

The first is, there is a growing tendency for businesses that have contractual obligations to retirees for them to abrogate or limit those health benefits in some fashion, whether it's an outright abrogation of the contract or some attempt to negotiate below whatever the level of promised benefits were, so that in fact there are more and more people in this time period before they're eligible for Medicare who are finding themselves without health coverage and who are not employed because they had taken early retirement or reached the requisite retirement age. This is becoming a problem for the general society that we believe we're going to have to deal with.

Secondly, those companies that are continuing to provide retiree benefits are doing so at an extraordinary cost that we think should be more broadly shared by the general public because their commitment to retiree health care is taking out of investment, wages, wage increases, profits, money that should rightly go there instead of taking care of the work force that is no longer working.

We think that, for example, those industries -- largely the older manufacturing industries -- that assumed these responsibilities are beginning to make a comeback.

They are increasing their productivity, they are competing with the Japanese, and the Europeans and others, but they are doing so still with one hand tied behind their back because of the extraordinary health care cost which they have borne, which in many instances they have borne not just for their own employees and retirees, but indirectly for other businesses that have shifted the cost onto them, because they were willing to pick up those costs. And we consider that that kind of benefit, which -- (inaudible) -- to the entire population in indirect ways, ought to be borne by that entire population.

And finally, we have costed this out as I expressed to Senator Packwood, it is about four-and-a-half billion dollars, but we think that it is an investment in our competitiveness and our manufacturing base, as well as picking up the cost of people who are falling into the uninsured that is worth making. But obviously, we are more than open to talking with you and to exploring SEN. CONRAD: Thank you, Mr. Chairman, and again I want to thank you for holding this hearing and bringing us together around this issue because obviously this is the focus for the rest of the year and much of next as well. And I want to thank you, Mrs. Clinton, for the leadership that you have shown. I think your competence just shines out and I think that has made a difference in the way people are approaching this issue, and I think that's a real contribution to the country.

Let me ask this. One of the underlying assumptions is that we can save money by changing the incentives in the system, as I understand it. The current incentives in the system run toward doing more procedures, doing more tests, not only because you make more money if you're a provider that way, but also because you protect yourself from malpractice, and so we all understand the incentives run toward increasing costs in the system.<

As I understand it, one of the goals of this plan is to change those incentives so that we begin to control costs. Obviously when you change incentives in this system, that then creates a potential vulnerability of providing too little care, doing too few tests, doing too few procedures. What is your reaction to those who say I'm very concerned that we're going to wind up with a system in which the incentives run toward doing too little rather than too much?

MRS. CLINTON: Senator, I would ask them honestly to look at the system we have today, where because of the wrong incentives, we do too much at too high a cost, for too few people. And what we need to be doing is figuring out how to deliver high quality health care to everybody. And there are several examples I would just like to share with you.

I have pulled this out at every hearing and I keep it with me because I think it's the best example of what I am talking about.

If you take a look at this Consumer Guide to Coronary Artery Bypass Graft Surgery that is put out by the Pennsylvania Health Care Cost Containment Council, it makes the point that I would like to answer those who worry about this.

This document has all of the costs of providing coronary bypass surgery in all of the hospitals in Pennsylvania that perform the surgery. The cost runs from $21,000 to $84,000. The information has tracked the quality indicators as to what happens to the patients who receive this surgery, including how many die from this surgery, and they have done so by comparing population and demographic statistics of the patients, so that we compare

pples and apples.

If you look at this, the hospital that is doing coronary bypass surgeries at $21,000 has better quality than many of the hospitals performing surgeries at much, much higher costs. Now, if more hospitals in Pennsylvania learned how the hospital is doing it for $21,0000, you would actually have more coronary bypass surgeries able to be done in Pennsylvania at less cost than is now happening, and that is repeated all over the country.

The second example I would just like briefly to mention was explained in a speech that I heard when I was in Minnesota with Senator Durenberger. A physician there who was the chief of quality and the head of one of the very large health networks in Minnesota talked about how one of the health care providers in Minnesota has created a new test to determine whether a lump in a woman's breast is or is not cancerous, without having to have a surgical biopsy. And this physician said that this procedure is much cheaper, less invasive and can be done more quickly than often a woman having to wait and having sleepless nights until she has her surgery. Why is it not being done? Because it would require, in this doctor's words, ``surgeons giving up up to $40,000 in income to radiologists.'' So there's no incentive in the current system to move toward a procedure that has here to make these different choices, but there is no question that these different choices would preserve and even enhance quality if we could structure our health care system so those choices were made instead of other ones.

SEN. CONRAD: All right. I think I'm right at the end of my time, Mr. Chairman, and in the interest of allowing others their full time, I'll deed back what I have.

SEN. MOYNIHAN: You're very generous, Senator Conrad. Thank you.

And Senator Durenberger?

SEN. DAVE DURENBERGER (R-MN): Mr. Chairman, thank you. I thank my colleague from North Dakota.

And thank you very much, Mrs. Clinton, for sharing your time, your talent and your commitment with us. Thank you also for mentioning Minnesota with some frequency, which leads me to a point that you and I talked about yesterday in another committee, and that is that everything that's going on in Minnesota is because people want it to go on, not the government insisted on it. Not a thing that you've heard from Mrs. Clinton today, nor that you've heard from me over the years, is because Minnesota state government said it ought to happen. It's because people who are providers of care, consumers of care, insurance plans, creative doctors, creative multi-speciality groups have decided that the relationship between the consumer and the provider of care is critical to improving quality and lowering costs.

This committee is a very awesome place because we have $903 billion in medical spending this year, 14 percent of the GNP. Forty- two percent of it comes from government, most of that the federal government, and practically all of it is generated by the policies made by our -- us and our predecessors. And that's an incredibly awesome responsibility. Economic policy, tax policy, Medicare, Medicaid -- go on up and down the line -- most of the driving forces in the income security system originate in this committee. So I think that's why your time spent here is incredibly valuable.<

Two observations that I'd like to make about the so-called tax cap and your response to that and the FEHBP.

Health care reform means -- has to mean that the taxpayers of his country can't have the government subsidize extravagant buying. And hat's your husband's sixth principle: responsibility. We can't just have

responsibilities for the docs and the hospitals. We have to have responsibility for everybody, and people have to start taking that responsibility.

The FEHBP. If we're going to cop out to the Postal Service plan or any existing plan to not take on the driving force in this community that causes the health care costs in this community to be higher than anywhere in the country -- Medicare in this District of Columbia is at the top in the country -- 33 percent -- not because people are more ill. Take that out of it. Just because of the way Medicare -- the way health care is practiced here in the District of Columbia. Thirty-three percent higher here, above the national average. Hawaii is 43 percent below the national average. And so is -- and Oregon is down there, and Wyoming and Utah and a bunch of other states.

Those of us who are buying in the private sector here probably pay 60 percent, 100 percent, 200 percent above the national average, what you'd pay anywhere else, in this community. So, unless we take that responsibility principle seriously and we deal with the big health alliance or whatever you want to call it around here that might change the way medicine's practiced, the FEHBP, and do that right up front where everybody can see it, everybody can take responsibility, I don't think we're going to make it.

Secondly, to get at the point we talked about yesterday and sort of illustrated by Bob Packwood's description of take two aspirin and something, the answer to the question is, if the doctor knew the doctor knew the doctor was responsible for the quality of your care and gave you what you actually needed, and you and the doctor were rewarded at the end by something other than one of these prescriptive benefit plans, you wouldn't worry.

That's the answer to the problem.

So, I need -- perhaps, I need you to share with us why we can't do Medicare reform right now, why you can't come to us, and the president can't come to us with a plan to provide -- since we've had (tougher risk ?) contracts going since 1986, and we know what's happening out there. The people who are doing efficient health care in our communities through (tougher risk ?) contracts are being penalized.

I'll give you an example -- New York. In 1994, here's what HCVA just decided. This proves that there are savings in the market, but it also proves how dumb government is, i.e., HCVA. (Laughter.) In 1994, the (tougher risk ?) contractors in New York who currently charge Medicare $569 to get into one of these plans will go up 15 percent. In Minneapolis and St. Paul, where the charge for the very same service for the very same kind of people is only $351, they're going down. And that's for the benefit of everybody here, who is making, you know, the current policy. Now why, if we have all these demonstrations around the country, why, if they're that successful, why don't we just go to changing Medicare right now? Give the elderly the same kind of comprehensive benefit that we're promising everybody else, put it through one of these accountable health plans. We have the model of the (tougher risk ?) contracts operating in many of our communities. Why not just do it?

MRS. CLINTON: Well, Senator, you make a very compelling argument about what is currently going on in Medicare, and we ought to be able to figure out incentives so that more people will use those systems that are better organized, and we'd be happy to work with you on that.

You know, as you know in this committee better than most, dealing with Medicare and explaining it and making sure the public understands what

ou're trying to do is a big task. But if we could come up with a bipartisan pproach that would explain how we are actually making Medicare better, then I think we ought to take a hard look at trying to do that. I have no problem with doing that at all, because you're absolutely right, there is no explanation other than the way care is delivered and organized to explain these differences in cost.

And yet, we have a system that rewards inefficiency and penalizes efficiency. Minnesota will get less money because it's done better. New York and many others, not to pick on New York, will get more money because they are not as efficient. And that is not the right kind of incentives that we want to have in the system. So, we'd be happy to work with you to try to figure out how to reverse those incentives within the existing Medicare system.

SEN. MOYNIHAN: Thank you, Senator Durenberger.

Mrs. Clinton, may I say this being the United States Senate, it's all right to pick on New York. (Laughter.)

MRS. CLINTON: I love New York, Mr. Chairman. It's New York, New York, as far as I'm concerned.

SEN. MOYNIHAN: Senator Bradley.

SEN. BILL BRADLEY (D-NJ): Thank you very much, Mr. Chairman.

Let me say, first of all, Mrs. Clinton, I think you're providing an enormous public service to the country. I'm personally grateful, and I think there are millions of people who are very pleased that you're doing what you're doing and you're where you are.

One of the most, I thought, poignant moments in the president's peech the other night on health care was when he leveled with the American eople about their own self-destructive behavior and the fact that it's going o be pretty difficult to get health care costs under control in the long run if every American doesn't recognize that they have a part in this process. He mentioned tobacco and he mentioned violence.

Now, on tobacco, as you know, as anyone knows who looked at this, the Office of Technology Assessment says that costs are $68 billion a year, $2.59 per pack. It seems to me that in talking about a tobacco tax that, A, it should be very high, and, B, it should be talked about in terms of health, not only in terms of revenue.

On violence, one of the most startling numbers that I've come across in recent years is that if you want to be a gun dealer in America, it costs you between $30 and $75 to get a license. There are 276,000 gun dealers in America. There are more gun dealers in America than there are gas stations. And that, to me, is a remarkable number.

And I think it's directly related to the accessibility that guns have in the country today. And if we simply put a 25 percent sales tax on the sale of the gun and raise the dealers' fees from 30 to 75 to $2,500, we'd raise $600 million. That would be a tax directly on the purveyors of violence in terms of the sales of the means of violence.

Now, what is your opinion on the tobacco tax, how high do you think it'll be, and what is the increase in the dealers' fee -- how do you react to that, and how do you react to a 25 percent sales tax on handguns and on automatic weapons?

MRS. CLINTON: Well, senator, with respect to the tobacco tax, we agree with you that tobacco should be taxed as part of this package, and rgely for health reasons, and particularly to try to deter smoking among oung people. And we're, you know, still trying to make sure that we know exactly how much revenue we will need, but the tax will be between 75 cents

d a dollar additional to what is already the federal tax.

Speaking personally -- and that's all I can do with respect to your second proposal -- I'm all for that. I just don't know what else we're going to do to try to figure out how to get some handle on this violence. And one of my best friends, a woman I've gone to school with since grade school who is a full-time homemaker, has three children in a suburb of Chicago, is just outraged because a gun dealer has opened a store in a strip mall across the street from the local high school. And the parents -- mothers like her -- have picketed, they have tried to talk with this person, they've even tried to find alternative places for him to go so that he could still be in business, and he's just absolutely pleased as he can be to be in a gunshop across the street from the high school. He thinks it will increase his trade remarkably.

And I share my friend's outrage, you know. She's somebody who is not political and doesn't march or picket, but there's just something wrong when it's that easy to sell guns to high school students after school. And this is a suburb, and we know what happens now in every part of our country with that kind of availability of weapons in the hands of teenagers. And I know Senator Chafee has been concerned about this issue for a long time, and it has to be addressed. And we will look at your proposal and be happy to talk with you about it. I'm speaking personally, but I feel very strongly about that.

SEN. BRADLEY: Well, let me say that there is no more important personal endorsement in the country today, and I thank you very much. (Laughter.)

SEN. MOYNIHAN: Thank you, Senator Bradley.

May I just interject the thought, Mrs. Clinton, that the epidemiologists have begun to think in terms of personal violence, handgun violence and the consequences and trying to think, as epidemiologists will, in terms of vectors and so forth. And the point can be made that guns don't kill people, bullets kill people.

We have a two-century supply of handguns in this country. There have been 50 million sold since Jim Brady was shot. We only have about< a four-year supply of ammunition. And the federal government through the Bureau of Alcohol, Tobacco, and Firearms -- which doesn't seem to know this, but it is the fact -- has the right to tax the sale and manufacture of bullets, of ammunition. That's right there in the statute. And I think they do issue -- for $30 you can manufacture 300 million rounds of 9 millimeter ammunition and you don't have to report back. I suggest --

SEN. PACKWOOD: Could I give you an addendum to that?

SEN. MOYNIHAN: Sure.

SEN. PACKWOOD: I quoted your figure when I was in Oregon last week in some hearing, and I said ``Whether or not gun registration works I'm not sure, but there's a relatively short supply of ammunition which could be easily run out.'' I said ``There is not a century's supply of ammunition in this country.'' The witness says ``There is in my basement.'' (Laughter.)

SEN. MOYNIHAN: (I heard ?) the sometime gunnery officer of the United States Ship Quirinus (sp) say ``If it's in his basement, it won't be worth a damn in about ten years' time.'' (Laughter.) Powder, the secretary of the Navy will assure, powder degenerates very fast, .45 caliber pistols do not. And that's -- I'll stop right there. But you took that note down, did you not?

MRS. CLINTON: Yes, I did. (Laughter.)

SEN. MOYNIHAN: Senator Riegle.

SEN. DONALD W. RIEGLE JR. (D-MI): Thank you very much, Mr. Chairman, and let me just say to our very distinguished guest, you're just giving terrific leadership to this country, and you raise a level of hope for people across the nation that something good can happen by giving it this intense personal leadership as you have. And I've had a chance to watch that at close range, as we all have. It's just really been extraordinary, and I thank you for everybody in Michigan, everybody across the country.

I want to just make two points. One is that on this committee now, there are four of us who have announced we will not be seeking reelection in 1994, so Senator Wallop and Senator Danforth and Senator Durenberger and I are in that group, and so we all not only are relieved of the time and the effort that it takes to be engaged in a campaign, but it gives us the chance to work across the partisan aisle, which we really must do to succeed in this effort. And you've been so diligent in your efforts to talk with members on both sides, and we've talked privately and we talked down at the White House the other day with the president, when all of us were there, about this is the only way we can get this done. The only conceivable way that we can enact health care over the next year is by working on a bipartisan basis.

And I want to just say again to Senator Chafee, the ranking member on the Subcommittee on the Uninsured, that I am chairman of, and to the colleagues on that side, I intend to do this in a fully bipartisan way, and I have also said that to our colleagues over on the Labor and Human Resources Committee. And Bill Roth and I came here together 27 years ago in the same party. So it's easy for us to work together despite an occasional difference here or there.

So you've got a pledge from me that for my part we're going to work across this party aisle and try to get this done. And Senator Dole has said as much, and I have complimented him for doing that.

Let me just talk about the comprehensiveness of the program and how quickly we are able to phase it in. We have talked before about the fact that we have this very important model for us in Hawaii, where we've had now comprehensive health care for about 20 years. And the cost of health care as a percent of the Hawaiian economy is about eight percent, the rest of the country it's 14 percent. So we know that after that 20 year experience, that we are getting this huge financial dividend, plus the health outcomes are much better.

But when you go over that 20 year history, it takes the first 10 years before those cost lines really break apart and you really start to get the big financial benefits and savings of good primary care and good preventive care.

Now our problem here is going to be how quickly do we phase this in? And the problem is going to be, we're going to try to measure the results, essentially over a five year budget time frame, and we're basically going to be measuring public costs, because that's what we deal with, so we're going to have to do something special to factor in the private savings and the impacts out there, and then we've got to think about what the time frame is over which we really measure the returns of this program.

If we try to just take and finance it based on the returns over five years, when you look at Hawaii, that's not going to be a long enough time period in which to really understand how these savings will accrue as we avoid a lot of diseases, we avoid a lot of problems of people with high cost care and so forth.

So I am wondering what your thought is as to how we sort of

reconcile that, in terms of how we think through this question of how we cost this out so that we don't fool ourselves, in a sense undershoot on the front end, when we've got to make, in a sense, the investment in good health in order to save the huge dollars later on down the line?

MRS. CLINTON: Oh, Senator, that is such a good question and it is made so complicated by the way the federal budget is structured and operates, because it is very hard to achieve savings based on investments in prevention, or savings based on competition in the private sector as part of the budget analysis and projections.

It has been one of the issues that I have really struggled over as I have tried to understand it, and I just hope that this committee, which certainly has so much credibility on these issues, will continue to stress that even though something may not be scorable in Washington, D.C., budget talk doesn't mean it's not real. You know, we know that prevention will work if we can get prevention in place. It is absolutely one of the clearest commitments we can make to getting costs under control. But we also know that some people will claim, well, utilization will go up a little. If everybody is going to get prevention, utilization will go up.

Well, utilization should go up, we want it to go up. The average citizen of Hawaii has more doctor visits than the average citizen of the other 49 states. But because they are doctor visits for primary and preventive care, as more likely to occur there than here, their overall costs are less. So yes, we will have some increased costs in the beginning to get this system set up, and what we're going to have to figure out how to do, is within the constraints that this budget imposes on your deliberations and on your ability to deal with your colleagues, we have to explain that.

And we have the other problem, which we believe, competition will increase savings as practices styles change, as administrative loads go down, and all the things you know so well, but we can't get those scored either because they're not considered within the budget world that exists here, to be savings that can be actually laid out for people to see and realize.

So we have to be willing to make a strong stand for investment and stick to it because we know it will pay off if we do.

SEN. RIEGLE: I thank you, and I'll just say, Mr. Chairman -- I know my time is up -- maybe one of the things we can do is when we lay out the cost numbers, do it with the five-year projections, the ten, the fifteen, and maybe even the twenty, recognizing that that's what experience has taught us so that we don't fool ourselves on how we really get this job done and save the money at the same time.

SEN. MOYNIHAN: Good -- that's a good proposal, and let's, indeed, undertake to do. Senator -- thank you, Senator Riegle.

Senator Daschle.

SEN. GRASSLEY (?): Mr. Chairman, will I get a chance to --

SEN. MOYNIHAN: Yes, sir, you're after Senator Daschle.

SEN. DASCHLE: Thank you, Mr. Chairman. Mrs. Clinton, I -- Senator Grassley and I may be the last two questioners you get this week, and I want to commend you for the quality of your answers. The clarity and the command of the facts that you've demonstrated all week is admirable, and I appreciate very much your contribution to the debate this entire week. Somebody recommended today that maybe somebody offer you a sweatshirt that says, ``I survived.'' I think it ought to be ``I flourished,'' because all week long you certainly have done that.

You've answered in characteristic fashion my concerns about some of the aspects of the plan in rural America, but I was home this last

ekend, and three concerns are raised that perhaps you might be able to ldress: the first, from insurance holders who have been told by some that this is going to radically change the way they buy insurance; the second, by state officials who express concern that we may be dealing with yet another unfunded mandate as we change the structure in the relationship between the federal government and the states in addressing governmental responsibility, and the third has to do with those who benefit from alternative health care -- home health care and other forms of care, especially evident in rural America. But if you could address those three concerns, I would appreciate it.

MRS. CLINTON: Thank you very much, Senator, and thank you for all of your help on getting this project underway and particularly for the health care university work that you did. With respect to insurance holders, we are trying to design this so that those who are currently insured will see very little change. Every year they will be given the opportunity to choose what health plan they wish to sign up with. They will then have a cost that is assigned to that health plan based on how the health plan has costed out its services. Under our system then, the employer and the employee will be making a contribution to the alliance, and the individual will see very little difference in terms of making payments into the alliance as opposed to making payments into the insurance company. The most important feature will actually be enhanced, and that is the individual insured will have the choice as to what plan to use his insurance dollars for. That decision will not be made by his employer if he has insurance through an employer. So we really are trying to keep this system as much like what most Americans know right now, and we lieve that we can do that.

With respect to the unfunded mandate for states, that is an issue e've spent a lot of time talking with the states about, particularly the governors with whom we have worked closely. We certainly do not intend for this to be in any way an unfunded mandate.

The states feel very strongly, and with good cause. They've had more than their share of unfunded mandates. And the most difficult to deal with has been health care, particularly in the Medicaid program, where now, for the first time, states are spending more on Medicaid than they are spending on higher education. So, we understand that that is a legitimate fear on the parts of states and we intend to give states flexibility and responsibilities that they have largely asked us to give them, but not the kind of costs that come from unfunded mandates.

And then, finally, with respect to alternative health care, particularly home health care, this is one of these difficulties that we have where, on the one hand, I think there are legitimate questions raised about should we start a new program like long-term care? You know, this is a new investment that we would fund through the reductions in the rate of growth of Medicare. On the other hand, if we do not provide some support for long-term care, particularly for home health care, we will spend more money than we will if we make the investment in long-term care now, it is our belief.

So, we want to be providing a better array of alternatives to citizens, paicularly in the long-term care area, through home-based care and community-based care. And we think that investing in that now will reap dividends down the road, both in terms of human and family concerns, as well as economic. So, that's how we would like to begin to address what are ghtfully seen as alternative, but cost- effective, ways of taking care of eople.

SEN. DASCHLE: Thank you, Mrs. Clinton.

Thank you, Mr. Chairman.

SEN. MOYNIHAN: Thank you, Senator Daschle.

Senator Grassley.

SEN. CHARLES E. GRASSLEY (R-IA): Mrs. Clinton, Senator Durenberger asked you about Medicare being included. I want to hit it from a little different angle. Your plan calls for states having the option of taking over Medicare. My governor, former Governor Ray (sp) as well, are -- he's president of the Blue Cross/Blue Shield, and then our hospital association, lots of others as well believe that you're never really going to have health care reform unless Medicare is put into it. So, maybe in my state, we might opt for that. So, I have some questions about how this might work. And they're kind of based on the fear that, you know, we've got 65, 70 percent of our people in our hospitals are Medicare recipients, and so we don't get reimbursed on the cost or on the charges for that.

First, could you tell us how the amount of Medicare money coming to a state from the federal level would be calculated? Would it be on a per capita amount based on historical reimbursement patterns? Or would it be on some sort of new reimbursement methodology? And if it would be a new methodology, how would it work in general?

Now, I ask this question, as you probably know, because Iowa has one of the lowest cost and charge structures for health care in the country. And people in our state believe now and have believed for years that Medicare doesn't pay its fair share of the costs, not of the charges, of treating Medicare beneficiaries. Our providers believe that Medicare doesn't pay more than 70 or 80 percent of what it costs to treat a patient. And I've already mentioned that these costs are at the bottom of -- for my state of all the states. So, a reimbursement pattern that freezes in what is now an inadequate reimbursement level wouldn't be fair for my state.

One additional point, and then I'll let you answer. If the state were to take this over and under your plan was slowing down Medicare, would the slowdowns that are at the federal level also apply on the same basis to what the states might have, if they assume that cost?

MRS. CLINTON: Senator, those are really important questions. And the way that I would have to answer them is it will depend upon how we finally decide to deal with Medicare in this legislation. The way the plan is currently proposed, we would be starting from the historical levels that currently exist. And I share your concern. I come from Arkansas. I think Arkansas' rate is even below Iowa's rate. And it is something that has been a particular burden on rural states like ours because you start with a differential where Medicare pays less than the private sector and then you add burdens by making it very difficult for a lot of states and localities to even reach what is a fair differential because we don't get reimbursed at the same rate as others. So, I'm very conscious of this.

And what we have struggled with and what I would very much appreciate being able to work with you and your staff on is if we don't start from the historical rates and then move toward a fair allocation, we don't know at what level we could start. Because we've got built-in costs in many of these systems that we're going to have to get out before we can reach a fairer level of reimbursement across the country.

It concerns me because already now you've got situations where Medicare patients are being taken care of extremely well in Iowa or Arkansas or Minnesota at one-half or one-third the cost of what is being paid for Medicare patients elsewhere.

We want to bring the costs in those other states down. That is

he whole theory behind what we are doing. But we worry that, if we started / saying just off the bat, ``Okay, State X, you've been reimbursed at two or three times what Iowa has gotten; you're not going to get that anymore,'' that would cause too much of a disruption in the existing system. So we want to try to bring it down gradually. We also want to try to figure out how to do what Senator Durenberger is saying, which is, through the states -- is our proposal -- you would begin to move people into more cost-effective settings. You would begin to provide more care to more Medicare recipients for a better value for the dollar.

So we have looked at it on a state-by-state basis as opposed to a national reform. But we're open to looking at both your questions and Senator Durenberger's questions, because the bottom line is we know that Medicare recipients in Iowa are being well taken of and they're being given care at less cost than other states, and we need to reward Iowa for doing a good job instead of penalizing Iowa, which is what we currently do. And so we had thought the best way to proceed was to give more authority to the states, which is what the states have asked us -- like, you know, I know both Governor Ray and your current governor -- because think, frankly, they can do a better job than the federal government. But we need to look at both a state approach, which is what we favor, and the national approach that Senator Durenberger has alluded to. And we'll be glad to do that.

SEN. MOYNIHAN: Thank you, Senator Grassley.

I would note that the house of 1:00 is approaching, and there's only so much we could ask of our witness.

Senator Mitchell has been patiently waiting to ask some uestions.

SEN. MITCHELL: Thank you, Mr. Chairman.

Mrs. Clinton, my question builds upon that of Senator Grassley and your response to it and relates to some of the criticism that's been made of the president's plan. Following the president's address last week, in the official response to that address, it was criticized as, quote, ``a one-size-fits-all federal health care system,'' unquote. We each represent different states. I and others on this committee represent states which are called rural, with relatively sparse populations living primarily in small towns spread over large areas of land. And the people of Maine want some assurance that this will not be a one-size-fits-all federal health care system, that while there will be a basic package of benefits which will provide health care security to all Americans and will travel with that American wherever he or she goes, that the method of delivering health care will be substantially left to the states, provided they meet the threshold requirement of security for all Americans.

Is this criticism accurate? Will there be a one-size-fits-all federal health care system. Will Maine have to do what New York does and California have to do what West Virginia does? Or will the states have flexibility in the delivery of health care?

MRS. CLINTON: Senator, we are trying very hard to design it so that states do have flexibility within a federal framework. This will be, I think, one of the difficult challenges you will face in the Congress. There are states that are very anxious to take on the challenge of health care reform, that they've already passed legislation they want to see implemented, that they have a track record of doing something successful -- like a Hawaii, or example -- and they are just chomping at the bit for you to give them the ind of framework in which they can proceed. There are other states that don't want anything to do with health care reform whatsoever. They don't see

as their responsibility. They want the federal government to dictate the terms, and they want to be told what they're supposed to do and how they're supposed to get it done with as little interference as they can put up with, but just basically fulfill a federal program.

We believe that there ought to be a federal framework with state flexibility and that states ought to be given the opportunity to design their delivery systems to meet the population needs of their states. The Congress will have to decide how to make sure every state meets its basic obligation, so that if any state is unwilling to make decision about health care, then the federal government will have to be sure that the people in that state are protected. But other than that, we want there to be state flexibility to the extent we possibly can design it.

SEN. MITCHELL: What assurance can you provide now to the people of Maine who live in rural areas and small towns that the delivery and quality of care to them and to other Americans in rural settings will not be diminished, but rather will be enhanced under the president's program?

MRS. CLINTON: Senator I think there are a number of features that, in Senator Baucus' words earlier, will be greatly beneficial, enhance the delivery of health care in rural areas. I've driven through Western Maine. I know that people are sparsely populated in those beautiful forests. And we want to be sure that we have a system of delivering health care in rural areas that is firmly grounded in a solid financing mechanism, which is why we want everybody in the system and everybody making a contribution which identifies providers in those small communities as essential so that they are given a additional support to be there when the people need them, where we have the kind of incentives for physicians and nurses to practice in rural areas by forgiving loans and by extending loan paybacks and where we use technology better than we have to get health care services into remote and rural areas.

Those are some of the features that I feel very comfortable telling the people of Maine that they can count on, because it will enhance what they have now and give them health security, which they do not have now.

SEN. MITCHELL: Mrs. Clinton, finally, on the question of the reform is financed, I have here a chart which appears in the materials prepared by the administration covering the period 1994 through 2000, a seven-year period. Some of the critics of the president's plan have used this chart to suggest that there will be $700 billion in, quote, ``new government spending'' or $600 billion in, quote, ``new government spending.''

I'm going to ask, Mr. Chairman, that the chart be placed in the record at an appropriate point.

But as I read this chart, I interpret it that there will be approximately $350 billion over seven years for such new benefits, the remaining $350 billion will be merely transference of current Medicare and Medicaid recipients into the alliances and for deficit reduction. Is that your understanding as well?

MRS. CLINTON: Yes. I mean, the bulk of this money, Senator, will come from employer/employee contributions that are not now being made, from reducing the rate of increase in Medicare and Medicaid, from reallocating existing federal funding sources, such as disproportionate share, which will no longer be needed because we will be decreasing uninsured care, and from the tobacco tax and the contributions from corporations that choose to stay out of the system. And that's a very brief overview of where we're getting the money from, which we will, obviously, be going into great detail with

this committee in the weeks ahead.

SEN. MITCHELL: All right. Mr. Chairman, if I might just note for the record -- I know my time is up -- that the areas in which the funds will be used, according to this chart, are long-term care benefits for the elderly, Medicare drug benefit, a prescription drug benefit which does not now exist, public health and administration, a large of part of which I understand will go to improving the delivery and quality of care in rural areas, and finally, the largest amount will be subsidies for low-income firms and workers. That, I understand, is what you talked about earlier in the discount for small business and in the effort to help small businesses. Am I correct in that?

MRS. CLINTON: Yes, sir.

SEN. MITCHELL: I thank --

SEN. MOYNIHAN: We will place that in the record. Be happy to do it. There's a deficit reduction of $91 billion in alliance coverage. And we'll probably get revised numbers before we --

MRS. CLINTON: Yes, sir.

SEN. MOYNIHAN: -- the final legislation, which is --

MRS. CLINTON: Well, in fact, we're taking in all of the advice and suggestions that all the members are giving us and revising the plan as we speak, so -- but these are the broad outlines.

SEN. MOYNIHAN: Thank you, and thank you, Senator Mitchell. And now, the one Senator who has not been heard, has waited very patiently, Senator Boren.

SEN. BOREN: Thank you very much Mr. Chairman and Mrs. Clinton. I'll try to be brief, we appreciate the amount of time you have shared with us, and appreciate also the hard work and personal commitment that you have brought to this issue, and also the decision of the president to tackle this head on. I think we all realize we have a lot of problems in this country because administrations of both parties, and members of both parties in the Congress have wanted to shy away from tough issues -- would be very difficult to resolve. And I think the president deserves a lot of credit for being willing to take this one on head on and face up to it.

I suppose my biggest concern, because I share all of the goals that have been announced in terms of the president's program, is to make sure that we are adequately paying for it. I don't think there has been anything that has caused Americans to become more cynical about government, than the fact that we have overpromised sometimes, and underdelivered, and that we certainly, nearly always missed our estimates, so that the deficits have been higher than anticipated. That's happened to us in budget, after budget, after budget.

I think it's understandable that some Americans have skepticism as to whether or not we're promising too much and providing too little revenue to sustain it.

One of the criticisms that has been raised has been of the $51 billion projected figure that would come from anticipated new revenues due to increased wages and profits. I wonder if in making that estimate, if it was considered that some companies, rather than paying either higher wages or disbursing profits, might choose to reinvest their money in tax exempt ways, ways for example that would allow them tax deductible depreciation or other ways that might reduce the revenues. And I wonder, more broadly, that if indeed we find that we have underestimated the costs and overestimated our anticipated revenues, that we do get a gap between the money available and the outflow, is there some mechanism anticipated in the plan for dealing with

at?

Small businesses tell me, for example, well, we're due to get this subsidy, but what if the plan costs more than anticipated, or what if the revenues don't come in to pay for it as we anticipate? Will we see that subsidy cut back?

I guess the basic question is if the estimates end up not being accurate, will we solve that gap by cutting back on the amount of the benefits, scaling them back to what we can afford, or will we solve that by putting additional costs on the businesses and others that will be paying for the service?

MRS. CLINTON: Well Senator, let me answer your question in several ways. Let me start with the revenue gains to be anticipated from freeing up funds for increased taxable transactions, such as increased wages, profits, or whatever.

This is a figure that has undergone intense scrutiny. It has been run through the Treasury models. They have put into those assumptions matters such as you raised, what would be the trade-off if X percent went into non-taxable transactions or investment? And I am sure that the Treasury people will be able to explain that in much more detail than I can.

But it is the kind of change in policy that we think is not uncommon to this committee, because for example, if you were to make a policy change to shift funds from non-taxable compensation to taxable income or to deal with pension income in a different way, you would run the same kind of modelling in the treasury that we have done to come up with this figure.

And so I think that the Finance Committee particularly will derstand how we arrived at that.

Now, clearly, there has to be an understanding that that is an pproximate figure, because who knows precisely how new revenues will be used. But those kinds of assumptions have been taken into account.

With respect to a gap that might develop between the costs of the program and the amount of money available to pay for it in both the private and the public sector, let me answer that in several ways.

First, in all of the cost projections that we have given you and that we have worked internally, we have tried to be conservative. We have not, for example, included any of the savings that we think will accrue because of competition and because of changes that physicians and hospitals will engage in on their own that will result, as I said earlier, in more coronary by-pass surgeries being done closer to 21,000 instead of 84,000. None of those figures are in these cost estimates. We believe -- and we believe we have very strong support for this -- that this proposal will realize a very significant amount of savings. So we think that helps to cushion whatever gap there is.

In addition to that, we have included padding, if you will. We have tried to be as conservative as possible. For example, in looking at how much the benefits package would cost, we have tried to run through all kinds of scenarios -- what will happen if there's an earthquake in California followed by a plague -- and we've tried to make sure that we have sufficient dollars allocated for that so that there is the opportunity for this gap to be filled. We do not anticipate that with the combination of the revenue that we have already laid out, with the savings that to some degree or other everyone is confident will come if we pursue this plan, and with the kind of dditional funding we have put in to cushion any eventuality that we can at east foresee at this point that there should be grounds for concern about any individual or business having to step up and fill the gap.

Now, we know that even though we intend to get savings out of this system to make it more competitive that the history of health care costs is that they at some point will continue to rise because something will happen that will cause more care to be given at certain periods of time or whatever.

It is difficult at this point to know what that continued growth rate might be, but we think if we bring the base down, if we squeeze out the savings and the cost to be obtained from it, we will be a lot better off than we are on the current course, where the gap between any of us who are insured and uninsured is growing bigger, and the gap between what we pay and will have to pay is growing larger. So that's the kind of analysis we have undergone to get to the point where we are, and we're going to be sharing obviously much more of the details of that with you as we continue with this.

SEN. BOREN: Thank you very much.

SEN. MOYNIHAN: Thank you, Senator Boren.

Now, Mrs. Clinton, are there any questions you would like to ask us? (Laughter.)

MRS. CLINTON: Do you all ever take a lunch break? (Laughter.)

SEN. MOYNIHAN: I think on that practical note, I'd like to express the great gratitude of the committee, I think we all -- what do you say we give a little hand here. (Applause.)

Thank you very much, and the committee stands adjourned.

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