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FROM: Jeffrey L. Eller
Office of Media Affairs

SUBJECT: HRC Transcript from A.M. Hill testimony

THE REUTER TRANSCRIPT REPORT
HEARING OF THE HOUSE WAYS AND MEANS COMMITTEE
SUBJECT: THE CLINTON HEALTH CARE PROPOSAL
CHAIRED BY: REPRESENTATIVE DAN ROSTENKOWSKI (D-IL)
WITNESS: FIRST LADY HILLARY CLINTON

LONGWORTH HOUSE OFFICE BUILDING, ROOM 1100, WASHINGTON DC
TUESDAY, SEPTEMBER 28, 1993

REP. ROSTENKOWSKI: (Sounds gavel.) The committee will come to order.

Mrs. Clinton, I want to compliment you. I hope that you set the pace for the rest of the cabinet when they testify before our committee. It's very unusual that a witness comes in early to testify. (Laughter.)

Today the committee embarks upon an historic mission to ensure health security for all Americans. Tragically, far too many Americans are afraid to seek the care they need because they can't afford it. Without health insurance, any encounter with the health care system presents a devastating financial burden to most American families.

Last Wednesday, our president outlined six simple basic objectives for the reform of our health care system. They are security, savings, quality, simplification, choice, and responsibility. The president then challenged the Congress to enact reform legislation that achieves these goals. Today I pledge that I will commit all of my energy and resources to meet this challenge and to enact health care reform legislation before this Congress adjourns next year. *

Many are skeptical. But it can be done. It would be a tragedy for this country not to do it, to fail in this endeavor.

It is appropriate that we begin an historic task with an historic event for this committee. Today it is my extreme pleasure and honor to welcome to the committee the First Lady, Hillary Rodham Clinton. This is the

first time that a first lady has testified before the House of Representatives' oldest standing committee.

Mrs. Clinton, you have developed a very significant, comprehensive proposal. You and your staff are to be congratulated. At the same time, you and I are both aware that many members of Congress and many Americans have honest concerns about the plan you have developed. These concerns must be addressed during the legislative process.

As just one example, I have concerns about how your plan will affect the many small employers in my district. We must assure that health care reform does not impose an unfair or crippling burden on struggling small employers, while recognizing that many employers can and should meet their obligations to help their employees pay for health insurance.

This and other issues will have to be carefully analyzed and solutions developed. We expect to work closely with you as we go through this process.

Before you testify, I will ask Congressman Bill Archer to make a short opening statement to be followed by short statements by Congressmen Pete Stark and Bill Thomas, chairman and ranking minority member of the Health Subcommittee.

Mr. Archer.

REP. BILL ARCHER (R-TX): Thank you, Mr. Chairman. And welcome to the committee, Mrs. Clinton. I join Chairman Rostenkowski in that sincere welcome.

Yours has been a unique role, really, in shaping the administration's national health care proposal, and your appearance today is certainly unique in the history of this committee.

I'm glad we can now begin to explore the details of the president's proposal, and so thanks for being with us as we start this process.

No other issue touches the lives of each and every American so personally and so directly. Clearly, the current system has problems that need to be addressed, and we all agree on that. We must provide for security of health care coverage, protecting those who change jobs or have a preexisting condition. We need to reduce the growth of health care costs and simplify and streamline the system. We need to ensure that individuals take greater responsibility for their own health care decisions. Above all, we must maintain the quality of care and guarantee Americans the right to choose their own doctors and their health plans. Sometimes you don't know the benefits that you have until you lose them.

There are fundamental disagreements, however, on how we achieve these worthy goals, and this is the room in which many of those decisions will be made. So it's fitting that we begin the process right here. There are a number of reform proposals on the table, as you know. They take a variety of approaches. None of the others place such reliance on an overwhelming new bureaucracy as the plan that you've laid before us, and it is very complex, as you know.

And you understand it extremely well, but it has never been tried anywhere else in the world. Our task is develop a package that has the broad support and the confidence of the American people, and I must say that I have sincere concern as to whether massive government intervention arising from dozens of new government agencies can achieve that consensus.

I was born and raised in Texas, and I've lived there all my life. But today I'm going to join my colleague, Mel Hancock, and adopt Missouri as my temporary residence. Someone has to show me why we should put at risk the health of our people and that of our economy, which is embodied in such a complete, incredibly complex overhaul of our health care system without an empirical pilot program test. There are 10 million Americans employed in health-related fields today. Nearly all their jobs would be changed to some extent under your plan, and many would be eliminated. We don't yet know how many jobs, particularly in small business, will be lost as a result of the $275 billion tax increase in the recent budget. And now the administration is talking about employer mandates and a new tax on small businesses as health care costs are shifted to that job-producing sector of our economy.

I'm personally genuinely skeptical about the claim that the president's plan will create new jobs at all. Because evidence is that it will do just the opposite. Martin Feldstein (sp) last week estimated the president's plan will cause a 6.4-percent decline in worker take-home pay, $115 billion decline in aggregate wages, and the disparity between the administration's in-house analysis and Dr. Feldstein's is certainly alarming.

You know, we've got to reflect back, too, that Lyndon Johnson was told back in the '60s, according to a Washington Post article last week, that the Medicare program would only cost a half billion dollars when fully implemented.

Health care reform isn't a product to be packaged and sold like a toaster on the Home Shopping Network. We've got to know how it works, what it will really cost -- both government and the private sector, and how those costs are going to be paid for, and we must be sure the American people read the warning labels and that the information that they're given is accurate. And that's what this committee is all about. I know that's why you're here today, not as the first lady per se, but rather as lead architect of the administration's approach to health care.

I do believe this process will ultimately result in changes to our health care system that will benefit the American people, and I intend to do my part to help bring that about. And I commend you for personally taking on what I think is the single most daunting domestic problem facing this country in the next ten years.

REP. ROSTENKOWSKI: Mr. Stark?

REP. STARK: Thank you, Mr. Chairman, and good morning, Mrs. Clinton. It's an honor to join Chairman Rostenkowski and the members of the Ways and Committee to welcome you to our committee this morning.

The administration has put forward a bold and comprehensive health plan which embraces the goals of universal coverage, cost control, and a fair way to pay for it. For years, we've struggled to address the problems of health care system, and only intermittent, incremental and limited successes have been ours. At long last, we have a president and a first lady in the White House who understand the need for a comprehensive solution and are committed to real reform.

The ball now comes to our court. It's up to us to enact a plan that will achieve the goals enunciated so well by you and the president. This will be the most important and far-reaching challenge ever tackled by any sitting member of Congress.

The president's plan includes many positive features which I support and will work to retain in the final legislation. In particular, I support the president's courageous decision to impose responsibility for financing on all individuals and all employers.

None of this will work unless we limit the rate of growth, however, in public and private health spending.

Of course, in a plan as complex as has been suggested, there are areas in which there may be some questions and doubts. For example, I don't believe that states should be given the primary responsibility to enact, implement and enforce the provisions of the national plan. Our California governor, for instance, the Honorable Pete Wilson, has already issued a release to announce that the president's plan is unnecessary and he will oppose it. So much for his concern for millions of Californians with no health insurance.

I can't in good conscience ask my constituents to put their health security in the hands of a governor who appears to have no desire or commitment to carry out President Clinton's plan. We must have a definitive federal plan from which any state may opt out if they match or improve upon the federal standards of cost, quality and coverage.

I look forward to continued cooperation with the administration over the next year to resolve the technical differences and to achieve significant reforms in our health care system. Thanks very much for being with us this morning.

REP. ROSTENKOWSKI: Mr. Thomas.

REP. BILL THOMAS (R-CA): Good morning, Mr. Chairman.

Mrs. Clinton, I join my colleagues in welcoming you here today to discuss the president's proposal for health reform. I commend you and the president for undertaking this enormous task.

The president's proposal for health care reform has laudable goals --health security for all, controlled costs, improved quality, less bureaucracy and waste -- goals, I think, that we can all agree upon. We could, I'm sure reach agreement quickly on several important aspects of the president's plan, including insurance market reform, administrative simplification, antitrust, malpractice reform, and the reduction of fraud and abuse.

There are, however, for me several areas of concern. First, I believe the regional alliances as currently structured will result in micromanagement of health care plans and providers participating in those plans. The proposal delegates a tremendous number of functions to the regional alliance, and I share the concern of my colleague about the governing board, which will not include representatives from the health care community whose participation will be critical to the success of any plan.

Second, I doubt the assumed effectiveness of premium caps for controlling the growth of health care costs. Furthermore, I believe that this policy could result in a harmful reduction in health care quality.

Third, this plan contains an employer mandate that will likely compromise to a degree our economic recovery.

Fourth, I'm concerned that the plan relies too heavily on Medicare and Medicaid cuts that in all likelihood will be unattainable. The remaining financing elements are equally problematic. Senator Moynihan called them a fantasy. Regardless of the nomenclature, the mandatory premium payment will have the net effect of a payroll tax.

Fifth, I worry about the plan requiring states to perform critical responsibilities that will be all but impossible for some states to meet.

Sixth, I'm troubled by the potential of this proposal for stifling innovative new technologies and treatments.

While each of these concerns is serious, none is insurmountable. The American people are counting on us to sit down and work out our differences. I'm optimistic that we will not disappoint them, but we do need to be honest with the American people about what meaningful reform will entail. We need to be honest about the financing of these changes. No new benefits until after real savings have been achieved, no desserts before the vegetables.

The American people desire and deserve a health care delivery system that will hold costs down and keep quality high. Each of us believes we have the answer. All of us need to dedicate ourselves to the proposition that we will not let the good or the better slip away because it does not meet our particular definition of the best.

Thank you for putting health care reform in the spotlight. Together, we can turn promise into a reality.

REP. ROSTENKOWSKI: Let me close out the opening statements, Mrs. Clinton, by saying that in my opinion, we have already come an enormous distance in this long journey. The president has succeeded in changing the debate from whether we should have reform to what type of reform it should be. He has put a bold and comprehensive plan before the Congress. Now, it is up to us to respond with the same sense of urgency and commitment which he has demonstrated. I intend to do no less.

Mrs. Clinton, welcome to the committee. After you have spoken, members will be able to ask questions. However, because you must leave by noon, I will ask the members of the committee to observe a limit of one question in order that the question and your response will take no longer than two minutes for each member. Mrs. Clinton, please proceed with your statement.

MRS. CLINTON: Thank you, Mr. Chairman.

I want to thank you and all of the members of the committee for the many hours of meetings and consultation, review and good advice that you have provided us throughout this process. It has been a real personal pleasure for me to get to know many of you personally and to work with you and to watch all of us move toward the realization that health care reform must be achieved for the good of our country.

During the past months, as I have worked to educate myself about the problems facing our nation and facing American citizens about health care, I have learned a great deal. The official reason I am here today is because I have had that responsibility. But more importantly for me, I'm here as a mother, a wife, a daughter, a sister, a woman.

I'm here as an American citizen concerned about the health of her family and the health of her nation.

Like so many Americans, I have seen first-hand the strengths of our health care system as well as its frailties. I know what it's like to be overwhelmed with forms and regulations and confusing medical choices when a family member is dying. I know the anguish that comes when it is impossible to weigh choices or make rational decisions, to understand what the government regulations or insurance fine print might say. I know the frustrations that are felt when judgments about health care too often seem divorced from common sense and human experience.
I know from my own experiences and from the conversations I've been privileged to have with thousands of our fellow citizens across this country that something is wrong with our health care system and that it needs to be fixed.

I realize that we all have our own perspectives on how to solve the health care crisis. Each of us brings our own personal perspective to this issue.

Let me say, though, that when the president set up the health care task force and began this journey, he was committed to a simple principle: to build on what works in our current system and to fix what is broken.

Throughout this process, we have not lost sight of that goal. The president's plan honors and preserves the high quality of care Americans have come to know -- our unparalleled doctors, nurses and other health care professionals, our hospitals and sophisticated technology. It also honors and preserves every family's ability to chose a doctor and other care givers. But we must acknowledge that parts of the system are broken and if we go on without change the consequences will be even more costly for millions of Americans and even more disastrous for the nation in both human economic terms.

While we do look forward to the discussion on the details of the reform, and I am so grateful for your willingness to engage in this process with the seriousness and commitment you bring to it, the president will insist on certain overriding principles: security, simplicity, choice, savings, quality and responsibility. Each detail we discuss should be measured against how far a resolution of that detail moves us toward achieving one or more of those principles.

We may disagree on the exact formula for achieving reform, but I hope we can, and trust we will, agree on one thing from the outset: that when our work is done, when the Congress has done what only the Congress can do to bring all of the disparate voices of America into these rooms to hammer out the choices that confront us, every American will receive a health security card guaranteeing a comprehensive package of benefits that can never be taken away under any circumstance.

I have listened, as you have, to thousands of ordinary Americans across our country talk about health care. I know about the tragedies of hard-working families and innocent children who are locked out of our health care system for all the wrong reasons. As a mother, I can understand the feelings of helplessness that must come when a parent can't afford a vaccination or a well-child exam or cannot pay for that x-ray or prescription for a sick child.

As a wife, I can imagine the fear that grips a couple whose health insurance vanishes because of a lost job, a layoff or an unexpected illness. I can see, as a sister, the inequities and inconsistencies of a health care system that offers widely-varying coverage, depending on where a family member lives or works. And as a daughter, I can appreciate the suffering that comes when a parent's treatment is determined as much by bureaucratic rules and regulations as by a doctor's expertise. And as a woman who has spent many years in the work force, I can empathize with those who labor for a lifetime and still cannot be assured they will always have health coverage.

If we put ourselves in the position of people around our country who face these issues every day, if we recognize that the upcoming debate is not about any one set of citizens but about all of us, if we recognize that every single month, 2.25 million Americans who are insured lose their insurance for some period of time, then we know when we talk about security, it is not about security for someone else; it is about security for all of us.

I've had a rare opportunity to meet with literally thousands of Americans across our country. I've sat in living rooms talking to farm families in Iowa. I've sat on loading docks talking to uninsured workers who've worked in the same place for 10, 15, 20 years without insurance. I've sat in hospital waiting rooms talking to doctors, nurses, pharmacists. I've had a unique opportunity to hear firsthand about what is right and what is broken.

I have read letter upon letter of the more than 700,000 that we've received from citizens all over the country who took the time to sit down and share their concerns.

The president's plan is not the product of any one person's work, nor even of the group that he asked to do it. It is literally the product of the work of thousands of people who shared their ideas, their research, and their personal experiences and time with us. Their overriding message to all of us is that Americans can no wait for health care reform.

As we sit here today, literally hundreds and hundreds of Americans will lose their health care insurance. Hundreds and hundreds of families will make a decision to postpone getting that primary or preventive health care because they cannot afford it. Thousands more will show up at the doors of our emergency rooms to seek help because it is the only place available to them. Business owners both large and small will be struggling with insurance premium increases and trying to figure out how to keep doing the right thing for themselves and their employees.

The task confronting us is complex, but it is urgent. The American people rightly are watching all of us. They are impatient, but they are also hopeful. They want change, they expect change, they deserve change. And they want to see the government at the highest levels work for them. They want to know that we have heard their stories.

Last week, the president outlined for Congress a plan that will provide health care for every American, health care that can never be taken away. As the president said and as he believes, this is not a partisan issue, it is not an ideological battle, it is a problem to be solved that affects all of us. And if all of us put it beyond politics as usual, open ourselves up to look at whatever evidence comes our way to scrutinize that and to analyze it, we will respond to the needs the American public have.

I know that you on this committee share these goals. As stewards of the public trust, this is your responsibility. And I'm looking forward over the next weeks and months to not only working with you, but to watching you craft the most important social policy that our nation will have confronted in many decades. This is the chance for the Congress, this is the chance for all of us to make a difference for every American no matter how rich or how poor, whether employed or not, whether living in the country or the city. This is a chance to make a statement that we know what is important in our country and we're about the business of getting it done.

Thank you very much.

REP. ROSTENKOWSKI: Thank you, Mrs. Clinton.

I want to underscore the fact that I'm going to try to limit the question to one question and an answer in a two-minute frame period.

Mrs. Clinton, last week at the White House when we met, the president made the observation that he would have a bill to submit to the Congress in the next two or three weeks. Is that still the same time frame?

MRS. CLINTON: That's what we're trying to accomplish, Mr. Chairman.

REP. ROSTENKOWSKI: Thank you very much. Mr. Gibbons will inquire.

REP. GIBBONS: First of all, Mrs. Clinton, a very fine presentation, and I am -- I believe that the system that has been put forward by the president satisfies security problems -- health security. It satisfies the quality of choices that are provided for individuals. I am concerned that as a nation we're spending 14 percent of our gross domestic product for health care which doesn't measure up very well with the other industrial competitors we have out there in the world.

What I want to hear from you is how do we expect to achieve national savings in this program?

MRS. CLINTON: Mr. Gibbons, let me begin by asking the chairman if I can have more than a minute to respond to that -- (chuckles) -- because I think that not only is that a critical issue for the country to understand and work over, but it is the key issue for this committee, whose responsibility extends to matters of financing and revenues.

Let me begin by saying that the primary source of payment for the health care system will remain as it currently is -- employers and employees contributing to their own health care. And I think it's important to stress that there will be additional revenues coming from employers and employees who do not now make contributions into any kind of health insurance plan.

We have adopted this approach because we believe it builds on what is already available for most Americans. More than 90 percent of Americans who are insured are insured through their employment, and rather than creating any new system, we have built on that system.

However, we are also very sensitive to the fact that many businesses and individuals will face some burdens that they have never had before. That is why we intend to provide discounts for lower wage employees and small businesses and those that employ low-wage employees so that we can keep the cost of health care that will be required to as low an amount as possible.

Now in order to achieve that, we believe there are savings in both the private and the public systems that can be realized and better used, and let me just give you one example of that. Currently, because we have so many uninsured Americans who do show up at the emergency room to achieve care at the last possible moment, we provide -- as you well know on this committee -- something that's called disproportionate payment to hospitals that have a disproportionate burden of individuals who are neither privately nor publicly insured.

Once everyone is insured, we will no longer have to be spending those federal dollars to reimburse hospitals that will now be able to obtain reimbursement through the insurance that everyone will be required to have. That money then can be used to help provide the kind of support and subsidy for low-wage workers and their employers that will enable everyone to be in the system. So, we think that it's these kinds of reallocations within the system that will make a difference. And we could go on, but my red light is on, Mr. Gibbons.

REP. ROSTENKOWSKI: Mr. Archer.

REP. BILL ARCHER (R-TX): Thank you, Mr. Chairman.

It's pretty hard to get into this health care thing in ten-second soundbites. I agree with you, Mrs. Clinton, that we need to do something now to solve some of the real problems for coverage and for preexisting illness and portability and that sort of thing. Can you tell the committee what the timetable is for the implementation of your program? I understand that the first state will not be required to come on board until 1996. Is that correct? And if so, when would it be fully implemented under your program across the nation?

MRS. CLINTON: Mr. Archer, it will depend, of course, as to when the legislation is passed and becomes law. Assuming that we are able to do that before the end of this Congress next year, we do believe that having two years to set up the system while we have some transition reforms, including some of the insurance market reforms you talked about, would enable states to start meeting their obligations starting in '97. Some states, as Mr. Stark pointed out, are more willing and also more ready to meet those obligations, and we expect they would be coming into the system before others. We would like, however, to have all the states in by the end of '97-'98, somewhere in that area. We will look at those years, though, and the phase-in, depending upon what the final legislation looks like. But we are firmly committed to the belief that the sooner we can achieve universal coverage, the better our system will function, both in terms of the savings we can derive from it and the overall economic impact at both the federal and state budgetary levels.

REP. ARCHER: Thank you.

REP. ROSTENKOWSKI: Mr. Pickle.

REP. J.J. PICKLE (D-TX): Thank you, Mr. Chairman.

Mrs. Clinton, we are proud to have you here today and proud of your leadership. Now, I'm deeply concerned about the effect it will have on small business and about how we pay for it, but
I think that's going to be a common denominator through this whole hearing.

So, I want to jump ahead and ask you a question down the line about the alliances where, under the state program, if you're under 5,000, they'll all pool their resources. Now, in my district, many of my employers are using a third-party administrator. They contend strongly that they save 30 to 40 percent. They're lean, they're mean, and they're local. Yet, your plan would say any under that level of 5,000 would be done away with. Now, they're doing locally exactly what you want to do nationally. And it seems to me that it's not enough to say, well, you pool it, they can do it cheaper. We ought to have an alternative. So, I'm speaking now for the third-party administrators. Why don't we have a choice, an alternative?

MRS. CLINTON: Mr. Pickle, there will be roles for third-party administrators in the new system. Their roles, though, will be attached to the accountable health plans.

What they will be doing is working with accountable health plans, the providers, those who are actually delivering the services to make sure that the services required to be delivered are done so in the most cost-effective way. Because, you're right, what third-party administrators have been able to do is to serve as kind of an intermediary between the purchaser of insurance and the provider of services. What we would like to do is see their expertise located in the accountable health plan arena, where they can continue to help the providers work to get their costs as low as possible to be efficient.

REP. PICKLE: All right. Now, Mrs. Clinton, I don't see anywhere in the proposed plan a specific provision where the third-party administrators can operate along the lines you say.
I hope we can make that clear, because to me they are making a real savings, and we ought not to do away with that choice if it's a practical approach to take.

MRS. CLINTON: Thank you.

Q I thank you.

Charles Rangel (D-NY)

QUESTION:

Will the Medicaid matching formula change to make the distribution of Federal Medicaid funds more equitable?

ANSWER:

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.

REP. ROSTENKOWSKI: Mr. Rangel?

REP. CHARLES RANGEL (D-NY): Thank you, Mr. Chairman.

Madam First Lady, if I had more than two minutes, I would spend more time congratulating you and the president for having brought this issue to where it is. I think what we're saying in the Congress is that the nation knows we have to do it and we've never got to this advanced stage before. Now the question is: How do we do it, how do we pay for it, and how do we reach a consensus?

I'm concerned about the impact on medically-underserved communities, as well as what we call just disaster communities. The illnesses that are related to poverty, drug and alcohol abuse will not even allow us to be considered to be entering any risk pool. In addition to that, my state -- and the question I'm asking now -- suffers an inequity in the distribution of Medicaid funds. It's a 50- 50 split, where some states get up to 75 percent of reimbursement. And there's hardly a relationship between the cost of our care and the income of our people along poverty lines. In this plan, have you considered a more equitable split between the federal share and the state share?

MRS. CLINTON: Well, Mr. Rangel, let me just quickly say, as to your first about underserved communities, because it's related to the share that would be required for Medicaid, we share your concern. And that is why we want to have large pools in which all risks are rated at the same community level and you do not, therefore, eliminate whether it's an individual with a preexisting condition or a population area with a concentration of medical problems from coverage.

We think by pooling all people in these large risk pools, which is the way insurance used to be done, where we were community rated instead of experience rated, we will fairly bring in people who up until now have been denied insurance or rejected for it. And I think that will be particularly beneficial in underserved urban and rural areas which have a disproportionately high number of uninsured people, because even in your district, Mr. Rangel, there are many, many hardworking people who cannot get insurance. They are not privately insured and they're not publicly insured. They will all have insurance streams now that will go with them, which will enable them to be better taken care of.

As we fold in the Medicaid system, we will not be distinguishing any longer between Medicaid recipients and others. The Medicaid stream will follow the Medicaid recipients into the overall alliance, but they will not be identified as a Medicaid recipient.

And because they will no longer be in what is an ancillary health program only for those who are means tested and eligible, they will have the benefits that will flow to all Americans, and we think that will eliminate some of the problems we've had in the past about states having to pay a certain percentage and the like because we will bring more resources into the entire insurance coverage pool.

REP. RANGEL: Will the --

REP. ROSTENKOWSKI: The time of the --

REP. RANGEL: -- formula change?

MRS. CLINTON: I'm sorry; what?

REP. RANGEL: Will the formula change at all?

MRS. CLINTON: For the initial period, we're looking at a maintenance of effort, but we think that that can be made to work because of the new funding that will come in through the public health system, through identifying providers as essential providers and having them part of the network of care, and I'd be glad to put that into more detail for you.

REP. RANGEL: Thank you.

REP. ROSTENKOWSKI: Mr. Thomas.

REP. THOMAS: Thank you, Mr. Chairman.

Mrs. Clinton, the president's plan not only changes the health care system but envisions a $91 billion reduction in the deficit, as well. It's clear that this plan could shift from a deficit reducer to a deficit increaser in the twinkling of an eye if Congress votes benefit increases in the plan but doesn't vote the Medicare and Medicaid reductions. Can you join me today in promising the American people that no new benefits will be adopted and implemented until after real and sufficient, banked savings have been achieved?

MRS. CLINTON: We think, Mr. Thomas, the savings go hand in hand with the benefits. Under the president's plan, the reduction in the rate of increase in Medicare and Medicaid would be used in part to fund new benefits, namely, prescription drugs for the elderly and a beginning on a long-term care proposal.

They go hand in hand. One doesn't precede or follow the other. But clearly, in answer to your question, if we did not have the reduction in the rate of increase in the public programs, we could not offer those benefits.

And I would only add one additional point. As we reduce the rate of increase in the public programs of Medicare and Medicaid, we have to have some means to try to restrain the growth in the private sector, otherwise we will merely have cost-shifting.

So either savings in the absence of some effort to control in the private sector or no savings and new benefits would not work under our plan.

REP. THOMAS: If we vote the benefits and don't vote the reductions, we will have failed.

MRS. CLINTON: Unless you have another revenue source, Mr. Thomas, but you're right. If we do not bring down the rate of increase and vote the benefits, our plan would not be able to support that.

REP. THOMAS: If we do it in that order, I'm with you.

REP. ROSTENKOWSKI: Mr. Stark will inquire.

REP. PETE STARK (D-CA): Thank you, Mr. Chairman.

Mrs. Clinton, our committee and the Health Subcommittee are very proud of the success of the Medicare program. It's popular, it has an overhead of only three cents on the dollar, and it leads the nation in reducing the burden on providers in the use of electronic billing. It took the lead in initiating hospital cost containment in the '80s, and real growth in hospital spending was only 3.2 percent last year as opposed to 5.4 percent nationally. In the first full year of physician payment reforms, Medicare spending for physician services grew only 4.3 percent, about half the rate of the private growth in physician spending. Overall, Medicare is a program about which the federal government and the federal employees who run it can be very proud.

Now, you mentioned personal reference, and my reference is my mom. And she's concerned that you want to cut 200 billion bucks out of Medicare from providers and beneficiaries.

She knows she's going to get a pharmaceutical benefit and some minor increase in long-term care, but she'll have a benefit that's worth about thousands of dollars less than mine and yours under this plan, and her costs are going to go up -- Part B premium and her Medigap.

I said, "Mom, trust me. Trust Mrs. Clinton." But what can you add to reassure mother? (Laughter.)

MRS. CLINTON: Well, let me start -- I have a mother, too, Mr. Stark, so if we can't pass the mother test we're not going to be able to succeed, are we?

REP. STARK: (Laughing.) We're in trouble! (Laughter.)

MRS. CLINTON: I do want to say that this committee, and particularly your subcommittee, certainly do deserve an extraordinary amount of honor and respect for what has proven to be our only universal health care program, namely for those citizens over 65. And I think there are many good lessons to be learned from the efforts you have engaged in over the years to make the Medicare program even better.

What I would look to, though, and what I will tell my mother and hope to tell your mother is that one of the struggles that you have had, and the federal employees who have run the Medicare system, is that although it is a system that does provide care, it does so at very different rates in different parts of the country. And we have countless examples of this, which you know better than I, where you have, for example, Medicare recipients in a city like New Haven, Connecticut being served at one half the cost as a Medicare recipient in Boston just 100 miles away. You can look at a 300 percent differential in the service cost provided to Medicare recipients between Miami, Florida and Milwaukee, Wisconsin.

Now, there is something that is not working in the Medicare system to make the delivery of health care to our mothers cost- effective while remaining high quality. And what we believe is that as we begin to organize our health care delivery system better, as we put some of the initiative into the hands of physicians and hospitals to make some of these choices and move away from what we've tried to do, which is to tell them exactly how much to charge but then give them a big bump if they say they're in an area that costs more even though it's hard to justify that differential in cost, that we can reduce the rate of increase in the Medicare program without in any way undermining quality.

Now if all we were to do, though, is to say go out and reduce it without on the private side trying to make some of these changes which the Medicare people have been on the forefront of trying to figure out how to initiate and reward, that would not work. So they go hand in hand -- the changes in the public system and the changes in the private system.

But I feel very comfortable telling my mother that the kind of care that I want her to have can be delivered in a cost-effective, high-quality way, and there are many places around this country that are doing a better job, and we need to be rewarding them and we need to be changing our system so that more providers do that instead of what is currently much too costly care that has no discernible difference in quality in the Medicare system.

REP. STARK: Thanks, I'll pass it on.

REP. ROSTENKOWSKI: Mr. Jacobs.

REP. JACOBS: When Otis Bowen was secretary of HHS, he made a study of the cigarette tax. The cigarette tax then was one-fourth what it was in 1952 on account of inflation. In real copper pennies, it is still substantially less than it was in '52 before anybody knew the dangers of the use of tobacco. Teenage smoking fell off 17 percent merely and apparently as a consequence of moving the tax up from 8 to 16 cents per pack. I say that for the Record because I know that this is part of the proposal to do even more.

Somebody said in a town meeting to me last night, "Well, what if people quit smoking? We wouldn't be able to collect any tax." And I said, "Horrors," -- (laughter) -- "that would really be a substantial loss to the nation, wouldn't it? How much would you pick up in cost -- health cost savings?"

The president mentioned violent crime as a health problem and some critics have taken him to task for that. I agree with him. I'm a former police officer. I know what he's talking about except for the ones who are doing it. And by chance, you and I corresponded in the late 1970s about early intervention -- childhood intervention of cognitive training to break a chain of educational deprivation in the early years of life, and I submit that that very program is probably the best housing program, probably the best crime program, and probably the best health program if you believe -- and I know you do, as I do -- that an ounce of prevention is worth lots of billions of dollars.

My point is that in 1988 in the welfare reform, we adopted an amendment which require HHS to have pilot programs in the ten AFDC regions which would cost practically nothing, giving college credit to students who would participate on a voluntary program of visiting in poor homes for the purpose of helping the moms and the ultimate purpose of inculcating correct linguistics and, well, really, social grace. That has never been implemented. It was not implemented during the past four years. Secretary Shalala said before the committee at the beginning of the year, I believe, that she would implement it. Is she going to?

MRS. CLINTON: I --

REP. ROSTENKOWSKI: How about a one-word answer, Mrs. Clinton.

MRS. CLINTON: Yes. (Laughter.)

REP. ROSTENKOWSKI: Mrs. Johnson.

REP. NANCY JOHNSON (R-CT): Thank you, Mr. Chairman, and welcome, Mrs. Clinton. Whether the payroll tax cap holds or increases as social security taxes have an other such taxes, and whether the global budget is a benign backstop or a hostile and arbitrary eroder of quality and access depends on whether your plan will in reality develop the savings you anticipate.

As a member of the Health Care Subcommittee that has struggled hard to control the cost of Medicare, and rarely seen us be able to exceed 2 percent -- I think maybe one year we got as far as 3 percent -- it troubles me that in the single year between '95 and '96 you're going to assume we're going to be able to control -- reduce Medicare costs for 4 percent and that over three years we're going to be able to more than cut them in half. And the same you're assuming in Medicaid. Now, those are two programs that Congress has 100-percent power over in recent years, and they have -- the costs in those two programs have risen far faster than in the private sector, where there have been very creative and aggressive efforts at both prevention and wellness programs and a lot of things that have progressively cut costs.

So, given your assumptions in those areas, could you back them up? Because, when coupled with your assumption that growth will be 5 percent in the economy, I wonder whether or not we will be able to avoid an absolutely skyrocketing payroll tax or the global budget as a heavy-handed backstop to make your projections came true.

MRS. CLINTON: Well, Congresswoman, I think that those are very important questions, but the way that we look at this is starting from a base that is much higher than it needs to be. When we spend 14 percent of our GDP, we know we're spending more than we need to spend. When we have a Medicare program that, even after the budget, will grow at 11 percent and a Medicaid program that will grow at 16 percent next year, when neither the populations nor the morbidity statistics affecting those populations groups are growing anywhere like that, we know we can get savings.

Now, the real issue is: How much and how fast? When can we realize them, and how much can they be stabilized over time? And I think that the lessons that we've learned in the private sector in those areas where we have been successful in beginning to get a handle on costs should be applied to the public sector. And I just want to make one quick example of this, because I this is a very key point. I brought with me just one of the millions of pieces of paper that we've looked at over the last months. And it's a consumer guide to coronary artery bypass graft surgery that is put out by the Pennsylvania Health Care Cost Containment Council.

Now, this group here in Pennsylvania, before the president was even elected, had been collecting information about this particular operation and others. If one looks at this and realizes that, if you first of all take the differing costs so that the cost of this particular surgery ranges from $21,000 to $84,000 in one state and then if you look at the mortality in each of the hospitals that charges somewhere between 21 and 84, there is no quality difference between the 21,000 and the 84,000. In fact, if I remember correctly, the 21,000 actually had a better-than-average survival rate and quality outcomes than some of those at the upper end.

There are so many lessons to be learned. There are no incentives in our current system overall in the private or in the public to move physicians and hospitals toward making decisions that will result in better-delivered, higher-quality, cheaper coronary bypass surgery, when if we had a system that, in both the Medicare and the private sector, began to push toward making some of those decisions, we could actually in the state of Pennsylvania provide more coronary bypass surgery at a cheaper cost than we currently are to more people and retain quality.

And those are some of the issues that we want not only the country to be talking about but we want our whole reform, through using market and competitive forces, to help move providers toward making those decisions, and that's why we don't think any kind of budget cap would truly be enforceable in most instances but would serve as a backstop so that there would be some overall budget discipline but much of the work will be done in the doctors' offices and in the hospitals as better information becomes available so that these better decisions can be made.

REP. ROSTENKOWSKI: Mr. Matsui will inquire.

REP. ROBERT T. MATSUI (D-CA): Thank you, Mr. Chairman.

Mrs. Clinton, I would like to commend you, the president and your staff for the tremendous job that you and all of you have done in terms of putting this package together. I think it's a tremendous package. It's not only a first start but it's
a basis upon which all of us can add to make sure we have affordable health care in America during this session of Congress.

I'd like to ask you a question regarding the mandated benefits.

We're going to receive a lot of opposition from so-called small businesses on that particular issue, and I think it's essential to this program if, in fact, we continue to have health care delivered on an employer-based system as you have proposed, it's my hope that during the course of this debate, you and the president and others that will be speaking on this will explain to the American public the benefits and the justice involved in making sure that all employers insure all their employees, because now there's a cross-subsidization, as we know, insurance premiums go up, because of the fact that some employees are not covered by their employers.

Perhaps you can comment on that because I thought your explanation at the conference we had at the beginning of our session from the August recess was very, very helpful to many of us.

MRS. CLINTON: Well, Mr. Matsui, as you pointed out, what we have is a situation in which the majority of our businesses, both small and large, do provide some insurance. For them, the cost is not only the direct cost that comes from making their contribution to their employees' insurance, but it is the indirect costs they assume because other businesses do not provide any assistance for their employees.

Now, if you go down any Main Street in America, you can go by a store where they provide insurance and then a store that doesn't and then a store that does, and you can just go on down the block. Well, when the employees of the store that does not provide any insurance and there's no opportunity because of the wage level of the employees for them to enter the market to buy their own insurance, when those employees get sick, they go to the same hospital in the same town that is paid for with the health care premiums that are paid by the employers and employees of the two stores on both sides. The result is that the uninsured, then, shift the cost of their care onto the health care premiums paid by those businesses and individuals who do bear the burden in our society. It doesn't strike us as fair that those businesses that have made the commitment to health care should not only bear the burden for their own employees but literally the burden of the employees of others who have not made the same choice.

Yet at the same time, we are sensitive to the costs that confront some of those who have not. And one of the problems in this debate about small business is that many small business owners are looking at the insurance market as it currently exists. And they are saying "How on earth could I afford to go into this market and pay the average going rate for insurance that I know is what is being charged?"

We are talking about a reorganized, re-formed insurance market that businesses would be in. They would not only be part of a very large purchasing pool, which we know will bring down their costs, but for the small businesses and the low-wage employees, they would be given a discount, because we want all businesses to be fairly treated, which means all should contribute, but it also means we should cap the costs at the lower end for the small businesses. And we have run now some computer simulations, and we've had actually a number of businesses go into the Small Business Administration and sit down with their spread sheets and their balance sheets and they've run those figures themselves. And for many small businesses that currently ensure, they will see very large decreases. And for those that do not, the costs will be affordable as we have laid them out.

REP. ROSTENKOWSKI: The chair is going to make the observation that we're running a little behind schedule in hopes that members will shorten the question as opposed to making the statement. We will get back on track.

Ms. Kennelly.

REP. BARBARA B. KENNELLY (D-CN): Thank you, Mrs. Clinton, for coming.

Mrs. Clinton, under the president's plan, he specifically mentions reproductive health services. Currently under most insurance plans, they are silent concerning this. They leave those decisions up to the doctor, up to the patient. And under current law -- and I cite specifically the Public Health Service Act -- there is a conscience clause, and that, for example, would apply to a Catholic hospital. My question to you: Is it possible that this conscience clause could cover an entire health plan?

MRS. CLINTON: Yes, because in our conversations with the Catholic Hospital Association, which presented a plan very similar to the one that we are coming forward with, even again before the president was elected, we anticipate that their will be, for example, catholic health plans in many areas that will link hospitals and maybe even teaching hospitals and providers, and we do think that that would be possible and would be permitted.

REP. KENNELLY: Well, then, take it a step further. Could a conscience clause cover an entire alliance?

MRS. CLINTON: In a whole state?

REP. KENNELLY: Or a large alliance?

MRS. CLINTON: I don't believe so, because I think that what we are attempting to do is to provide the same kind of access to pregnancy-related services that is currently in force now. And, certainly, some states have constitutionally protected regulations that govern abortion, which would be abided by, but I don't think any state or any region of a state that's set up an alliance would, under current constitutional law, be able to prohibit that.

REP. KENNELLY: Thank you, Mrs. Clinton.

REP. ROSTENKOWSKI: Mr. Houghton.

REP. AMO HOUGHTON (R-NY): Thank you very much, Mr. Chairman.

Mrs. Clinton, when I was a little boy, I used to look up at the wall and see those wonderful Normal Rockwell paintings, "The Four Freedoms," and you're really instituting a fifth freedom, the freedom from care, the freedom from the ability to worry about health considerations. The thing that I would like to ask you is this. We have a very delicate system here, and it's called democracy. And why is it that the whole concept of managed competition has moved away from the original thought proposed by the Jackson Hole group towards mandates and federal controls and price controls, away from the federal government spelling out the basic outlines and then stepping back and letting private industry, private individuals, communities, have incentives and have tax credits and things like that to accomplish the same thing?

MRS. CLINTON: Mr. Houghton, we believe that we have taken what managed competition has developed theoretically and analyzed it and actually come up with a plan that rests on competitive and market forces, but recognizes that there are certain problems within our health care system that competition alone either could not handle or could not handle in a timely enough manner to deal with the extraordinary budget and economic pressures we are facing.

And one example is universal coverage, that the theorists of managed competition who have worked on this for a very long time will admit that it is not clear at what point we could reach universal coverage under a pure managed competition theory.

Yet, if we do not reach universal coverage, then we continue to have cost-shifting, and among the problems that would then be faced in any managed competition system is how to deal with the continuing health care costs of the uninsured and how to adjust risks for them. We believe, if we have everybody in the system, that will give us, for the first time, a truly competitive health care system, which we have never had up until now.

You know, many industries, like the ones that you're intimately familiar with, have had to become more efficient in the last decades because of external competition -- a threat from Europe, a threat from Asia. So they had to look hard at where their costs were and make some hard decisions. We don't have external competition in the health care industry in our country. We have to create it, and we believe that the plan the president's proposing takes the best of a competitive approach and puts that to work. And we do want the government to get out of the way, but we think everybody needs to be in the system as an example for the competitive forces to work most efficiently.

REP. ROSTENKOWSKI: Mr. Andrews.

REP. MICHAEL ANDREWS (D-TX): Thank you, Mr. Chairman.

And good morning, Mrs. Clinton. I'd like to follow up on what my friend from New York asked you about and just visit with you about a concern I have about your proposal. And that is that what I think may well be an inordinate amount of government regulation and ultimately micromanagement, which is exactly where we want to move away from. The idea of global budgets and premium caps, it seems to me, may well cause our providers not to compete to keep their costs down but to maybe game the system to get to the cap. And with a situation like global budgets, where different states give different amounts to Medicare recipients, some as widely as disparate as two to one, don't we run the risk, by these kinds of controls, undermining the very kind of competition we're trying to create in the marketplace?

MRS. CLINTON: Well, Congressman, you know, that is one of the sort of great theoretical debates we will have in the coming months, because I certainly appreciate your concerns. But it is very difficult to understand why this particular industry should essentially be without any kind of budgetary discipline, since every other industry has some kind of discipline built in, whether it's competition from the Japanese on how much a car costs or competition from the retailer down the street to see whether or not you get a good deal.

Now, in order for us to move from the kind of system we've had, which has basically been a blank-check system, without any kind of effort to rein in costs in any reasonable way over time to where you and I both want to get, which is high-quality providers competing on the basis of quality and price and not necessarily the kind of continuing micromanagement, overregulated approach that we have seen that does not control costs but continues to reward inefficiency, we believe that the premium cap provides a balance between the micromanagement and over-regulation we do want to eliminate from the system in order to simplify it, and the danger that in the absence of some kind of budget targets, we will continue to have a system that is out of control, that pushes on political levers instead of competitive ones.

But as you and I have talked in the past, we want to make sure that the way we structure this works the way we intend for it to structure, and to that end, we're continuing to have very fruitful discussions with many of the original theorists behind managed competition, with the American Hospital Association, the AMA, other groups that are very concerned as well.

But from our perspective, the country has been basically not facing up to what health care costs and not creating a system in which health care providers were encouraged to make cost-effective, quality- driven decisions. Therefore, we have a lot of practice styles out there among providers that are responsive to the continuing kind of flow of money from the public or private sector. In order to change that, we think we need some kind of budget discipline against which they will measure their decision-making.

REP. ROSTENKOWSKI: Mr. (Levin ?) will inquire.

REP. SANDER LEVIN (D-MI) (?): Thank you.

Mrs. Clinton, this is a special moment for the committee and, I think, a very special moment for women in this country, including my wife and two daughters.

Could I ask you: You've combined a deep commitment with a willingness to negotiate. Give us a further glimpse of your priorities. What, as you negotiate, do you hold most dear?

MRS. CLINTON: Well, Congressman, the way that I would say that is pretty much the way that the president has said now on several occasions in his public appearances.

We believe that we have to achieve universal coverage as soon as possible, as one example, in order to achieve security, but I think that as we work through the details on this, how soon we get there, what the level of benefits are, you know, we want to make sure that the pieces of the system that will get us to universal coverage can work.

Another example might be the whole issue of quality. We want to be sure that the information available to consumers so that they can make good choices is quality driven, and we want to do that in as straightforward and simple a way as possible so that we can sit down and every one of us can know how to choose a health plan that we think is better for us and our families.

But there are many ways of getting to that end point. We want this system to be as familiar as it can be to Americans. That's why we built it on the employer-employee system that already works for so many. But there are many details about the actual way it would function that we want to have a good conversation about, but we want to measure it against the goals that the president has laid out.

REP. LEVIN (?): Thank you.

REP. ROSTENKOWSKI: Mr. McCrery will inquire.

REP. JIM MCCRERY (R-LA): Thank you, Mr. Chairman.

Welcome, Mrs. Clinton. I look forward to future hearings when we have more time so that those of us who are lawyers on the committee can practice our art of develop a line of questioning which is designed to elicit responses to shed light on a particular area of the debate that we think the jury -- in this case, the public -- needs to know about. But in the two minutes that we have, just as a point of information, I hope that this debate revolves around facts.

There are problems in the system. And I hope we discuss the facts about those problems and the cost of solving those problems. Immunization, for example: in my state of Louisiana, a poor state by any standard, there's no excuse for someone not getting immunization. In our community health centers anybody can walk in and get their child immunized for $5. And if they say they can't afford the $5, it's waived.

So that's not a problem in Louisiana. If it's not a problem in Louisiana, as poor as we are, I submit it shouldn't be a problem in any state under the current funding.

One problem in the system, though, is the escalation of insurance premiums. That means a lot of people can't afford insurance, small businesses can't afford to provide it. What in your research through your task force have you found is a primary reason for those insurance premiums going up? Let me answer it: the cost of medical services going up. So what is the underlying cost drivers that you've found, if you could just name three or four, that get to those medical costs going up, driving those insurance premiums up?

MRS. CLINTON: Well, there are a number of costs, and I share your hope that we will continue to have this kind of a dialogue because I do want the facts to get out. I'm very confident that when the facts about what works and what doesn't work get out, the American people and the Congress will make a better decision. So that is something that I am committed to.

There are a number of issues. One is the kind of reimbursement system that we have. When you reimburse on the basis of procedures and tests as opposed to a per capita rate in which a plan or a provider is given a certain amount of money to provide all services, you have a difference in both motivation and incentive. If the way that you can be paid is by ordering more and more tests, then it's human nature to order more and more tests. And as Dr. Koop said the other day, he believes there is about $200 billion in our system of unnecessary costs driven largely by what he views as unnecessary kinds of tests and procedures.

The second issue I alluded to earlier is what is called practice styles. Now, some of that I would argue is a result of different kinds of pressures in a region or different kinds of training. But if you take certain kinds of procedures and you try to determine why one is hospitalized in one community and not hospitalized in another for the same kind of illness or accident, you will find that practice styles of physicians determine often how much a community pays for medical care when in a neighboring community a practice style that, for example, wouldn't hospitalize somebody for the same disease will keep the costs lower. So those two are major reasons.

Thirdly, the way that we have created a system in which some people are paid for in certain ways and other people are not paid for or paid for less causes the whole system to be trying to figure out how to get the most return they possibly can from everybody who's got any money who walks in the door. So it's not just the issue of shifting costs from the uninsured to the insured, it is the issue of trying to figure out how many more patients you can get into a hospital or a clinic who are insured.

And then you're got the problem that we see in the insurance market and the related costs associated with that in the providers of health care, which is that once you don't insure everybody, you essentially, as they say, "cherry pick" among people. Then you've got all different kinds of policies with all different kinds of risk factors associated and costs, and then you raise costs within the insurance market in order to decide who is insured at what cost, and then you raise costs within the doctors' offices and the hospitals to try to figure out how to get under whatever policy words are written so that you can get reimbursed for the services you've provided.

You know, 15 years ago, give or take a few years, most physicians were not spending more than 20 to 25 percent of their income on filling out forms and paperwork. Today it is closer to 50 percent. Now, if you have to hire more clerical workers and bookkeepers, if you have to hire, as many doctors do, a person to sit on the phone to argue with insurance companies as to who will get paid how much for providing which service, you then charge more for the service you've provided because you have to pay for the bookkeeping costs.

So all of these things together have helped to create the kind of atmosphere in which we see costs continuing to go up.

REP. ROSTENKOWSKI: Mr. Cardin.

REP. BENJAMIN L. CARDIN (D-MD): Mrs. Clinton, thank you for your leadership in this area. First an observation on coverage, and then a question on state flexibility.

There are very reasons to be very pleased by the initiative as to the coverage. I am particularly pleased to see references to lead poisoning with our children both in the public health initiative as well as screening being part of the coverage package. Senator Bradley and I have come forward with a way to finance a program to try to prevent lead poisoning with our children, and I would request that we work with you and you designate someone on your staff that we can try to expand the lead poisoning initiative.

Question, though, on state flexibility. I'm very pleased about the state flexibility issues, and while we can be proud of some of the accomplishments in Medicare, some of that has been at the cost of shifting to the private sector. In your draft document, you mention exemptions or exceptions to the ERISA statute to allow states to have all-payer rate systems. My specific question is, will the initiative allow a state like Maryland to continue its all-payer rate system on hospital care? Maryland's looking at expanding that to physician care -- all payer rates. Would that be permitted? And would the authority be exercised either by the state or by the alliance?

MRS. CLINTON: Well, congressman, that would be permitted if that were an option that the state chose, and it would be up to the state to determine how that would be implemented within the state. And I think that's the kind of flexibility that we're talking about. But I'm very conscious of Chairman Stark's concern, because Maryland, to take Maryland as an example, is much further along in devBC-HWMC-H CLINTON 23THADD

x x x year?

How do you do that since he is not an employee so there is no cap on his premium of 20 percent? He has to pay the entire premium himself.

MRS. CLINTON: Well, Congressman, there will be a cap because he is -- we are treating the self-employed and the independent contractor as though they were small businesses. We think that is the fairest way to do this.

REP. MCDERMOTT: So the cap will be 80 percent or 20?

MRS. CLINTON: The cap will be applied to the independent contractor and the small business person who is self-employed. We will give them the 100 percent tax deductibility, but we will also treat them as though they were a small business with only one or two employees, because if the independent contractor uses his wife on some jobs, or his son on some jobs, that will be treated as a small business unit, so they will be entitled to the discounts and caps available to small businesses plus the 100 percent tax deductibility.

REP. MCDERMOTT: And if he can't pay it or doesn't pay it, or she can't or doesn't pay it, what are the enforcement mechanisms?

MRS. CLINTON: Well, we do not want to create some large bureaucracy to go chasing Americans who have not paid their health insurance premiums, which is one of the reasons why we favor the employer-employee system because then it will become automatic for most individuals.

For those individuals who are outside of any other employment relations and are self-employed or an independent contractor, we believe that the incentives and the opportunity to have affordable health care will be very difficult for people to turn away from. And if they show up for care and they cannot show their health security card, then there will be a process put into motion to collect what is due for the care that they have received, so they will be in a sense billed at the point of service, and it will be either deducted from their wages or obtained through tax deductions in some other

way.

REP. MCDERMOTT: Thank you.

REP. ROSTENKOWSKI: Mr. Shaw will inquire.

REP. SHAW: Thank you, Mr. Chairman. Mrs. Clinton, I'd too like to express my appreciation for you being here today.

Mr. Stark raised his mother's question a few moments ago and it seemed like we were going right along the line of everybody being concerned about their mother. I do want to return to that in that my mother is now one of my constituents in the 22nd Congressional District of Florida.

You -- in response to Mr. Stark's question, you made reference to the comparison between Milwaukee and Miami. Miami is one of my -- is part of my new district which stretches from the southern part of Miami Beach up the Atlantic Coast north of Palm Beach to Jupiter. This constitutes the most elderly population of any congressional district in the country. This makes me very concerned about the question of cuts in Medicare. Quite frankly, and to be very blunt, a $200 billion cut in Medicare is totally unacceptable to the 22nd Congressional District of Florida. It may even be unacceptable to the Congress.

The hospital I was born in -- St. Francis Hospital in Miami Beach -- that was in business for over 70 years, a Catholic hospital, recently went broke, and it went broke because it was a high Medicare hospital. In other words, they had so many Medicare patients who weren't paying their full way now under the formulas set up by this Congress that they just did not have a universal population to spread this expense over.

There are many other hospitals in my district, non-tax-supported hospitals that are holding on by their fingernails. Quite frankly, a substantial cut in Medicare as it applies to the payment of hospitals will do these hospitals under and we will no longer have non-tax supported hospitals in the 22nd congressional district of Florida.

This is also true across much of the Sunbelt and many areas that have a high elderly population.

Assuming this is true and that we are unable to pass the cuts in Medicare that you have suggested in your plan, where would we go to make up the shortfall of $200 billion and how is that shortfall projected in your formula as it would apply to hospitals versus physicians?

MRS. CLINTON: Well, Mr. Shaw, let me start by saying we project $124 billion in cuts over seven years, not $200 billion in Medicare. And of that $124 billion, we intend to provide new benefits from not cuts but reductions in the rate of growth of Medicare. Because I think as we all know, we are not talking about taking the Medicare currently available and cutting below that amount. We are talking about beginning to reduce the rate of increase in Medicare of $124 billion, which would bring us down from about 11 percent increase annually to about 6 or 7 percent increase annually.

Now, we believe that there are several advantages to your mother and your other constituents in the 22nd congressional district. The first is that with the reductions in the rate of increase, we will for the very first time be providing a prescription drug benefit for the elderly.

Much of the hospitalization costs and much of the large costs of Medicare are due in no small measure from people either being inadequately or wrongly dealt medication that they cannot afford and that they then end up self-medicating themselves. This is a particular problem among the elderly where you often have elderly patients on Medicare being discharged from the hospital with a prescription in hand which they cannot afford to fill, which means then they don't take the prescription, they end back up in the hospital which costs us more money and we're caught in a vicious circle. We think providing this prescription drugs will help both hospitals be more efficient and individuals be better taken care of.

Secondly, we want to provide a long-term care benefit for the elderly. Those two, prescription drugs and long-term care, are the single biggest issues to the elderly that we have encountered, whether it's individual anecdotes or from ARP and other groups that represent the interests of the elderly.

Specifically as to hospitals like the one that you are talking about, we want those to be considered essential community providers, and we have funds in this system to provide money for them because they do provide a service that would otherwise not be available if they were not there. So we intend to shore them up.

REP. ROSTENKOWSKI: The chair will make the observation that if the question is going to be a two-minute question he's going to suggest that the witness submit the answer in writing at a future time.

Mr. Kleczka will inquire.

REP. GERALD KLECZKA (D-WI): Thank you, Mr. Chairman.

Mrs. Clinton, I join my colleagues in congratulating your

Gerald Kleczka (D-WI)

QUESTION:

What is the size of the National Health Board and what is the cost?

ANSWER:

The National Health Board will be an agency in the Executive Branch of the Federal Government with a modest staff of approximately 100 people.

We have estimated federal administrative costs to be about $9.6 billion over the 1995-2000 period. These costs include the Board, HHS, Labor and other Federal Departments.

QUESTION:

Doesn't the early retiree policy have a notch when the person turns 65 and has to pay 25 percent of the Medicare premium when they were previously paying 20 percent of the regional alliance premium?

ANSWER:

The federal government pays the employer share of the early retiree premium until the individual is eligible for Medicare. The goal of this policy is to bridge the period between retirement and eligibility for Medicare for older workers so as to ease the financial worries of those who may not now be able to afford insurance as well as increase the global competitiveness of employers with a disproportionate share of older workers.

QUESTION:

How was the benefits package priced?

ANSWER:

The first step in HCFA's simulation process was to determine each individual's insurance status. The modelers used CPS indicators for this, and considered a person to be insured if he or she was covered by employer-sponsored insurance, other private insurance, CHAMPUS, Medicare, or Medicaid. Insurance could be either in one's own name or through inclusion in a policy held by an adult in the insurance unit. Also, some dependents are covered by private insurance policies owned by people outside the family (for example, a child of divorced parents may be covered through insurance carried by the parent who does not live with the child).

HCFA modelers then adjusted health expenditures to reflect the coverage offered through the regional alliance plan. That coverage is restricted to hospital care, physician and other professional services, prescription drugs, and durable medical equipment other than vision and hearing products. Therefore, the analysts excluded all other National Health Accounts expenditure categories. The cost of coverage for mental health, dental, and preventive care in the standard benefit package was estimated separately, from aggregate data, and added in at the end of the process. Once expenses were adjusted for coverage differences, the modelers applied the fee-for-service plan deductibles, coinsurance, and cost-sharing limits to each person covered through the regional alliance.

An insurance-induced demand adjustment was applied to all those enrolled in the regional alliance. The basis for the induced demand was the difference between out-of-pocket spending under current law and that determined by the reform simulation described above. The induction factor varied by type of service. The application of the factors and the specific values used are described in appendix A. Post-induction spending is equal to the expenditures calculated previously plus (minus) the induced spending calculated as described.

Following these steps, HCFA analysts imputed expenses to currently uninsured people. Existing patterns of use for the uninsured person were discarded, because those patterns are influenced by the absence of insurance. An imputation file was created for each service covered under the regional alliance. To create the file, insured people (excluding people who received SSI cash payments) were divided into groups according to gender, four age classes, and three poverty status classes. Expenditures

were tabulated for each group to determine: (a) the proportion that had no expenditure and (b) mean expenditures and use for each decile of the user distribution.

Expenses were imputed for an uninsured person using these imputation files. For each type of service, the person was assigned a random number ranging from 0 to 1. If that number fell within the nonuser proportion for the service, the person was given no expenditure for the service. Otherwise, the person was given the mean expenditure and use for the decile of users into which the random number placed them. Analysts assumed that facility and physician use was correlated for hospital services, and used the same random number for hospital inpatient and physician inpatient use. They did the same for hospital outpatient and physician outpatient, and for hospital emergency room and physician emergency room use.

Analysts performed a final simulation to determine which people were covered by the alliances. Typically, they excluded people who received AFDC or SSI cash payments. Similarly, most Medicare enrollees were excluded; only those who worked or whose spouse worked were included in the premium calculations. The remaining people were divided between the corporate alliance and the regional alliance according to the worker status of the adults in the insurance family, and were assigned to one of three policies: individuals (and couples with no dependents), one adult plus dependents, and two adults plus dependents. In a final pass through the family's health expenditures, analysts applied the family limits on out-of-pocket spending to determine the plan benefits and copayments.

In order to generate an upper-bound subsidy estimate, whenever a two-earner couple had one worker in a large firm (5,000 or more workers) and one in a firm that would be covered through a regional alliance, the couple was assumed to choose coverage in the regional alliance. This maximizes the potential subsidy costs given that no government subsidies are available through the corporate alliances.

After plan benefits had been determined, premiums were calculated for each of the policy types and alliance types. An offset was applied to expenses to reflect current-law cost-shifting attributable to uncompensated care. Under the current system, private sector premiums are higher than they would be if there were no uncompensated care in the system since providers pass these unpaid costs on to insured, paying patients. Under reform, all persons will be insured; consequently, baseline premiums should be reduced to reflect the elimination of non-payers from the system. A load factor was applied to the (reduced) benefit cost per policy. The load factor was 15 percent for the regional alliance.

leadership on this most important issue. And in reading the material that has been presented to us, there's so much that I agree with. However, the three areas which I'm having a problem with is the basic benefit package, which I think is more a Cadillac plan than basic. In fact, I'm told that the cost could be $6,000 for a family plan in 1985 instead of your $4,200. The National Health Care Board -- my fear there is that it's going to be a bureaucracy; where on the one hand we're trying to cut the paperwork in the private sector and for the providers and we're going to set up this National Health Care Board which is going to grow. And my question is, what is the size of that or what do you envision the size to be and what is the cost?

The last concern is the 80 percent federal pickup for early retirees. I think that's going to be a gigantic cost, which we're going to -- (inaudible word) -- cover, and I think it's probably an employer responsibility in the early retiree years, and it's going to be kind of unique when this early retiree turns 65 and he or she will have to pay 25 percent of the premiums, wherein for the last 10 years they're only paying 20.

MRS. CLINTON: Well, I can't possibly answer those questions in this time period, but let me just quickly say on the benefits package, we have priced that out very carefully, Congressman, and are willing to sit down and show you what the figures are. We have a total agreement among all of the actuaries inside the government who have pounded out these figures. It's the first time that the government actuaries have all sat in the same room and actually struggled over exactly what benefits would cost. And we think that the benefits package is a fair one, particularly because it emphasizes primary and preventive health care, which is not usually included in insurance policies but which we think will save us money over the long run. So I'd be glad to sit down and show you that in detail and also give you additional information about the national board and about the retirees.

REP. KLECZKA: Thank you very much.

REP. ROSTENKOWSKI: Mr. Lewis will inquire.

REP. JOHN LEWIS (D-GA): Thank you, Mr. Chairman.

Mrs. Clinton, I want to say to you what I've said before. As a nation and as a people, we're more than lucky, but we're very blessed to have you leading this effort for comprehensive and universal health care. I really believe when the historians pick up their pen and write about this period, they will say that you were largely responsible for health care reform in America.

Now, my question is very simple. In the inner cities, providers must face high crime and serious health problems. In rural areas, also as in the inner cities, resources are limited
So I'm deeply concerned about how the proposed plan will impact both inner city and rural citizens. How do we ensure, how do we guarantee that these people receive universal and quality health care?

MRS. CLINTON: Well, Mr. Lewis, that's one of the key issues facing this country because in our underserved urban and rural areas, we have literally millions of Americans who are basically denied health care because there are not providers there and they have no insurance to give them the resources to be able to pay for their care. We have a series of proposals, including once again reinstituting and strengthening the National Service Corps of health care providers so that doctors and nurses and others will have their loans paid back and will be encouraged to go into urban and rural areas where there are not health care professionals now.

We also want to see technology used to link areas where there are not enough providers with those where there are, to provide the kind of specialty care. But mostly, we think we will for the first time have a market in which everyone will bring with him or her adequate funding so that they will be able to therefore create a demand which will be met by health care providers.

We also believe, though, we must look at making sure that alliances and accountable health plans do not discriminate against any area geographically or any population, and we intend to put in protections against that.

REP. ROSTENKOWSKI: (Off mike.)

REP. RICK SANTORUM (R-PA): Thank you, Mr. Chairman.

Thank you, Mrs. Clinton. Two quick follow-up questions. You responded to one of the earlier questioners that your full plan would not be implemented for several years and that there would be certain reforms that could take place immediately, like insurance reform and others that we could act on. Would you be amenable, would the administration be amenable to actually doing that in two phases, doing something immediately, getting something up and going that we can implement right away, and then waiting down the road possibly for a longer debate, maybe later next year or the following year, to pass a more comprehensive reform of the program -- of the system?

MRS. CLINTON: No.

REP. SANTORUM: Okay. (Laughter.) See, I ask easy questions, Mrs. -- number two, you -- in follow-up to Mr. McDermott's question about the number of people who may, in fact, fall through the cracks in this system, have you folks done any analysis of what percentage of the people in America will still be uninsured under your proposal -- homeless people, people who have dropped out of the system? What percent are still going to end up at the emergency room without care, without an insurance card?

MRS. CLINTON: A very small percentage, Congressman, and we have done the best analysis we can on that, and we've also looked at Hawaii, which as you know, has an employer/employee mandate, and they cover all but about 2 or 3 percent of their population. And what we know will happen is there will be people who are homeless, who have perhaps mental health problems, who have not gotten into the system. But as they show up for care, they will be. And we have enough funding in the system, we believe, to be able to take care of their needs.

REP. SANTORUM: Under time, Mr. Chairman. (Laughter.)

REP. ROSTENKOWSKI: (Off mike) -- Payne.

REP. LEWIS PAYNE (D-VA): Thank you very much, Mr. Chairman.

And thank you very much, Mrs. Clinton, for taking up the task of reforming our nation's health care system. And I look forward to working with you and with the administration to ensure that implement this within this Congress.

I represent a very diverse congressional district. The University of Virginia's Medical Center is in my district, one of the finest in the country. I have 13 of 17 rural counties, though, that have been classified by HHS as medically-underserved areas. And I'm pleased that the plan does look at rural areas and the special needs that exist there.

I'm troubled, though, by one aspect of the president's plan, and that is the reliance on the tax of tobacco and tobacco products in order to finance health care reform, and I believe that there are some fundamental questions as to the fairness and equity of singling out one product grown in rural areas in one section of the country which will bear the burden of paying for and generating new revenues for the health care system. I have some 5,000 tobacco farmers in my district who rely on their product to support their families, and I would like this question: Can we continue to work together? Will the administration be open to discussing the source of financing for the health care system and open to discussing the amount of the increase on -- of tax on tobacco and tobacco products?

MRS. CLINTON: Mr. Payne, I want to assure you and the tobacco growers in your district that the president and the administration are sensitive to the economic burdens that they will confront when faced with additional taxation. That's one of the reasons, as you know, that the administration supported the domestic content legislation that was part of the budget reconciliation bill, to try to ensure that domestic tobacco growers were treated fairly by the big tobacco manufacturing concerns. And I hope that the growers in your district know your support of that and the fact that the president supported it, so that we can try to have at least a more level playing field against imported and foreign tobacco.

But it is the president's belief that, even though we want to be sensitive and we want to do things like domestic content to try to understand and support the growers, that tobacco is the only product that, if used as directed, can have such damaging health consequences.

And it's particularly damaging to young people. And we hope that price sensitivity about tobacco products will discourage young people from using them.

So we've tried very hard to balance our concerns about the tobacco growers -- whom I know and you know often are not big growers, but small growers with, you know, several dozen acres of tobacco -- against both the health consequences of tobacco use, the need to discourage use among young people, and the belief that tobacco taxes are a fair way to support health care. But as always, this president will have an open door and will be willing to talk, but there will be a tobacco tax as part of this legislation for the reasons I've just enumerated.

REP. ROSTENKOWSKI: Mr. Hoagland will inquire.

REP. HOAGLAND: Let me add my kudos, Mrs. Clinton, to the efforts of you and your staff on the health care task force that have placed health care reform on the national agenda where it belongs.

I have long felt that one of the major defects of the Medicare program is a lack of emphasis on preventive care. For instance, Medicare does not pay for annual preventive physical exams. It waits until our senior citizens are sick before providing physician services, and by then, of course, their condition is often advanced, it's more expensive to treat, and less likely to be cured.

I've introduced legislation for three years now to expand the Medicare program to include a physical exam. I'm particularly interested in the aspects of your program which encourage preventive care and lifestyle changes to make people healthier, and I wonder if you might elaborate on those.

MRS. CLINTON: Mr. Hoagland, we believe so strongly in primary and preventive health care. We think it is good for the individual, and we think it is good for the health care system, and it is both physically very good and also economically because we think we will save money, which is why in the benefits package that we are proposing to be guaranteed to every American, we emphasize primary and preventive health care. It is also why we are going to encourage medical schools to begin doing what they can to encourage more young people to go into primary care. We have examples around the country where that will make a difference. In fact, if you look at the Medicare admissions and if you look at admissions of the under-65 population, hospital admissions often correlate with the number of specialists that are in a particular area. And there is often no discernible difference in the kind of treatment that is given in one community and another community in terms of quality and outcome except that in one community there are more primary and preventive care physicians as opposed to specialists so that our balance has gotten wrong. We have 70 percent specialists, 30 percent primary care physicians. We need to move toward 50-50, and we believe we can do that without in any way undermining either quality or care and access for the entire population.

REP. ROSTENKOWSKI: Mr. Bunning will inquire.

REP. JIM BUNNING (R-KY): Thank you, Mr. Chairman. Mrs. Clinton, I do agree with you that something needs to be done. I just have serious doubt that the administration's plan, as we have discussed it, is the way to go. But I will wait for the plan in bill form to make any kind of decision on what's going on.

My concern is -- the humorist P.G. Rourke (sp) mentioned recently if you think health care is expensive, wait till you get it for free. The administration claims that it wants to tax -- and I'm following up on Mr. Payne -- smokers to make them pay for part of the new system, about $105 billion over five years or the $730 billion of the total cost.

If revenues from taxing cigarettes decline, do you think the administration would consider taking other like substances, like caffeine, cholesterol, salt, sugar, alcohol, and putting a tax on those like substances?

MRS. CLINTON: Well, Mr. Bunning, there is no free lunch in this health care plan. It is not going to be free; everybody is going to be paying something. Even people who are on Medicaid now will be paying something if they work, unlike today. And we think that is a big step forward for responsibility.

Secondly, we don't take just taxes on tobacco, we are also looking at assessing those corporations that are going to continue to be self-insured because there will be certain benefits in the health care system, such as the funding for academic health care centers that we believe they should be part of supporting. If there is a way that you can ever come up with to tax substances like the ones you've just named, we'll be glad to look at it.

I've not seen any that would be realistically implemented. But, again, I would repeat that tobacco, insofar as we are aware, is the only substance that if used correctly, as directed, has these health care benefits. Neither alcohol nor caffeine nor the others, if used in moderation or in small amounts, are proven to have the same kind of effects.

REP. ROSTENKOWSKI: Mr. McNulty.

REP. MICHAEL R. MCNULTY (D-NY): Thank you, Mr. Chairman.

Mrs. Clinton, I want to join with my colleagues in commending you for your outstanding work and also in saluting the president for having the guts to tackle this very complicated issue.

In our previous discussions, I have raised with you the issue of treatment for the disease of addiction to alcohol and other drugs, and I think that the evidence is very clear that lack of such treatment results in tremendously increased health care costs, loss of productivity on the job, lost wages, and, heaven forbid, if someone gets involved in the criminal justice system, tremendous costs there. I know I've mentioned to you before in New York state, in the new prison cells that we've been building in the past several years, it costs $100,000 per cell for every new cell we're building, between $25,000 and $30,000 a year per inmate to keep them incarcerated. And it just seems to me that if we're catching people in the earlier stages of their addiction, that we could save a lot of these costs.

Now, I understand that there is some coverage provided in your proposal which will be expanded in later years. And I just wanted to ask for the record if you could briefly explain what that coverage would be.

MRS. CLINTON: Mr. Reynolds, we very much respect the proposal that you've come with and have really worked to develop. And we will continue to work and consult with you about it. We are not including it. I think the president's preference is to get semiautomatic weapons out of the hands of people who are killing themselves and each other with them and to take the kind of steps that we need as a nation to put an end to this senseless violence that is not only causing great human tragedy, but as you correctly point out, causing unnecessary health care costs. Violence is a public health problem, and in many respects, it ranks at the very top because the leading cause of death among young men of a certain age now is murder. And then we have all of those costs associated with the individuals who are not killed but who suffer grievous wounds and long-term injuries that we then pay for one way or the other.

So we are committed, as you are, to trying to eliminate the level of violence in this country, both as a moral matter but also as a health care imperative.

REP. REYNOLDS: Thank you, Mr. Chairman.

REP. ROSTENKOWSKI: Mr. Grandy will inquire.

REP. FRED GRANDY (R-IA): Thank you, Mr. Chairman.

Mrs. Clinton, as we move from the principles articulated by the president last week to the program that you designed with your staff that we will consider, I want to say that I am impressed not just with the awareness that you have created on this program, but with the understanding that has begun even at the grass root level of the details of this program. And that leads me to want to ask a responsibility question, taking the six principles.

There are two areas that were addressed this weekend at town meetings that I would like you to at least answer a little bit. One is the 10-year grace period for corporations and unions to extend very generous health benefit plans for a much longer period than a contract negotiation. And the second is the transfer of responsibility from corporations to the public sector to fund early retirees. And those are two tenets in your proposal.

Here's the question: What is the cost of those two attempts to transfer responsibility and, in some cases, forego revenue? And are these items negotiable in terms of perhaps scaling them down to pay for benefits or otherwise provide access earlier?

TAB REF # 3

Fred Grandy (R-IA)

Nature of Promise:

Structure of grace period for tax preferences for health benefits.

ANSWER:

Benefits beyond the basic benefit package remain tax preferred to the employee if they are part of a benefit plan until the year 2002. They become taxable income to the employee beginning in 2003.

Fred Grandy (R-IA)

Nature of Promise:

Structure of grace period for tax preferences for health benefits.

ANSWER:

Benefits beyond the basic benefit package remain tax preferred to the employee if they are part of an existing benefit plan until the year 2002. They become taxable income to the employee beginning in 2003.

MRS. CLINTON: Mr. Grandy, yes, how we do these are certainly negotiable, because what we are attempting to do in the first instance with the grace period is to avoid imposing a tax on people who have basically foregone wage increases by having health benefits increase. And it's a very difficult problem that we confront. Because what we have seen in our economy over the last decade is that real wages have stayed largely flat and where the increase in compensation has come has come in increasing benefits which have had to increase faster than they should have because of the inflated cost of those benefits.

We don't want to tax the middle class, and it's not just negotiated bargaining contracts. It's many employers who have been willing as a competitive device to provide benefits that they would not otherwise have had to and which may, for some period of time, exceed the guaranteed benefits package. So we believe the fair thing to do is to give notice to these employers and employees that, at a date certain, they will no longer get tax preference for any benefits above the comprehensive benefits package. How soon we get there and how quickly we can implement that without the kind of tax increase that it would result in to many people is something we will show you our figures on and talk about, because we want to reach a fair and equitable resolution.

With respect to the retirees, we have costed that out at about $4&1/2 billion. And there are several ways of looking at this issue. One is that, for many employers who have large retiree costs, they have been the most responsible businesses in our country. They have basically assumed a huge social cost, not only in direct dollars in terms of insuring their employees and their retirees, but in subsidizing many other sectors of the economy that refuse to or neglected to insure their employees because those employees were married to people who were taken care of by employers who bore more responsibility.

So, there's been a direct cost and an indirect cost. Huge sectors of our economy have been subsidized and able to provide either very low or no benefits because they have hired spouses of people who have been given big benefits. And we even have companies that have been giving cash bonuses to spouses not to go on their plan, but instead to let their employers, the spouse's employer, bear the full cost.

So, we think there's been a real showing of responsibility that has distorted the economy to the disadvantage of many of the businesses that have borne the larger costs. Now, how fast we do that, the number of retirees that are covered, the extent of the coverage, the sharing of the responsibility, all of that is something that we want to be sure works out and we'll be happy to talk to you about.

REP. GRANDY: Thank you.

REP. ROSTENKOWSKI: Mr. Coyne will inquire.

REP. WILLIAM J. COYNE (D-PA): Thank you, Mr. Chairman.

Welcome, Mrs. Clinton, and thank you for your testimony and your very comprehensive statement.

I see no reference in the preliminary reports of the plan to the National Institute of Health or biomedical research, and it has been suggested that possibly a $5 surcharge on monthly policies, health insurance policies, might be a route to go to be able to provide for our medical research costs. And beyond that, what is our plan for the unemployed, the 20 million unemployed that we have in our economy today?

MRS. CLINTON: Well, Mr. Coyne, we believe in enhancing our research capacity and we do have funds earmarked for that. But I agree with you that if we can get a steady stream of funding into our research institutions, we are likely to save money again in the long run by finding cures and by making other decisions that will enhance health. And we'll be glad to look at the idea you just presented, as well as any others.

The unemployed will be federally subsidized because the unemployed will sometimes work part of the year, but not all of the year. When they work, they and their employer will make a proportionate payment into the health alliance. The time of the year when they are unemployed, they will have a federal subsidy. But we think a lot of the unemployed are seasonally unemployed. They are periodically unemployed. They come in and out of the labor market. So that there will be some money coming in from them and their employers to help match the federal money that will make sure that they are fully covered.

REP. COYNE: But, as you know and everyone knows, there's a lot of unemployed that have been unemployed for an awful long time, beyond even the 52 weeks of benefits that they get in compensation. And I think they need to be attended to.

MRS. CLINTON: They will be. They will be members of the alliance, and their share will be paid for by the federal government.

REP. ROSTENKOWSKI: Mr. Jefferson will inquire.

REP. WILLIAM J. JEFFERSON (D-LA): Thank you, Mr. Chairman.

TAB REF # 4

William Jefferson (D-LA)

Nature of Promise:

Details of infrastructure support for public hospitals and clinics.

ANSWER:

The Health Services Act proposes new initiatives under Title III, Subtitle E, to improve access to health services for urban and rural medically underserved populations through the development of qualified community health plans and community health networks. The new programs provide **grants, contracts, loans and loan guarantees** to improve access to these populations by expanding capacity and supporting the provision of enabling services (eg. transportation, translation, outreach, etc). The funds may be used for planning, training and development, capacity expansion, development of information systems and other purposes to be approved by the Secretary.

Public hospitals, traditionally set up to serve only as a safety net for provision of personal medical services requiring hospitalization, now struggle to provide primary, secondary and tertiary care. The public health infrastructure currently cannot accommodate all of the needs of these underserved populations because of severe financial and capacity constraints. The populations that the public hospitals serve are usually medically underserved, and need a regular source of primary and preventive care. The grants will be used to develop community health networks and qualified community health plans whose purpose is to provide the comprehensive benefits package to underserved populations.

Mrs. Clinton, I, like the rest of the committee members, want to thank you for your leadership in this area and for your personal investment, particularly coming to my district and the others around the country to inquire of our citizens.

Charlie Rangel and John Lewis have asked questions about the reform -- how reform affects the inner-city residents. I want to ask a question that has two aspects. One is, most of the primary health care that's being provided (in inner ?) cities is being provided by minority physicians, particularly through the Medicaid program. They have combined themselves as small cooperatives. They're concerned about how they'll be able to manage their affairs when it looks as if the small groups are going to be squeezed in this plan. The second is, there's a promise in the outline that I have seen of infrastructure support for public hospitals and clinics. Could you please tell me how the details of that might be developed and then comment on the earlier part about how the small physician groups might operate in the larger plan?

MRS. CLINTON: Mr. Jefferson, let me answer the first question orally and then the second in writing because I can't possibly meet the chairman's deadline trying to do both of those, if that would be all right.

With respect to minority providers, solo practitioners, others in both rural and urban areas, we anticipate several advantages in the proposal that we have. The first is that in every region of the country, there will be guaranteed in every alliance a network for all physicians to be members so that no physician will be shut out from being able to compete for the business of all of us who will put our health insurance premiums into these large pools. There will be a guaranteed network on a fee-for-service model, just as current medicine operates in most areas.

Secondly, there will be no permitted discrimination against any physicians from joining more than one plan, if that physicians chooses to do so, so that a physician could be both a member of the fee-for- service network, and a PPO, for example -- a preferred provider organization, and there would be no penalty or prohibition against that.

We also anticipate and have had conversations with the National Medical Association, with representatives of Hispanic physicians and others as to how -- when accountable health plans come in a bid for our business. They will find it in their interest to make alliances with and to have those physicians as part of their networks because in order to serve the populations that are already used to receiving care from certain physicians, they will want those physicians to be affiliated with them so that it is more likely when an individual comes to sign up for a plan, if they know the name of the doctor or the name of the clinic that they are familiar with, they are

more likely to sign up for that plan. So there will be, as I learned when I was in New Orleans and talking with representatives from some of the large hospitals and clinics there, an incentive that has never existed before to create partnership and relationships with inner city physicians and rural physicians to make them parts of these networks.

REP. ROSTENKOWSKI: Mr. Camp will inquire.

REP. DAVE CAMP (R-MI): Thank you, Mr. Chairman, and thank you, Mrs. Clinton. My question -- I have a two-part question involving primarily farm families. Specifically, how will seasonal and migrant workers be covered, and who will be responsible for their participation in a regional plan?

And secondly, many farm families fall under the self-employed category, and will the payroll tax be required even in unprofitable years, often not a result of anything they've done but because of weather or other conditions, so that they can continue to have, maybe, the small number of employees they have and continue in business?

MRS. CLINTON: Well, in our work on behalf of health care needs of farm families in particular, we believe that treating a farm family as a small business, giving them 100 percent tax deductibility for their health insurance costs, and capping the amount of money they have to contribute will make health care affordable for farm families in ways it has never been before.

In many of the instances where I've sat down and actually looked at the bills of farm families and sat and looked at their records, what I have been struck by is how they are among the most responsible people in our whole country. Oftentimes, they make enormous sacrifices to be insured. Often they send a member of the family off to work in a business where insurance is offered which then hurts the farm, but they at least are insured. And I think that what we're offering will be very beneficial.

Now with respect to seasonal and migrant workers, the health care benefits will be available to legal residents and citizens of this country, and that is a decision that we have made, looking at all the numbers. Certainly the public health facilities, the emergency rooms -- as they are now -- will be available to those who are not currently citizens.

Now seasonal employees -- just as now, when a farm family pays a seasonal employee who is a citizen, they make some kind of report or the responsibility shifts to the individual to make the report to the IRS about wages. If the individual is an individual contractor as opposed to an employee, then that individual will be responsible for his or her health

care. If it is an employee, then the farmer will be responsible for the proportion of time that the individual works for him, just as he would be with FICA or Social Security or any other payments that are now required, but the caps and the discounts would, of course, apply because of the wage of the worker.

REP. ROSTENKOWSKI: Mr. Deal will inquire.

REP. NATHAN DEAL (D-GA): Thank you, Mr. Chairman, and thank you, Mrs. Clinton. I think all would agree you've done a superb job this morning of answering the questions. I would guess in your next life that we ought to submit your name for Jeopardy. (Laughter.)

One of the perceptions we're going to have to overcome in this debate, those of us who are proponents of restructuring the health care system, is the suggestion in some quarters that we are going to be subtracting from the quality of health care for a percentage of our population.

In Massachusetts, we have many of the best hospitals in the world, and this is going to be part of the debate. But like Mr. Rostenkowski and Mr. Gephardt, Congressman McCrery and Speaker Foley, I have a Shriners' hospital in my hometown in Springfield. They don't accept any government money, no insurance payments. They're funded exclusively through charitable contributions. There is no other totally free hospital system in this country that I'm aware of. And the Shriners have petitioned me on behalf of that hospital that gives extraordinary care to anybody to raise the question of you whether or not they're going to be subjected to a host of new rules, regulations, or paperwork requirements that don't make sense for a hospital that doesn't charge its patients. And if you could speak to that question this morning, that would be much appreciated.

MRS. CLINTON: This is the first time I've ever been asked that, Mr. Neal, and my response --

REP. NEAL: I'm moved, I have to tell you. Thank you. (Laughter.)

MRS. CLINTON: But my response is I surely hope not. You know, that is one part of the system that's not broke, and we ought not to try to fix it. And if they are totally subsidizing the care that they provide without any government assistance of any sort, then we will certainly do what we can to make sure that continues.

REP. NEAL: And I hope I might extend an invitation to you to visit a Shriners' hospital, although I assume that the chairman will lobby hard for Chicago. (Laughter.) He might prevail over me.

MRS. CLINTON: I've actually visited the Shriners' hospital in Chicago. I share that hometown with the chairman, so -- .

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

REP. ROSTENKOWSKI: (Laughs.) Mr. Brewster will inquire.

REP. BILL BREWSTER (D-OK): Thank you, Mr. Chairman.

First, I would like to applaud your efforts in this monumental task. As a person who spent most of my life in health care, I know there's no issue more complicated than this one.

For many of us, the small business mandates will be a very difficult part. As a person who's been in small business, I know workers' comp is also a problem for small business. I would hope that you would look at the possibility of rolling the two together. I think it can be very workable.

But the small business subsidy in the plan I notice also is temporary. I don't see a timeframe listed. What is the timeframe you're considering on subsidizing small business, low-income-type business in this plan?

MRS. CLINTON: Mr. Brewster, we may very well have to extend that beyond what is normally thought of as temporary because we want to get the system on stable footing, as a friend of mine said, sort of stabilize the patient, and make sure that we get the kinds of savings and efficiencies that we know will come once we have a better organized health care system. But we certainly don't want to do anything that would impose unnecessary burdens on small business at any point in this process. The whole hope and what many people like Dr. Koop and others who have studied this really believe is that once we get better organized systems of care, then a lot of these costs will continue to decline even though we are in the short run -- and I think this is an important point to make -- we are in the short run going to be increasing health care expenditures.

You know, that is something that when people talk about the impact on small business is not a factor that is often looked at carefully. We are going to be putting billions of new dollars into this system largely from the employer-employee contribution, but also we're going to be very soon lowering the cost to other employers so that jobs will be created, new hires will be made, wages will be increased, and then at the same time if we are able to add the prescription drug benefit and the home health and long-term care benefit there will be more jobs opening up for people in health care.

So this is an issue in which there are many factors at work at one time. And we are very confident that small business will in the medium and long run and most small businesses in the short run be advantaged by what we are doing and other small businesses will be created by what we are doing.

So we intend to look very carefully at how we protect small businesses and give them the kind of fair, affordable health care they deserve to have.

And I can't help but add, Mr. Brewster, as a pharmacist, you know that one of our primary problems is getting affordable costs of prescription drugs available to everybody, whether they're small business, big business, individuals. And we want very much for this health care reform to make retail pharmacy, discount pharmacy, pharmaceuticals in general more available at more affordable costs. That, we think, will help bring down costs in the long run.

REP. BREWSTER: Thank you.

REP. ROSTENKOWSKI: Mr. Hancock will inquire.

REP. MEL HANCOCK (R-MO): Mr. Clinton, one of the greatest strengths of our society has been -- and our system of government -- is that it has historically stressed individual responsibility and initiative. Now, during the long period of development of the president's health care plan, was there any consideration given to the inclusion of a "Medisave" type account, which would be similar to a 401K or an individual IRA, but dedicated to pay to the individual's health care expenditures? Was this considered? And, if not, why not?

MRS. CLINTON: Yes, it was, Mr. Hancock. We looked, I believe, at every proposal for a "Medisave" or a medical IRA that we're aware of. And we do believe that it does promote individual responsibility, but we had several questions after analysis that we had that we could not adequately answer. One is that the medical IRA concept, in which individuals basically put aside money that they will then be able to keep so long as they do not use it, does nothing to encourage primary and preventive health care.

In fact, it is a continuation of one of the real weaknesses, we think, in our current system, which is that many people are insured only for catastrophic encounters and they, therefore, postpone seeking help as long as possible. We want people actually to get in and get good primary and preventive health care so that their diabetes, for example, doesn't end up with having to amputate a foot or whatever the other kinds of problems will come from not being taken care of.

And that was one of our problems with the medical IRA concept, is that it did not provide the kind of incentives that we think are necessary to reverse what has been one of the real problems in the health care system of emphasizing catastrophic and medical emergency over primary and preventive health care.

And the second issue is how we would ensure that all persons were covered. Many people will not be encouraged, unless required, to be responsible, so that the medical IRA might work for some members of the society who would either be encouraged to do so by their employer or would understand the tax benefits. But for millions and millions of other Americans, without some kind of mandatory system, either the kind of individual mandate that the Senate Republicans have talked about or the employer/employee contributions that is in our plan, we are afraid we will still continue to have millions of uninsured and underinsured Americans and the costs will continue to be shifted and will continue to go up. And those were our two primary problems.

REP. ROSTENKOWSKI: Mr. Kopetski will inquire.

REP. MIKE KOPETSKI (D-OR): Thank you, Mr. Chairman.

Welcome. I understand and appreciate the fact that under the president's plan, the mental health component of the benefit package will reach parity with the physical injury care by the year 2001. In spite of this, we need to provide a wide range of services to the mentally ill, and in most cases the least-restrictive treatment setting is the cheapest and, in many cases, the most effective. Given the need for a shift in focus from inpatient settings to outpatient settings, why are there 60 days of inpatient hospitalization coverage available in the mental health package but only 30 visits for outpatient psychotherapy?

MRS. CLINTON: The reason for that, Congressman, is that we are trying to start with emphasizing the care of the most severely mentally ill, those who do require the kind of inpatient intervention that often is linked to the most severe kinds of mental illness. We thought that would be our first responsibility, to provide that kind of system. And we intend to build on the 30 days of outpatient treatment as we go forward. We also believe that with a prescription drug benefit, the costs of medication will be more readily available for all different degrees of mental illness, and that the 30 days outpatient treatment combined with more affordable and accessible medication is an adequate benefit. It is not where we think we should end up as a country; that's why we have additional benefits that we would recommend be phased in as we realize savings. But we think it is a very good and strong beginning for mental health coverage.

REP. KOPETSKI: Thank you.

REP. ROSTENKOWSKI: Mr. Herger?

REP. WALLY HERGER (R-CA): Thank you, Mr. Chairman.

Mrs. Clinton, as you're well aware, we have a very major illegal immigration problem in our nation today, and regrettably, there isn't any state where this is more pronounced than my own home state of California. It's been estimated that between $400 million and $500 million a year is spent on Medicaid for illegal immigrants. Could you tell me, under the president's program, to what degree states would be mandated to continue this unfunded coverage?

MRS. CLINTON: Well, Congressman, you're right that this is a very serious problem, and in fact, one of the reasons why we have adopted the position we have, which is that only legal residents and citizens will be entitled to the comprehensive benefits and the health security card, is so that we do not do anything to encourage even more illegal immigration in return for trying to get those kinds of benefits. And that's why we have drawn the line as we have drawn it. But we are left, as you rightly point out, with a serious problem because we have a number of undocumented workers and illegal aliens in the country right now, and they do show up at our emergency rooms and they do use our public health facilities.

We are hoping to work out a more equitable sharing of that responsibility, and that is something that we will be looking at, and we would welcome your advice about how best to do that so that individual states don't bear the entire national burden for this cost.

REP. HERGER: So in other words, you're saying that where a state like our state is paying the bill themselves -- again, of almost a half billion dollars a year -- that you would be looking at a way to finance this? I've heard that perhaps there might be a pool. I don't know if you are familiar with that, if there's been any talk that's gone on on that extent or to what the cost you felt this might be.

MRS. CLINTON: Well, congressman, we are looking at a variety of alternatives, because we share your concern about this issue and the burden that it places on local hospitals as well as state budgets. And we don't have a final recommendation on that. But we do wish to work with you and others who represent the affected states to try to come up with a more equitable solution to those costs.

REP. HERGER: Thank you.

REP. ROSTENKOWSKI: Mrs. Clinton, it's very difficult here trying to keep the trains running on time. I know what your schedule is, and I want to make an observation.

I hope that your experience here has been as pleasant as I found you a pleasant witness. I'm tempted to applaud you, but then again, that would be only -- (applause) -- that would truly be only if you didn't perform as exceptionally as you did. And you were marvelous. You're a marvelous witness.

I've been here for a few years. And I've seen not exclusively this committee, but members of other committees wrestle with the health problem of this country. One of the reasons I ran for reelection was so that I could try in my little way to help solve this problem.

I think you and your husband are certain going to be the catalysts in this. We need leadership. We have on both sides of this aisle tried to solve this problem, but we needed somebody strong in the White House that was willing to bite the bullet. I think in the very near future the president will be known as your husband. Who's that fellow? That's Hillary's husband. (Laughter.) With the outstanding job that you've done here, my compliments to you, my compliments to the President of the United States for addressing this problem, and I hope that by the end of this Congress it will be on the president's desk, you standing at his side, for signature.

Thank you very much for joining us this morning.

MRS. CLINTON: Thank you, Mr. Chairman. (Applause.)

END

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Lewis F. Payne (D-VA)

QUESTION:

How will the Administration's proposal increase access to health care for residents of rural areas?

ANSWER:

The President's proposal will assure universal coverage in rural areas, which have higher proportions of uninsured and underinsured. It is well known that universal insurance coverage and market reforms alone will not eliminate all barriers to care nor will it ensure quality. In order to meet their obligations to provide comprehensive health care benefits, health plans will require assistance and financial incentives to expand into low-population areas and to ensure that hard-to-reach populations have access to quality care.

Therefore, the proposal features a series of Public Health Service access initiatives designed to:

- **Expand capacity** by increasing the supply of practitioners, practice networks, and health plans in underserved areas.
- **Assist alliances and health plans** to deliver culturally-sensitive care to appropriate populations.
- **Achieve accountability** by assuring that health plans enroll hard-to-reach populations and meet their personal health care needs.
- **Expand by five-fold the National Health Service Corps** to reduce the shortage of primary care practitioners in underserved areas.
- **Assist organizations and professionals supported by public funding** to adapt to the reformed system. Integration of these providers into practice networks or health plans will ensure that they receive payment for covered services from plans. It will also provide them with critical support services (administration, information systems, telecommunications, specialty services) to improve the delivery and coordination of care.
- **Shift the emphasis of existing public funding** away from the delivery of services covered in the standard benefit package and toward:

- -- Activities designed to enable, enhance, and ensure access to care by addressing persistent barriers, especially for hard-to-reach populations.

- -- Services not covered in the benefit package but essential to prevent morbidity and mortality among certain populations.

- **Give communities the flexibility** to improve access to care in ways that build on existing resources and that are responsive to local circumstances and needs.

TAB REF # 5

QUESTION:

How will the Administration's proposal provide savings in rural areas through managed competition where there is such a scarcity of physicians and hospitals?

ANSWER:

The Health Security Act is a unique blend of multiple proposals, and allows considerable flexibility for the State to decide a structure for health care which is best for its citizens. In rural areas, where there are scarce resources, a system of cooperation may serve as a better model than competition. The Act also allows states to choose a single payer system.

TAB REF # 5

QUESTION:

How will the President's plan ensure that rural hospitals remain viable in large managed care networks? Does the plan envision closing down small hospitals and sending rural patients to urban centers for treatment?

ANSWER:

The plan provides funds to promote the establishment of provider networks and to develop linkages with other health care institutions. Also, grants will be provided to the Academic Health Centers to assist in the development of the information and referral infrastructure to support these rural networks. Taken together, we expect that these efforts will result in improved quality of care, attracting and retaining providers in rural areas.

In addition, under Title III, Subtitle E, Part 4 of the Health Security Act, payments will be made to eligible hospitals serving vulnerable populations.

QUESTION:

The draft proposal provides that after a five year phase-in period, at least 50% of new physicians will be trained in primary care rather than in specialty fields. How will this goal be reached in such a short period and how will residency programs be assigned in medical schools?

ANSWER:

One element of health care reform is to increase the proportion of resident physicians entering primary care fields rather than specialty practice, from about 30% today to 55% (including Ob/Gyn) after a five year phase-in.

To reach this goal, a National Council on Graduate Medical Education will be named by the Secretary of Health and Human Services. The Council will examine national needs as well as special community-level factors that influence the health care workforce.

In 1997, the National Council will make recommendations for reaching the goal of 55% primary care residencies between 1998 and 2003.

QUESTION:

Will individual States be allowed to determine the allocation of residency positions?

ANSWER:

We expect that between now and 1998, activities by way of institutions and individuals will produce many of the changes needed in the physician workforce. This means that the recommendations of the National Council may resemble the residency training environment at that point in time.

If, after 1997, reductions are needed in the total number of training positions or the proportion of positions in specialty areas currently in oversupply, the National Council's recommendations would become part of the workforce allocation system that begins in 1998.

The number of specialty training slots would drop from current levels by about 10% over each of the five years in the phase-in period, while the number of primary care positions would rise about 5% each year.

The national council would make specific allocations of training positions, as needed. At this point, input is welcomed as to whether the National Council's methodology should be based on national, regional, State, or local models, and whether all specialties and regions should share a single methodology.

If a State program leads to changes in the residency training environment that closely resemble the federal goals, it seems reasonable that the National Council would accept the State efforts as it makes its own recommendations.

TAB REF # 5

QUESTION:

Where will graduate medical education funds come from and how will the allocation be determined?

ANSWER:

The plan includes a $5.8 billion pool that will replace the current Medicare payments for Direct Medical Education and the current indirect subsidies from private insurers with an all-payer pool to support graduate medical education (GME).

Under this new pool, GME payments will go only to those programs that agree to follow the provisions of the workforce allocation system, including the allocation of specialty training slots and overall positions.

In addition to the GME pool, the plan includes a second pool of $3.8 billion to support the special functions of academic health centers (AHCs) and their teaching hospitals.

This pool will replace the current Medicare payment for Indirect Medical Education (IME) plus similar indirect subsidies from private insurers. It will help support the unique features of AHCs such as research, training and tertiary patient care that would otherwise be uncompensated under health care reform.

Funding for both pools will come from the amounts currently budgeted under Medicare for IME and DME payments plus a 1.5% payment on health insurance premiums. Distributions under the GME pool would be made based on a national average per-resident amount, while payments under the AHC program would be based primarily on a resident-to-bed ratio.

QUESTION:

Won't this requirement (report information for the National Quality Management Program for outcomes research) impose additional administrative requirements on physicians which will greatly increase the amount of paperwork for their practices?

ANSWER:

No. In fact it will reduce this work load tremendously. The National Quality Management Program will set National standards for the provision of services by health plans which will replace the many different quality standards that health plans, third-party payers, and different health networks impose on physicians today.

In addition, the standardization of forms by the Council will simplify the administration of health services, and will reduce the paperwork for their practice.

TAB REF # 5

QUESTION:

How do you expect to obtain such savings from Medicare and Medicaid? Won't such drastic cuts adversely affect beneficiary care?

ANSWER:

Savings achieved through health care reform will be of a different nature than savings achieved through the current budget process because there will be a balancing of both private and public sector expenditures to control costs rather than just the Federal savings we seek to achieve through reconciliation acts. This new process will work to restrain increases in both public and private expenditures and will not compromise the current quality of care received by beneficiaries.

The President's plan will:

- guarantee a comprehensive benefit package to all and reduce expenditures for uncompensated care.
- remove enormous paperwork/administrative costs from the system.
- provide incentives and financial assistance for providers to organize into more effective networks within a structured budget.

Approximately half of these savings are coming from either an extension of expiring authorities for current reductions, or the elimination of programs which will no longer be needed due to health care reform. For example, the payments to hospitals for uncompensated care will no longer be necessary as universal coverage is implemented and providers receive payments for people who were previously uninsured.

QUESTION:

What will be the employment effects of the health insurance mandate on employment?

ANSWER:

The employment effects of health care reform are likely to be small.

The Council of Economic Advisers has concluded that the net effect of our health plan on aggregate employment is likely to be small; the estimates suggest a range of plus or minus one-half of 1 percent of the aggregate employment level. Neither the models nor the data that would be required to yield a precise estimate of the employment effects of health care reform are available. In the absence of an appropriately specified model, one can generate either small net positive or small net negative effects of our plan on employment, depending of the assumptions one is willing to make in using existing models.

The Employee Benefit Research Institute has also released a study that estimates employment effects in the same range as the Council of Economic Advisers. Using a variety assumptions, EBRI produced a range of estimates on the employment effects of the Health Security Act ranging from 666,000 jobs created to 168,000 jobs lost.

While the initial employment effects of the Health Security Act will be small, we believe that over time, as business spending on health care falls, the factors encouraging an increase in employment and wages are likely to strengthen.