DAVID CUTLER
x. 3114
Rm. 311

11-10-93
reviewing

QUESTION:

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

ANSWER:

Our current health care system has five negative effects on employment. First, it does not provide security to individuals, whether they are working or not. Second, it interferes with employment decisions of individuals, locking people into current jobs in order to retain health insurance. Third, health care costs are very high and rising. Fourth, the number of people who do not have access to insurance is large and increasing. And fifth, the current health care system is riddled with market failures, excess supply and inefficiencies. Our health plan addresses these fundamental problems. It will provide security, eliminate job lock, lower costs, provide universal coverage, and increase the efficiency of the health care system.

Many employers who currently offer health insurance will see their costs fall immediately. Gradually, our plan will lower aggregate business spending on health insurance. By the end of the decade, we estimate that aggregate business spending on health care will fall by over $10 billion. Businesses will be able to hire more workers, invest in more plant and equipment, increase dividends, or lower prices. All of these will stimulate the economy. In addition, our plan will result in greater employment in the health care sector in the short run, and a more efficient health sector in the long run.

However, 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. No existing models allow us to predict the employment effects of health care reform with precision. 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 on the assumptions one is willing to make in using existing models. The Council of Economic Advisors has concluded that the net effect of our health plan on aggregate employment is likely to be small; our estimates suggest a range of plus or minus one-half of 1 percent of the aggregate employment level. However, 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.

QUESTION:

How would the plan handle cross-state medical treatment?

ANSWER:

Under the President's plan, cross-state medical care will be simple: a health plan can contract with any provider, regardless of location. Health plans in your state can include providers located in a different state just as they can today.

Thus, while your constituents will not be able to enroll in a health plan offered by the North Carolina alliance, there will be no need for them to do so: they can choose a plan in your state that uses providers in North Carolina just as they can today.

In addition, the mandatory point-of-service option means that even your constituents who elect to enroll in closed-panel HMOs can use out-of-state providers, simply by choosing the HMO's point-of-service plan and exercising the point-of-service option.

This substantially improves options and choice for individuals, beyond what is available today.

QUESTION:

Will consumers be able to choose the type of provider they want for treatment, e.g., chiropractors, acupuncturists and homeopaths?

ANSWER:

The comprehensive benefits package covers services, not particular types of providers. For services in the comprehensive benefits package, health plans will be free to include any health care provider licensed by the State.

- If the enrollee chooses a fee-for-service plan, all providers licensed by the State will be available.

- Each network-based plan will assess its enrollees' needs and desires, and include the best mix of providers for that enrollee group. However, if a network-based health plan does not offer the type of providers a particular enrollee would like to use, that enrollee can exercise the plan's point-of-service option, and go out of network for care.

Finally, consumers are free to purchase services not covered in the basic benefits package from whomever they see fit.

TAB REF # 5

QUESTION:

What does the administration propose for an increase in the tax on tobacco?

ANSWER:

The cigarette tax will be raised by 75 cents from $0.24 to $0.99 on October 1, 1994. Taxes on other tobacco products, such as cigars and chewing tobacco, will increase in amounts comparable to the increase in the cigarette tax.

**** Please review carefully.**

TAB REF # 5

QUESTION:

Does the President also plan to raise the federal tax on liquor and beer as part of the "sin tax" revenues?

ANSWER:

No.

TAB REF # 5

QUESTION:

The plan's reliance on "sin taxes" would result in declining revenues in later years as consumption of heavily taxed items declines. How does the administration plan to make up for this gap in revenue?

ANSWER:

The expected declines in consumption are incorporated into the revenue estimates, so that there is no "gap".

WRITTEN QUESTIONS SUBMITTED FOR HILLARY RODHAM CLINTON FROM REPRESENTATIVE L.F. PAYNE, WAYS AND MEANS HEARING 9/28/93

FINANCING THE PLAN:

Medicare/Medicaid Savings. The Draft plan calls for financing the bulk of reform through savings in the Medicare and Medicaid programs - $238 billion over 7 years. Under the 1993 Budget-Reconciliation Act, Congress was only able to come up with $56 billion in savings over 5 years for these programs. How do you expect to obtain such savings? Won't such drastic cuts adversely affect beneficiary care?

Tobacco Tax. The President's proposal plans to raise $105 billion dollars through "sin taxes". The President indicated in his joint address to Congress that tobacco will be targeted for such a tax. The Tobacco Institute estimates that a 75 cent increase in the cigarette tax would result in a 12% decline in the retail market for cigarettes and would cost 273,000 job. What does the administration propose for an increase in the tax on tobacco? Does the President also plan to raise the federal tax on liquor and beer as part of the "sin tax" revenues?

- The plan's reliance on "sin taxes" would result in declining revenues in later years as consumption of heavily taxed items declines. How does the administration plan to make up for this gap in revenue?

SMALL BUSINESS:

The National Federation of Independent Business has estimated that an employer mandate would create severe economic problems, including the loss of as many as 1.5 million private sector jobs. A recent Gallup poll also indicated that 85% of the small-business owners surveyed oppose proposals that would

require employers to pay 80% of the cost of health insurance. Has the administration studied the impact of such an employer mandate on small businesses and their ability to compete and survive in the economy? Will the health care premium caps for small businesses be permanent?

RURAL HEALTH CARE:

The most significant factor limiting access to health care services in rural areas is the scarcity of physicians in rural areas. Nearly 1/3 of the rural population in the U.S. is without adequate primary care, thirteen of the seventeen counties in my district are classified by the Department of Health and Human Services as medically underserved. How will the administration's proposal increase access to health care for residents of rural areas?

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

Rural Hospitals. The financial viability of rural hospitals is threatened due to rising costs and competition with urban centers. Hospital closings can have a significant impact not only on access to hospital care, but also on the availability of primary care services since communities without hospitals have a harder time attracting and retaining health care professionals. 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?

MISCELLANEOUS

Cross-State Medical Care. Under the Clinton plan, states would be responsible for establishing one or more regional health alliances which will represent the interests of consumers and structure the market for health care services. According to the draft plan, these alliances may not cross state lines. My district borders on North Carolina and many of my constituents receive medical treatment out-of-state. How would the plan handle cross-state medical treatment? Would residents of my district be allowed to enroll in a North Carolina health plan if they desired?

Alternative Health Care. Under the Clinton plan, health plans will enter into agreements with health care providers to deliver services. These health plans will be authorized to limit the number and type of health care providers who participate in the health plan. The large managed care networks envisioned under the plan would most likely resemble todays HMO's and would be hospital and physician dominated entities, as HMOs are currently. Will consumers be able to choose the type of provider they desire for treatment in such networks, e.g. chiropractors, actupuncturists, and homeopaths?

Graduate Medical Education. 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? Will individual states be allowed to determine the allocation of residency positions? Where will graduate medical education funds come from and how will the allocation be determined?

Administrative Simplication and Performance Reports. The President's draft proposal calls for administrative simplification to reduce the amount of paperwork health care providers are currently required to perform. However, the President's plan also requires health care providers and plans to report information for the National Quality Management Program for outcomes research. Won't this requirement impose additional administrative requirements on physicians which will greatly increase the amount of paperwork for their practices?

Payment Scenarios. The health care plan provides that families and individuals will pay 20 percent of the premium for an average cost health plan while employers will pay 80 percent. It appears in the draft plan that for families in which both parents work, both employers will pay 80% of the family premium while the family is responsible for 20%. For families in which both parents work but one is self-employed, the self-employed parent must pay 100% of the family premium in addition to the 20% paid for the employed spouse's share. Finally, if one parent does not work, the family would only be responsible for 20% of the family premium. If this is the case, it appears that families in which both parents work would be paying more for health care, and also there would be disincentives for persons to start their own businesses out of the home. Could you explain how premiums will be paid by families, and whether there are such disincentives for self-employment in the plan?

EXECUTIVE OFFICE OF THE PRESIDENT

29-Sep-1993 08:52am

TO: (See Below)

FROM: Jeffrey L. Eller
Office of Media Affairs

SUBJECT: HRC afternoon transcript from 9/28

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

WITNESS:
FIRST LADY HILLARY CLINTON

2123 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON DC

TUESDAY, SEPTEMBER 28, 1993

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

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

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

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

Second, in order to enable the broadest possible participation of members today, it is the intention of the chair to observe the rules of the

committee strictly because Mrs. Clinton's time with us today is most limited. I know members will be fair to their colleagues who are waiting patiently for an opportunity to question Mrs. Clinton by limiting their dialogue with the witness to the allocated time.

Finally, and consistent with committee rule 4(c), members present at the time the hearing was called to order will be recognized in order of seniority, alternating, as is the custom, between the majority and the minority. In light of the fact that we have two subcommittees who will be

working on this legislation, the chair will treat the chairwoman and the ranking minority member of the commerce subcommittee, Mrs. Collins and Mr. Stearns, as having seniority immediately following that of Mr. Waxman and Mr. Bliley respectively. The rule also provides that members not present at the hearing when it was called to order will be recognized in order of their appearance, and staff will be making careful note of the arrival of members for this purpose.

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

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

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

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

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

Health care reform is not a new idea nor a revolutionary concept. But while most Americans favor reform, we have failed as a nation to make much progress when it comes to providing health security for every citizen. Sadly, health reform in this country is less a story of the typical American

"can do" attitude than a story of procrastination and parochialism and all too often greed, fraud, waste and abuse.

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

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

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

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

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

For the past 12 years, this committee has fought to extend health

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

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

Thank you very much, Mr. Chairman.

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

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

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

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

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

So I know it was my father's dream as well, and others around this country, that we finally have guaranteed access to care for all Americans. That's really what the core of the president's proposal is all about. And some of us who have worked in this area for a long time have felt that we needed a president who was willing to take the bold leadership to deal with

this difficult issue. I used to think that would be enough. Now I know that what we needed more was also a first lady like yourself to give us the expertise and guidance you have given us in preparing this plan before us.

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

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

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

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

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

We looked very closely at that and we are continuing to work with those who advocate that position, particularly the Senate Republicans who have advocated an individual mandate. But we have a number of questions about it. One is that we worry that it would undermine the existing employer/employee system in which on a voluntary basis, as a matter of either collective bargaining or employer choice for competitive purposes, employers have responded over the last decades in increasing numbers to provide health insurance. And that employer/employee system has served as the basis for insuring more than 90 percent of the people in this country who have private insurance. And we would worry that shifting the burden wholly

over to the individual would result in many employers who currently insure ceasing to do so, or maybe only insuring their high-wage workers and not their low-wage workers. And we would worry that if we subsidized individuals below a certain income level that there would be pressure on employers to keep wages below the subsidy level so that they would continue to be paid for by the government. So we have a number of problems with the individual approach.

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

REP. WAXMAN: Thank you very much.

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

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

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

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

REP. DINGELL: Without objection, so ordered.

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

Mrs. Clinton, like many others, we are currently working with a draft of the president's health reform proposal. To enable members to more fully understand this very complicated plan, I would ask that you make

available to the committee the task force quantitative working papers concerning financing, premium caps, actuarial analysis of benefits, job impact, and the national health expenditure data.

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

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

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

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

MRS. CLINTON: Mr. Bliley, that's an excellent question. I really appreciate your asking that, because this is one of the crucial issues that we have confronted. And let me start -- and I hope the chairman may give us just a little bit of leeway on time, because it's such a critical inquiry.

Let me start by saying that we anticipate realizing some substantial one-time only savings over the next several years. For example,

Thomas Bliley (R-VA)

QUESTION:

How will the President's plan achieve cost containment of the magnitude described when other western nations have had difficulty achieving that level of constraint?

ANSWER:

There are several sources of waste and inefficiency in the current U.S. health system that make us believe that we can rapidly slow the rate of growth in U.S. health costs.

First, experts estimate that as much as 25 percent of U.S. health care costs are spent on administration. Estimated savings for simplifying claims forms and from other measures to automate and standardize administration are between $4.2 to $5 billion. In addition, estimates for reducing hospital and physician salary expenses from simplifying billing functions range between $50 to $60 billion a year. As mentioned, these types of savings represent one time reductions in the spending base.

Second, as much as twenty-five percent to thirty-three percent of procedures in the United States are estimated to be marginally necessary or inappropriate. Although not all of these procedures can be eliminated, they represent almost $200 billion in marginal spending (assuming the lower estimate). If just one-fifth of these marginal procedures could be eliminated, we could save $40 billion a year.

Third, GAO has estimated that as much as ten percent of medical spending represents fraud, waste and abuse. That is another $80 billion a year. Again, if just one-fifth of that could be eliminated, we would save another $16 billion a year.

Fourth, there will be savings from consumers choosing low premium plans within the alliance structure. Although these are difficult to estimate precisely, it was found in Minnesota that cost growth was reduced by approximately six percent when consumers switched from high cost fee-for-service plans to low cost managed care plans.

It is for all these reasons that we believe that our projected budgetary rate of growth is reasonable and realistic.

we believe that insurance market reform, particularly in the non-group and small group market, will result in substantial savings. We believe that moving toward a single form system will result in substantial savings. We can outline in more detail and will gladly do so the kinds of changes that we anticipate beginning to bring down our base level of expenditures.

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

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

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

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

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

there is better utilization that we can obtain in this system, there is better quality to be given to the citizens of this country if we reorganize the way we deliver health care more efficiently.

REP. BLILEY: Thank you.

Thank you, Mr. Chairman.

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

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

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

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

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

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

REP. COLLINS: There is a community health center in my district called the -- I can't think of the name of it right now, but it's a health center just outside of downtown Chicago, and it was closed for a long period of time and has been reopened. All the people in that health center -- in

that neighborhood use that health center for primary care for children and everything else. And so I wondered if that is the kind of center -- Martin Luther King Health Center -- the kind of center that would be sort of an essential provider center, and more about that would be helpful to me.

MRS. CLINTON: Yes, that is what we anticipate, that community health centers that serve underserved populations in both urban and rural areas will be considered essential providers, and they will become part of larger networks that will serve the entire population, but they will have relationships with hospitals and clinics and others so that the people who use the community health centers as the primary care givers will therefore be able to be referred on to a specialist or to a more complicated kind of care that they might need; whereas now, for too many people who use our community health centers, they may go to the community health center for primary care, but because they are uninsured or underinsured, they have no real recourse except the emergency room, which is their entry into the additional health services that they may need. So we do intend for those linkages to be developed.

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

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

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

MRS. CLINTON: Well, what you're describing is what's happening right now, that insurance companies are very often overriding doctors' opinions and making decisions based on insurance coverage instead of clinical judgment that the doctor would like to bring to bear. That is happening right

now. We believe that moving toward the system that we've envisioned, there will be less of that, and in fact, doctors will, we hope, regain some of the autonomy and authority that they have had to give up. But the antitrust laws will still guard against monopolistic practices.

Now we do, though, want to make some changes in antitrust to permit doctors and hospitals to have the same kind of opportunity to organize

You know, we want to have alternatives to insurance company-governed plans. We want to have the Catholic Hospital Association or the Mayo Clinic or the local medical school to have the same kind of opportunity to join together with physicians to present services to the communities that will be covered, and we hope that we can strike the right balance in the laws to permit that.

REP. COLLINS: Thank you very much.

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

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

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

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

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

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

First of all, there is such a wide disparity of costs of health care right now in this country. And there has been a great deal of research

done to try to determine whether there are significant differences in quality or access between regions or communities that provide care at a higher price or a lower price. What we have found in looking at all of the available research is that there is no discernible difference in quality between a lot of the high-priced care and more moderately-priced care that is available in the country.

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

If you look at just this one simple booklet, which outlines how much it costs at every hospital in Pennsylvania to perform this surgery, you will find that the cost ranges from $21,000 to $84,000. Then if you look at quality indicators, including the number of patients who died and who were expected to die given the severity of their illness, you will find that there is no correlation between the high cost and better outcomes. In fact, the lowest cost of the operation in one hospital has some of the best results.

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

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

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

the price we are charging ourselves.

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

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

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

REP. STEARNS: Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

MRS. CLINTON: Yes, congressman.

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

The health alliances as we envision them are to be the conduits

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

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

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

REP. SHARP: Thank you.

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

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

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

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

But the question that's coming up time and time again -- on the radio, on television, the press -- is the financing. And I know you've been asked similar questions before. But there was one broadcaster this morning -- Charles Osgood -- said that if you thought you could save -- if you'd spend

$300 billion more in the next ten years and still be able to cut $400 billion out of it, he has a car that will run only on water that he'll be happy to sell you. And that's the kind of a sale you have to be able to make, because the public is very, very concerned about that particular issue.

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

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

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

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

If you look at the Medicare system, you can see that, in many communities that are relatively close together, like if you compare New

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

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

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

REP. MOORHEAD: Thank you.

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

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

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

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

MRS. CLINTON: Well, Congressman, I'd be happy to. And I don't

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

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

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

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

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

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

the spot helping the rural hospital or the rural physician take care of that patient.

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

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

REP. SYNAR: Thank you.

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

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

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

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

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

Joe Barton (R-TX)

QUESTION:

What is the basis on which the number of uninsured has been estimated at 37 million?

ANSWER:

This number is an estimate based on trending forward estimates from three "snapshots:" the 1992 (the most recent available) Current Population Survey (CPS) conducted by the Bureau of the Census; the National Medical Expenditure Survey (NMES) conducted in 1987 by the Agency for Health Care Policy and Research (AHCPR); and the Health Interview Survey (HIS) conducted by the National Center for Health Statistics (NCHS).

The Current Population Survey estimated 37.4 million uninsured in 1992.

The Health Interview Survey for 1990 estimated 36.8 million uninsured in any two week period over the year.

The National Medical Expenditure Survey estimated 36.4 million uninsured during the first quarter of 1987.

TAB REF # 7

QUESTION:

How many uninsured are expected in 1993?

ANSWER:

Obviously, any projection of the number of uninsured will be subject to some error. Still, in 1991, the number was 35.4 million in the Current Population Survey.

In 1992, the number had grown to 37.4 in spite of the improvements in the economy which caused the number of employed to grow by half a million and the number of persons employed full time for the entire year to grow by over a million.

If the number of uninsured increases by the same amount as in 1992, the number of uninsured in 1993 will be over 39 million, or very close to the 40 million Mrs. Clinton used in her "off the cuff" reply to the question.

Perhaps improvements in the economy will cause the number of employed persons with insurance (as part of their wages) to increase rapidly enough to keep the number of uninsured from growing to 39-40 million. Firm estimates will be available in late 1994.

QUESTION:

How many of the uninsured are uninsured by choice?

ANSWER:

This is a very difficult question to answer since no survey has successfully asked the uninsured about whether they had a choice of insurance which they turned down.

What little evidence we have, however, shows that very few actually turned down insurance when it was offered by their employer unless there was a substantial out-of-pocket premium involved.

In another sense, almost all the uninsured could purchase individual insurance if they chose to do so. Some 32.5 million persons in the March 1993 CPS indicated that they had insurance during 1992 from some source other than an employer.

Presumably most of the uninsured could similarly have purchased insurance through an agent or a business or professional organization from Blue Cross/Blue Shield or a commercial insurance company. In that sense, they chose not to do so perhaps because the coverage was expensive compared to the benefits they were likely to receive if they became ill.

Probably few of these persons were actually denied such insurance. The National Medical Expenditure Survey for 1987 showed that of the 36 million uninsured during the first quarter of 1987, only 37% investigated the cost of private health insurance and only 2.5% were turned down for insurance or allowed to purchase limited coverage. Thus of those who investigated the cost of insurance, only about 7% were turned down or limited in the type of health insurance they could purchase.

Most or all of the 33 million with individual insurance will welcome the new health plan because it will allow them to purchase insurance which is a much better value than the individual insurance they are now buying. Similarly most of the 37 million uninsured, the majority of whom work or have a family member who works, will now be able to have health insurance.

As I pointed out at the hearing, those who do not have insurance represent an unconscionable burden on those who currently have insurance.

insurance for an entire year, and the Congressional Research Service says that 35.4 million lack insurance at a given point in time.

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

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

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

The most recent work that was just completed was done by Families USA looking at every one of the statistics that you have cited, plus trying to determine how to make it an understandable figure for people. They have pointed out that what we are now in the process of seeing because of increasing layoffs and people losing jobs and downsizing in the economy that accelerated in the last two-year period, and that may in part count for the difference between the 35 million and 37 million, is there are people who are losing their insurance now every month, who unlike in the past are not being reemployed and, therefore, regaining insurance. And their figure is that 2.25 million lose insurance every month. Some may get it back in a month; some may get it back in a year. But based on their projections, they believe that, by this year next -- by this time next year, in the absence of our doing anything, we will be closer to 40 million uninsured. And I'll be happy to lay all that out and give you all of the statistics and the cites behind that as to how we have calculated it.

REP. BARTON: Thank you. And as a subset of that, we'd like to have, of the numbers that don't have insurance how many of them don't have it because they don't want it, or, conversely, how many of them desperately want it and flat can't get it. Because the Heritage Foundation and some of those groups have indicated that the number of Americans that don't have health

insurance that do want it and just simply cannot get it for any reason is a much smaller number, somewhere between 10 million and 16 million.

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

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

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

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

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

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

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

Now, I know you're opposed to it and have heard you speak in favor of it, but I wonder if we could look at two other ideas in addition to the plan that could help us stop this kind of back-door approach. One of them

would be to say that when you have a closed panel, a health maintenance organization, that panel would also have to give people the right to go outside the panel and get what they want by paying a little bit more. That would be one proposal. And the second would be in the area of technology, where we know that new products are fueling the cost increases so dramatically, whether we could look at a way to give the companies an incentive to provide up front information that would show why their product is superior to what's actually out there.

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

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

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

Thank you, Mr. Chairman.

MRS. CLINTON: Thank you.

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

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

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

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

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

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

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

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

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

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

So the assessment that we would be asking the corporate alliances

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

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

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

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

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

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

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

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

MRS. CLINTON: Well, Congressman, let me start by recognizing the extraordinary work that this committee, and particularly the subcommittee chaired by Mr. Waxman, has done over the years in trying to provide a medical

safety net for millions of Americans through the Medicaid program.

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

We think by eliminating the Medicaid program and integrating those recipients, we will end up giving better care to the recipients over the long run; we will, we hope, realize the kind of savings we think will come from having more Medicaid recipients in primary and preventive health care networks, the kind of reorganization that we anticipate; and we believe that we will eliminate a lot of the gross discrimination that currently exists against Medicaid recipients.

REP. SLATTERY: Okay, thank you.

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

MRS. CLINTON: No.

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

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

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

MRS. CLINTON: But under the direction of the state. I mean, it could be an intermediary kind of fiscal and negotiating collection function