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PRESIDENT'S HEALTH CARE PLAN

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

SEPTEMBER 30, 1993

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PRESIDENT'S HEALTH CARE PLAN

THURSDAY, SEPTEMBER 30, 1993

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:06 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Baucus, Boren, Bradley, Mitchell, Riegle, Rockefeller, Daschle, Breaux, Conrad, Packwood, Dole, Roth, Danforth, Chafee Durenberger, Grassley, Hatch, and Wallop.

Also present: Senator Mathews.

[The press release announcing the hearing follows:]

[Press Release No. 33, September 23, 1993]

FINANCE COMMITTEE SETS HEARING ON PRESIDENT'S HEALTH CARE PLAN; FIRST LADY HILLARY RODHAM CLINTON TO TESTIFY

WASHINGTON, DC—Senator Daniel Patrick Moynihan (D–NY), Chairman of the Senate Committee on Finance, announced today that the Committee will conduct a hearing regarding the President's health care reform proposal. First Lady Hillary Rodham Clinton will testify before the Committee.

The hearing will begin at *10:00 a.m. on Thursday, September 30, 1993,* in room SD–215 of the Dirksen Senate Office Building.

"The Committee looks forward to hearing from Mrs. Clinton regarding this extraordinarily important proposal," Senator Moynihan said in announcing the hearing. "As the President has said, we must meet the challenges of controlling health care costs and providing for the uninsured."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Mrs. Clinton, we welcome you. This is an auspicious occasion in every sense. It was in 1935 that the Committee on Economic Security, headed by Secretary of Labor, Francis Perkins proposed to President Roosevelt, and he in turn to the Senate, what became the Social Security Act of 1935. They had contemplated including health security as part of Social Security.

They chose in the end not to do so out of a sense that it would be more than Congress, and perhaps the people, were ready for at that time.

In 1945 President Truman returned to the issue, as later did President Nixon. But those two initiatives failed also. But now at least it is clear that the time has come around for an extraordinary moment of national consensus, which you have helped shape in a most extraordinary way.

So it is with a great sense of pleasure that I welcome you and turn to my colleague, and friend, the former chairman, now Ranking Member, Senator Packwood.

[The prepared statement of Senator Moynihan appears in the appendix.]

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, thank you.

Mrs. Clinton, there are two subjects I want to mention in my opening statement. One on the bill in general and the second one, frankly, is abortion.

On the bill itself, as you are well aware, I am somewhat pleased with the approach that you are taking. I like the universal coverage. I like the elimination of disqualification for pre-existing illnesses. I like, I call it an individual mandate where the people are going to have to buy, the employer will share the cost, which is very similar to the German plan, and I like moving toward community rating.

All of those issues are what Hawaii has now, with no price controls in Hawaii. They have competition among their providers. But in essence, they have those four issues covered.

If I have any misgiving, and it is not your fault or your husband's fault or your administration's fault, it is a misgiving based upon history; and that's the cost estimates of what we hope we can save and what we hope the new entitlements will not cost.

The only reason I say that is, over the last quarter of a century we have all been wrong. You have done more to attempt to quantify the cost as accurately as possible as I think can humanly be done, but I would still bet a dime to a dollar they are wrong. And maybe that is just 25 years of being burned.

So I would hope we do not jump too quickly into new spending entitlement programs—you have three big ones in this—before we are sure that there are going to be some savings.

Now let me move on to the abortion subject because we cannot avoid it in this bill. It has been almost a quarter of a century ago that I first introduced a Freedom of Choice bill prior to *Roe* vs. *Wade*, which is not unlike the Freedom of Choice bill that is now on the floor.

I was very discouraged with the vote in the Senate yesterday. I am normally outraged when we lose these. But in addition, I was discouraged with the vote in the Senate because my side lost it big. We thought it was 50/50 or 51/49 and we got trounced.

I am hoping that when the President offers his bill abortion coverage will be in it. We have it in Oregon. We have twice had this measure on the ballot as to whether or not we should eliminate public funding for abortions and we have beaten the initiative both times on the ballot. So we still fund abortions. Not with any Federal money—that is illegal—but we fund them with State money.

I would hope he would have it in the bill. And I will have real misgivings about supporting a bill that does not have that in it. But you and he have to understand after that vote on the Senate floor that it is not enough just to include it as it is offered and say to the Congress, take your choice, I will take the bill either way.

If he wants funding for abortions, he will have to fight for funding for abortions and I will help him. But without strong pushing from the Presidency, I fear that Congress would cut it out.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Packwood, we thank you for what I believe were welcoming remarks. [Laughter.]

Mrs. Clinton, I first should say that at 10:45 a.m. we will have two consecutive votes on the floor and so there will be that small break, which you probably can put to good use in some other way.

Good morning.

STATEMENT OF HILLARY RODHAM CLINTON, CHAIR, PRESIDENT'S TASK FORCE ON HEALTH CARE REFORM, WASHINGTON, DC

Mrs. CLINTON. Good morning, Mr. Chairman. I want to thank you and the members of this committee for the many courtesies and good advice and hours of your time that you have spent with me as a whole committee, and that many of you have spent with me individually.

I have greatly appreciated all of this effort that has gone into making sure that we are all moving forward in trying to realize the hope of providing health security for every American.

I am particularly pleased to appear before you, Mr. Chairman, because of the critical role you have played over the past decades in designing and preserving the programs that make Americans secure. For years you have protected our Nation's older citizens, making sure that we keep the compact between generations. For that every American, regardless of age, owes you a debt of gratitude.

You have, even before coming to these chambers, thought about how this Nation must deal with the changing social pressures that affect all of our families. And now 30 years later, this administration is ready to take action on reforms that you have advocated for so long.

As you have long advocated and know so well, welfare reform is a top priority for the President and he believes, as I do, that providing health security is a much needed first step. The risk of losing health insurance has forced many Americans over the years to cling to Medicaid benefits rather than seeking jobs.

As you have said, it will be impossible to end welfare as we know it until we guarantee every American health care that can never be taken away.

In one of my earlier appearances here on the Hill, I was asked a question about welfare lock. It was in the context of a story being told about a family that had to leave good employment that did not provide insurance to go on welfare to get Medicaid to cover a child's health care needs.

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

In the past few weeks, Mr. Chairman, you and other distinguished members of this committee have raised tough and impor-

tant questions about how we can best finance health care reform. This is, as we all know, a subject of great complexity, one that has been studied exhaustively, but which is still subject to a great many questions.

In the coming weeks and months ahead, we will have to work closely together to understand as fully as we are able the kinds of issues that are raised by the reforms that are offered, not only by the President, but by the Republican Senators represented here on this committee and others.

We have to be sure that we get the best value for the health care dollars we currently spend, and that we do the best job we can to reform the system so that health care is delivered more efficiently at higher quality to all Americans.

The simple fact is, that Americans are now spending nearly $1 trillion a year on health care; and we are not getting our money's worth. We have a health care system that stifles competition, breeds inefficiency, embraces bureaucracy and encourages waste.

You know as well as any the comparative figures on health care spending among the countries with whom we compete. Senator Packwood just mentioned Germany. They spend less than 9 percent of their gross domestic product on health care and they insure all their citizens and guarantee better benefits to all of their citizens.

We spend $1 trillion every year, leaving millions of Americans lacking insurance and millions more on the verge of losing it because of the changes in the economy. And too many Americans get the most expensive health care in the most expensive place—the emergency room.

That care is not free, even if they leave the hospital without themselves paying the bill. That care is paid by the rest of us.

And we know all too well how paperwork, administration and bureaucracy costs us at least 10 cents of every health care dollar. And for small businesses, administrative costs eat up one out of every three health care dollars. And finally, the Justice Department estimates that health care fraud, because of the kind of system we currently have, robs the American taxpayers and those who buy their own insurance of at least $80 billion a year.

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

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

There is no mystery, however, about how we pay for care. More than half of Americans' annual health care bill, and that includes both public and private funds, comes from employers and individuals, those who create the jobs, work hard, play by the rules, and pay largely for our health care system.

They pay for insurance premiums and they pay both through business and through individual payments. They pay through out-of-pocket expenses and they pay taxes to cover the public programs that include Medicare, Medicaid, the Veterans program, CHAMPUS, and other Federal outlays, such as uncompensated care payments.

This committee and millions of Americans are asking the right question. Who is going to pay the bill as we move beyond today's insecure system and guarantee health security to every American?

The President has decided first and foremost that we should not raise a broad-based tax to fund health care reform. Instead, we should build on what works, but make it work for everyone. Our goal is to take the world's finest private health care system and make it work better.

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

Second, to limit the growth in the Federal health care programs. Not to cut them, but to reduce the rate of increase in the Medicare and Medicaid programs.

And third, to tax tobacco. That is a tax that is not broad-based, but is health directed that we think could be used to fund some of the health care expenditures necessary, and to ask a contribution from large self-insured corporations that choose to continue to insure themselves.

Right now, nine of every 10 Americans who have health insurance get it through their employers. Even with all the problems associated with health insurance today, high deductibles, co-payments, incomprehensible policies and insecurity, this way of getting and paying for health care works for most Americans, like most of us in this room.

Under our health security plan, employers and individuals who pay premiums today will continue to do so. And six of every 10 Americans who currently have insurance will pay the same or less than they do today for coverage that is as good or better than what they get today.

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

Here is what is different. We are going to make our employer-based health care system work for everyone. As Senator Packwood points out, the individual will be responsible for making a contribution, but the employer will also be supporting that contribution.

Every individual will have to take responsibility and pay something. That is where two-thirds of the financing for premiums will come from. We believe this approach will provide the least disruption for people who have benefits, who have fought hard for their health benefits, and like how they get them now.

And it is an idea that some would argue is a pretty old-fashioned one because it builds on the system we have. It was advocated, as you pointed out, Mr. Chairman, by President Nixon, introduced by Senator Packwood, and it will provide a familiar way for Americans to know they will be secure.

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

There will be some who will fall through the cracks. For example, Mr. Chairman, as you rightly point out, those who are homeless, who are not connected to any kind of institution. But at least we will have a very limited number of people with whom to deal.

Hawaii, which has had an employer/employee system, still has trouble covering about 3 to 5 percent of the population, people who do fall in those cracks; and they are continuing to work on that. But they are at 95 percent of coverage at a cost less than what the rest of us pay with very high consumer satisfaction.

Even with this approach though, there will be people who have every right to ask, why do I have to pay anything. They will say, for example, I am young and healthy and I will not get sick. Or, I have fought hard for my health benefits. I already pay a lot and I do not want to pay a penny for anything else. Or, in the case of small business, I do not think I can afford to pay anything.

We believe the answer to these questions goes beyond responsibility and directly to the heart of what health care reform and health security is all about. Because the fact of the matter is that even young people who think they are immortal do get sick, do have accidents, do end up in our emergency rooms, and the rest of us pay.

And people who have good health benefits today are just a pink slip away from having no benefits, as countless, thousands of workers who have been laid off from very well established firms in the past years can attest to.

The small business owner who cannot in today's market afford health insurance is also taking a great risk, the risk that a family member will get sick and the business could very well be bankrupted as he or she faces a mountain of medical bills.

The second element in the financing plan is something Washington hears a lot about—trying to limit the growth of government spending. We all know—and you know better than most in this committee—that it is tough to stop, let alone try to control government spending.

But we do think we can slow the rate of increase down; and we intend to do so not with a cap that is not specified, but with specific, scoreable, line-by-line savings proposals.

This President, let me be clear, has no intention of putting Medicaid or Medicare beneficiaries at risk. Indeed, under this proposal Medicare recipients will see an increase in their benefits under the health security plan because for the first time we will be providing

Medicare beneficiaries with prescription drug coverage that they need and new options for long-term care that they deserve.

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

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

There are a number of serious health care reform proposals now on the table in Congress, including one supported by several Republican members here today under the leadership of Senator Dole, and particularly Senator Chafee.

They call for comparable Medicare savings. This committee, I know, will debate how fast those savings can be achieved and how big those savings can be. But I think we all agree there will have to be savings and they will be the second major source of financing for health reform.

Finally, Mr. Chairman, we do ask the Congress to place a tax on tobacco and to require large corporations who continue to self-insure to do their part to pay for the health care infrastructure, particularly academic health centers and research that we all use and which we all benefit from.

Other plans, as you know, have suggested a broad-based tax. Others have suggested capping the tax benefits on health benefits. Both of these, make no mistake about it, are tax increases. If we were to try to substitute for the private sector investment now, a broad-based tax, it would be an enormous, large amount of about $500 billion in new taxes. We do not believe anyone can justify putting that kind of money into this existing inefficient system.

Likewise, to fund health care reform with tax caps would be a tax increase on at least 35 million American workers who have given up wage increases in return for health care benefits. It would result in a substantial middle class income tax increase that at this point in time, until reform has begun, we do not support.

We do support changing the tax treatment on health care benefits once reform has occurred, once comprehensive benefits have been secured, and then to draw a line to remove tax preference on any health care expenditure above that limit.

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

will produce a result that they will be proud of and that Americans will feel good about.

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

The CHAIRMAN. Mrs. Clinton, we thank you for your superb opening remarks. We observe you no longer have a text and you do not even use notes at this point. This, of course, is not the first occasion we have met with you. From the beginning you have come and talked to us on a bipartisan basis. I particularly would thank you for noting Senator Dole and Senator Chafee.

Senator Durenberger has been very active as the Ranking Member of Senator Rockefeller's Subcommittee on Medicare and Long-Term Care. Mr. Chafee is matched with Mr. Riegle on the Subcommittee on Health for Families and the Uninsured, which is, of course, a particular concern of yours.

The Committee on Finance has the distinction of having among its members the Majority Leader of the Senate and the Republican Leader of the Senate. I am sure the committee would defer to them in the opening questions.

Good morning, Mr. Leader.

Senator MITCHELL. Mr. Chairman, thank you very much. I would like, if I might, to use my time to make just a brief statement.

The CHAIRMAN. Yes. Can we agree that with the exception of the two Leaders that we will keep ourselves to 5-minute questions.

Senator MITCHELL. I will observe the 5 minutes. [Laughter.]

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Thank you, Mr. Chairman.

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

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

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

Our challenge is to provide access to affordable health care to every American. To achieve this goal, the attitudes, the habits and the behavior of every health care consumer and provider must

change. Rising health costs threaten the long-term fiscal health of the nation. They represent the single, greatest contributor to the future growth of the Federal budget deficit, a deficit which drains needed savings and investment from the private sector.

Yet, despite the truly enormous national resources devoted to health care in our society, we have a system which does not serve all of our people. No American has security in the health care system today. Job loss, an unexpected illness or accident may result in the loss of health insurance even for those now covered.

Any plan for reform must meet the threshold test of providing health coverage for every American and assure that health care costs are controlled. I believe the President's plan meets that threshold test. It will assure access to health coverage for every American family. The plan also contains meaningful cost containment strategies to reduce the rate of increase in the costs of health care.

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

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

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

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

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

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

Whatever the outcome of the debate over those differences, it is important that on those areas where there is agreement, we recognize it and together build on it. Americans will be best served by a process in which all significant points of view are debated fully, with reason and civility.

We will have a better plan at the end and we will have built the consensus necessary if all participants know that their voices have

been heard, their ideas thoroughly debated. I believe, Mr. Chairman and Mrs. Clinton, that the result will be—one of the great events in recent American history when we next year enact comprehensive health care reform.

The CHAIRMAN. We thank you, sir; and I take it that was a statement. But I would like to assume Mrs. Clinton will agree.

Mrs. CLINTON. Yes, sir. [Laughter.]

The CHAIRMAN. There is nothing that needs to be added.

Senator Dole?

OPENING STATEMENT OF HON. ROBERT DOLE, A U.S. SENATOR FROM KANSAS

Senator DOLE. Thank you, Mr. Chairman. First I want to thank Senator Moynihan for convening this meeting. It will be the first of many, many hearings. It is a very difficult issue, probably the issue of this century if we approach it properly.

I also want to underscore what an extraordinary job you have done, Mrs. Clinton, not only in your testimony. To go before five committees is cruel and unusual punishment, except for this committee. [Laughter.]

And also for your work in helping craft the proposal that you have been discussing. I wanted to underscore many of the things that Senator Mitchell has said.

First of all, I do not think there is any doubt about anybody on either side of the aisle or anybody in Congress who is not prepared to try to reform our health care system. But I guess the question is: How do we go about it? How do we do it? Because as you have indicated, our health care system, notwithstanding its flaws, is the envy of the world.

So we have to start off with that very positive premise—we are fortunate in America to have the health care delivery system we have today. But, how do we change it to take care of the 30 million or 35 million?

I think I can speak for every Republican, I hope every Republican. Our intention is to be very positive. As I have said publicly—I spoke with the AMA before I came over; I hope that does not prejudice my remarks—we are going to start down the road together. Now there may be a separation somewhere down the road, but we want to start down the road together.

This is a very important issue. In my view, it ought to have broad bipartisan support, not just enough to make 51, or 52 or 53 votes. In my view, if it is broadly supported in the Congress by Democrats and Republicans, it will be, I think, better received all across America.

So, as far as I am concerned, nothing is off the table, no preconditions. We hope that is the view of the administration. Because, as Senator Mitchell pointed out, this committee has a good record of being very bipartisan. I can recall in the late 1960's, early 1970's, we had the 3–D approach to health care. I think Durenberger, Dole and Danforth; and I think we had the fourth D, Domenici came in a little later.

We were trying to do many of the things you are doing today and we worked together with Democrats and Republicans. And I do not think there has been any effort to label people who may have ques-

tions or differences of opinion. Maybe they are doctors, maybe they are hospital administrators, maybe they are pharmacists, maybe they are insurance companies.

I hope we just do not write them off as some special interest group. Maybe we have to have a villain, but I hope that we treat their voices like the voices of all Americans who have real concerns about the program. They need to be heard and we need to respect their thoughts.

I also want to put in a plug for this committee. Obviously, we think it is about the best committee around and we are very proud of its leadership with Senator Moynihan and Senator Packwood. They have resolved some of the most tricky issues, the most controversial issues, generally in a very bipartisan way.

Whether it is welfare reform or rewriting the Tax Code in 1986, I believe with our help, we can achieve a bipartisan consensus on health care. We know there are other committees that have other interests and certainly will have some of the jurisdiction.

I think it is fairly obvious there are some disagreements. Mandates bother us, even though you suggest that that may not be such a big problem.

I think we have to look at our States. In my State of Kansas, 99.4 percent of the employers have 250 employees or less. Most of them are much, much smaller—25 or 35 employees.

We only have about 60 employers in my State with over 1,000 employees and only 2 or 3 with over 5,000. There are a lot of States as I look around here that fit that same category, smaller rural states. So we may have a little different view on some of these areas.

We are concerned about purchasing monopolies, risk of quality in choice, and the creation of new entitlements. We certainly agree with the hope that we can achieve enough savings to have prescriptions and long-term care and take care of early retirees. But again, I think we have to be very specific about the cost.

Finally, I would say that whatever else happens, this issue is all about health care for American people. I think we have to talk as honestly as we can to the American people. No rosy scenarios, no smoke and mirrors, and no juggling of the books. That is true of us or anybody else—Republicans or the administration. Because there is no doubt about it, somebody has to sacrifice.

The thing that really interested me was President Clinton's sixth point he made, his sixth principle—responsibility. My view is, if we are going to delay responsibility for 10 years for individuals in some cases, we may never have responsibility.

It seems to me if you want people to better use the system and to save money in the system, there has got to be some individual responsibility. We think that is present in probably both packages. But I think it is very important.

I would just say finally, not to personalize anything, but I have had a lot of health care in my life and I know the importance of it—of good, affordable, accessible health care—and I have experienced not having the money to pay for it.

I think many hundreds of thousands, maybe millions of Americans, have had similar experiences. So our goal should be to provide quality care for nearly all Americans. You said some will slip

through the cracks. There is no question about it, we are not going to be able to reach everyone.

So I think we ought to remember the Hippocratic principle that guides our health care provides—"Do no harm." I think we may do a lot of good, but we do not want to do any harm. And we do not want to bury the American people under an avalanche of bureaucracy.

When we are talking about reinventing government, we do not want to reinvent bureaucracy. I think there is some concern about that. You have this very powerful seven-member board. For some States the health alliance will be spending, I do not know how many times more, for the health portion, than the State's entire budget. So it is going to be a big, big responsibility to make certain that any new bureaucracy that is created is going to work without causing additional hardships.

I do not care how good the package sounds—whether it is a Republican package or a Democratic package, the American people are concerned about big government. We are talking about one-seventh of our economy—14 to 15 percent. You may promise everything—free this and free that.

But somehow when the government gets involved in it, people are very concerned. I hope that we can somehow work together. We are prepared to do that and certainly appreciate your being here this morning.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Dole.

[The prepared statement of Senator Dole appears in the appendix.]

Mrs. Clinton, would you like to respond?

Mrs. CLINTON. No. I just want to thank Senator Dole for the kind of leadership you have shown on this issue and your willingness to work it through just as you said. We do want to preserve what is best about the American health system and fix what is broken.

I think we all agree on the health reform goals of security, responsibility, quality, choice, simplicity, and savings. If we then really hold up to scrutiny anything we are going to do to see whether it advances our goals, I am very confident that we are going to be able to come up with bipartisan support for a package that we will all be able to advocate for.

We may not all like 100 percent of what is in it, but in the natural course of putting it together, we will have made the right decision for the American people.

I thank you.

The CHAIRMAN. Fine. Let us start then in the spirit that Senator Mitchell and Senator Dole addressed, which you and President Clinton have addressed, regarding some of the questions that we of the Finance Committee have to ask ourselves.

The President on September 22 had a group of us down to the White House. You were there. Mr. Mitchell was there. Mr. Dole was there, as were a number of our committee members.

The President said at that time that he wanted to build into this legislation what he called a continuing reality check. He spoke of the kind of monitoring system we should build.

We might start that reality check right off with what, at least in my view, is the first concern. It is that the administration seems to contemplate a health care system on which has zero growth.

One of the budget documents you have given us speaks of health premiums. It says, "health premiums are allowed to grow at the inflation rate over time." That is a quote. Which means they do not grow at all in real terms.

The basic table in the preliminary document, which we have had for a couple of weeks, shows the private sector at the end of this decade growing at CPI, plus population, which is inflation plus population, which is no growth and Medicare/Medicaid at CPI, plus population, plus four-tenths of 1 percent.

I make a point that Medicaid, for example, this year grew at 16.5 percent. So there is a change contemplated. The question is—how would that survive a reality check? Here are the numbers. Between 1960 and 1992 the cumulative increase in the CPI, the consumer price index, is 375 percent. The cumulative increase in medical prices is just about 875 percent.

So we see prices behaving very differently. And prices do behave differently. In that period, the prices of computers would have dropped 90 percent. It is conceivable that innovation in medicine could turn out to be cost reducing and labor saving, but it has not been.

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

Mrs. CLINTON. Mr. Chairman, we are thinking zero growth as a budget target that this country should be moving toward.

Let me just expand on several points that you made. We believe, and I do not think you can find any health economist or student of the health care system who would disagree, that there are considerable, substantial savings in the existing system that can be realized both on a one-time only basis and on a continuing basis.

There are varying estimates as to what those savings are. Dr. Koop says, for example, that based on the work he has done with Dr. Jack Wenberg at Dartmouth, and others who have been studying health care expenditures, that there may be as much as $200 billion of unnecessary costs within the health care system.

And even if we take an estimate below that or above it, wherever it comes out, we know there are substantial one-time and continuing savings in the system. We also know that the reorganization of health care into different kinds of ways of delivering it than we currently rely on are much more efficient.

There are many examples of that: the Mayo Clinic providing high quality health care at a cost this year of an increase of only 3.9 percent, which is slightly below the medical inflation target that we have aimed for; the giant California pension and retirement system that is now realizing savings because of the way it has used its purchasing power to achieve the kinds of health care insurance cost reductions; the city in your State, Rochester, which is a much better organized health care market than most of our cities; or the Medicare program.

You can look at different parts of our country where Medicare is delivered at a cost ranging between one and three times greater. So that, for example, if you are in Miami, Florida you will pay

three times for a Medicare patient what you would pay in the State of Wisconsin.

To use one of Senator Durenberger's favorite examples, if you are in Duluth, MN, you will take care of a Medicare patient at one-half the cost in Philadelphia. There are many, many examples of that.

There is no demonstration of any less quality being given to the Medicare patient who is taken care of at a lower cost. One of the things that you and I have had the opportunity to talk about in the past is, what is the reality of health care cost increases around the world. Health care has, as a labor intensive service, increased when other goods and services have achieved productivity decreases. And your computer example is a perfect example.

One of the differences though in our health care sector than in those with whom we compete is that even though their increases have continued, we have grown at a much greater rate of increase without covering everybody in a universal system that would prevent cost shifting.

I would argue that the economic theory of the cost disease, which you know so well, which points out the difference in service and labor-intensive services, often uses the example that a Mozart quartet being played in the 18th Century and being played in the 20th Century still requires four people. There is no productivity increase if you are going to play that quartet.

The problem with the American health care system is if you can imagine that quartet has added people to hold the chairs, to hand the violins in, and has required the musicians to stop at the third or fourth page of the music to call somebody to make sure they can go on to the next bar.

That is the kind of waste and inefficiency that permeates our health care system. We believe very strongly that if we don't set very strong goals that we can achieve in both the public and the private sector, we will continue to reward this piecework, inefficient delivery system that does not guarantee quality at all.

I think most of us on this committee would be more than pleased to get all of our health care from a Mayo Clinic and we would get it at much less of a cost than if we went to many of the hospitals within a few miles of this building.

The CHAIRMAN. Mrs. Clinton, I have to say to you, the one option you have not considered sufficiently in this whole plan is we could just move half the population to Minnesota and half to Hawaii, our problems would be solved. [Laughter.]

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

The CHAIRMAN. Well, Senator Durenberger does not say otherwise.

A vote has been called, Mrs. Clinton. This is unfortunate but we're at the end of a fiscal year. There are two votes. The committee will stand in recess until 11:15. Mr. O'Donnell, if you would escort Mrs. Clinton to our committee room so she will have a moment to attend to other matters.

We thank you very much. 11:15, Senator Packwood, you pick up next.

[Whereupon, at 10:55 a.m., the hearing was recessed to resume at 11:15 a.m. this same date.]

AFTER RECESS

The CHAIRMAN. The hour of 11:15 having come and somewhat passed, we welcome, once again, the First Lady to this final hearing at which she will discuss health care reform. I would note that we do not have a bill as yet, but, of course, in due time we will. Next, in our ordinary sequence, we turn to the former Chairman and now Ranking Minority Member, Senator Packwood.

Senator PACKWOOD. And, Mr. Chairman, I understand we are going to hold pretty closely to our 5-minute rule. Correct?

The CHAIRMAN. We are going to stay to that rule, sir.

Senator PACKWOOD. Very quickly, on abortion, and then I will move on to something else. The President's bill includes pregnancy-related services. Will it include abortion?

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

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

Mrs. CLINTON. Yes.

Senator PACKWOOD. All right. Now, you are the company and you have got a 30-year plan. Somebody at age 55 can retire, and they get $1,000 a month. Their health plan costs $300 a month to carry them. The company is having to shrink; it is getting more productive.

So, it says to this person, Sally, Joe, listen, I will make you a deal. I will sweeten this offer and we will give you $1,100 a month to retire, and no change in your health plan. And Joe or Sally says, well, great. The government picks up $240 of the $300. Therefore, the company saves money. How do you estimate ahead of time what the volume of that is going to be?

Mrs. CLINTON. Senator, we have tried, with the assistance of the Treasury Department, and the Office of Management and Budget, and HCFA, and all of the other government actuaries to make the very best calculations we can, and we have costed that out to be about a $4.5 billion annual cost.

Senator PACKWOOD. But how do you get there, how do you know?

Mrs. CLINTON. Well, as you pointed out, rightly, in your opening statement, there is a lot of estimating that goes on with health care, and there is no precision attached to it. But we have looked at both rates of retirement and rates of retirement when benefits were offered, like early retirement bonus packages, and have used those figures in terms of the percentage of the work force willing to go into retirement.

Now, the company will, as you point out, still bear some of the responsibility. A number of early retirees go to work somewhere

else or start their own small business, so there will continue to be contributions coming in in that regard.

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

[The following information was subsequently received for the record:]

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

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

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

Mrs. CLINTON. Well, you are right that there has been that kind of situation, but we do not believe that it will be increased through this. In fact, what we think is that we will begin to get a better handle on controlling prescription costs and controlling the hospitalization and other related health care costs that are due to inadequate prescribing or the inability to pay for prescriptions.

And let me just give you an example. Based on the information available to us, it is estimated that approximately 23 percent of Medicare recipients are admitted to the hospital because of problems having to do with prescriptions.

Some of it is cross-medication, where one doctor does not know what the other doctor is giving, and there is no organized managed care system to keep track of that so the patient goes and gets one thing from one, and something else, and those interact, and nobody even knew that she was taking both.

Some of it is due to what happens, now, very often when a prescription is given to an older citizen. They cannot afford to take it in the way the pills say, for example, take four times a day and then get refilled. So, they self-medicate and take one a day because they think it will last four times as long and they end up back in the hospital.

So, if you look at the costs we are currently incurring because of medication-related problems, we think we will actually be saving money. And there may be, as you point out rightly, the occasional example where somebody wants a prescription instead of taking aspirin.

We think that is outweighed by the kind of benefits that better medication will provide in terms of better health care at more of a cost-effective delivery than the kind of hospitalization that results now from the inadequacies.

Senator PACKWOOD. Last question on my first go round. The administration very kindly granted Oregon's Medicaid waiver when we could not get it from the previous administration, and Oregon has set up a prioritized list of medical services, from number one to number 686, as I recall; number one is the one that is most likely to make you well, and some at the bottom we are not going to do anything at all because there is no known treatment. There is no point in spending money on something that no one thinks will work. But, part of what is in there also, is cost as part of the factor of consideration.

And, as you might expect, very high on the list are preventive services. It is cheap medicine. It works very well and pays off bundles in the end. But it is a ranking of procedures below which we will not pay for some. Do you think the Nation ought to be moving in that direction?

Mrs. CLINTON. I think that the Nation is implicitly moving in that direction every day in the fact that we ration care to many citizens who either cannot afford it or who access it too late for it to do them any good. Dr. Koop [illegible] the other day that an uninsured patient who enters the hospital with the same ailment as an insured patient is three times more likely to die than the insured patient. That is the most dramatic example of the decisions that are currently going on in our health care system.

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

Senator PACKWOOD. Thank you, Ms. Clinton. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Packwood.

Senator Baucus.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you very much, Mr. Chairman.

Ms. Clinton, all of us praise you and the President. I think it is clear that our country is on the verge of making a truly historic step. This step will benefit individuals and give them health care that they do not now have at lower cost. Even more fundamentally it will make the American people feel better about the country and ourselves as a people. We will join the ranks of other nations where health care is essentially a right. It is something that all of its citizens are entitled to.

You are trying to steer us in that direction, the President is trying to steer us in that direction, and we all are tremendously grate-

ful and appreciative of the efforts you are taking. It is truly monumental, it is truly historic, and it is wonderful that we are doing this.

As we move in this direction, each of us has unique concerns because we, after all, represent different States. One of the main concerns in our part of the country is rural health care, as you well know. The problem is cost and access.

In Montana, for example, over the last decade, health care costs for the average Montana family rose 400 percent faster than wages. In addition, in Montana we spend about $3,000 a year per family on health care, while our average income per family is about $28,000, one of the lowest in the Nation.

Access, too, is a major problem. Half of the counties in the State of Montana have no doctors who will deliver babies, and there are eight counties with no doctors whatsoever. We have 56 counties, but 8 no physicians. I know there are many provisions in your plan which very directly address rural health care.

When you were visiting Montana in April, in Billings, MT and to Great Falls, MT, we were all very impressed with your understanding and sense of the nature of rural communities in the West. You coined a phrase, which has become very popular. You said, hey, this is not just ordinary rural America, this is hyper-rural. This is mega-rural. And it is true. The rural communities in the West are further from each other than rural communities in the East.

Would you go over what you plan to do and what this plan contains that directly addresses the concerns of many Americans who are isolated and who pay very high cost today because they are unable to enjoy the benefits that people in cities enjoy?

Mrs. CLINTON. Senator, I would be happy to. I am very grateful for the opportunity that I had to go with you to Montana. I care deeply about rural health care. The first thing I ever did when I found myself, in 1979, being married to the Governor of a State that was predominantly rural was to work on a task force to try to improve access to rural health care in Arkansas.

But, as I told you, there is rural health care, and then there is rural health care. And some of the difficulties that you face in Montana are even more dramatic than what we faced in Arkansas in trying to make sure access was real for our people. We have given a lot of time and attention to this, and there are a number of ways that we believe it should be addressed.

The first, is that there is a higher proportion of uninsured Americans in rural areas than there is in any other part of our country. That, combined with a higher-than-average proportion of the elderly, places the primary burden on financing health care in many rural areas on the backs of Medicare and the uninsured.

Through universal coverage, we will be providing more resources for reimbursement in the rural areas by ensuring that there are no uninsured and that there are contributions made that will be available for reimbursing for care.

Second, we believe there should be what we call essential providers in both under-served rural and under-served urban areas that are targeted for additional funding because of the difficulty of being able to support emergency facilities or hospital facilities in many

rural areas, even though we might now have a better-insured population to take advantage of those.

The third, is we want to provide more physicians, and nurses, and other allied health care professionals in rural areas. We have targeted assistance to physicians and nurses, particularly advanced practice nurses, to go into rural areas in return for having educational loans paid back, or even forgiven.

We also want to be sure that other States do what Montana has done, which is to make it possible to keep emergency rooms open, even though a doctor may not be there, by permitting the laws to permit that kind of enterprise where emergency technicians, physician assistants and advanced practice nurses are available in rural areas that are otherwise totally inaccessible.

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

But, I would just add, as you well know, Senator, that it is very difficult to imagine how, in many of our rural areas, there will ever be a sufficient level of competition that will realize the kind of efficiencies that we expect to see in urban and suburban areas.

And I think we have to continue to be very sensitive to the needs in rural communities to make sure that there is a base level of delivery of high-quality care available for every American, no matter where that American lives.

Senator BAUCUS. Thank you very much, Ms. Clinton.

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

Mrs. CLINTON. Thank you.

Senator BAUCUS. Significantly better than the status quo.

Mrs. CLINTON. Thank you, Senator.

The CHAIRMAN. Thank you, Senator Baucus.

Senator Roth.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE

Senator ROTH. It is a great pleasure to welcome you here, Mrs. Clinton.

One of the great concerns of all Americans, of course, is coverage of the non-insured. And, as you know, I have been very much interested in the possibilities of using the Federal Employee Health Benefit Program (FEHBP) as a means of providing coverage to millions of uninsured who are working for small business.

I would point out that FEHBP has been a very successful program. For example, this year its cost is only increasing 3 percent. It is well below the average; in fact, 40 percent of FEHBP policy holders are getting a decrease in premiums. OPM is adding new

preventive benefits to it. So, it is a program that I think can be said is working very well.

It was my idea that we would open this up to small business so that they could provide insurance at the same low prices: I think, roughly, $1,800 for the individual; a little over $4,000 for a family. This approach has not been included as part of the plan.

I would hope that you would take a second look at my idea, as it does seem to me a means of providing coverage. With FEHBP, you have networks that cover the rural areas, as well as the urban, it would not require the creation of a new bureaucracy, and yet we could give good coverage.

Mrs. CLINTON. Senator, you are absolutely right that the kind of program that the Federal Employees Health Benefits Program provides is the model for what we are attempting to do nationally. We have looked very closely at that. And, as you know, the Federal Government pays a considerable portion of the share for the employee.

And, really, the idea of the alliance that underlies our program is, again, that all employers would, in effect, follow the model of the Federal Government and pool their resources to realize the same kind of gains that you point out this program has achieved.

We think that, although it is a good model and one that we have learned a lot from, that, in its current condition, it would not meet all of the needs we have to reach universal coverage.

If you would like us to look further at whether, given the same proportionate sharing—I think it is 70/30 now—if all employers were willing to have a 70/30 split, how many employers could be covered, and what the problems with access would be, we will give you a report on that. We have looked at that. I do not have all of that information with me.

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

[The following information was subsequently received for the record:]

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

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

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

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

Senator ROTH. One of the advantages with my concept, as I mentioned of course, is you do not have to create a new bureaucracy. My understanding is, in the President's proposal he is keeping the postal employees in its current form, so there is some precedent for keeping this kind of a program.

I would like to turn, for a moment, to a two-part question. I think we are all concerned about how we pay for national health care reform. And, certainly, a lot of the callers I am hiring from home are asking what is going to happen to Medicare? Mrs. Streitz, for example, is worried about what is going to happen to her medigap, and so forth.

I think that there are some serious questions in this area as to the proposal's estimated Medicare savings. As I understand it, you expect to save something like 20 percent of the increased cost over the next 5 years. In the judgment of many people, that cannot just be made from eliminating waste, fraud, and abuse, but would require very substantial program cuts.

What is the answer to this, because Medicare, obviously, is of great importance to the senior citizens?

And this brings me to the second part of the question. Because, as was said earlier, a lot of these estimates are really guesstimates. I mean, they are the best you can get. There is no assurance of their accuracy. Would we be wise to try some demonstration programs before we move nationwide?

We are talking about a seventh of the economy, we are talking about jobs, so that whatever we do will influence not only the quality and kind of health care, but the economy and growth of jobs. Are we wise to put it in nationwide? Or, is there any merit to the idea of trying some of these proposals first on a demonstration basis?

Mrs. CLINTON. Well, Senator, I think it is very important to be cautious and to be very careful. But I would respond by saying, there are many examples around the country of high-quality care being given to Medicare recipients at much less of a cost than in other parts of the country.

In effect, we have demonstration projects. We can point to a number of States and a number of communities where Medicare recipients are taken care of very well, at one-half or one-third the cost of Medicare recipients in the exact same situation but in another part of our country.

What we fear is that, if we do not build on what we know works—which is changing the incentives in our health care system, better organizing the way health care is delivered, and persuading people that they will get high-quality care if their physicians and their hospitals are making the decisions instead of insurance companies and government bureaucrats—that we will only fall further and further behind the cost curve.

So, I will, again, be very happy to share this information with you. There are a number of examples all over the country of what works, which is why we feel confident, as does Senator Chafee in his proposal, that we can reduce the rate of increase in Medicare without undermining quality for Medicare recipients.

I do not think you would find the President, and I know you would not find any of the Senators on this committee, supporting

that rate of reduction if they thought it would, in any way, hurt my mother or any of your family members.

But we have too many examples, now, of how it can be done better at lower cost, with the same or better quality. And that is what we are counting on the rest of the country being able to do as well.

[The following information was subsequently received for the record:]

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

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

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

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

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

Senator ROTH. I would only add, we do have a number of proposals. We have the Chafee, we have the Clinton plan. I guess my question is, would it be wise to try those out, on a smaller scale, first? I do not think anything is exactly the same that is in operation at the current time.

Mrs. CLINTON. I think both of them, Senator, recognize that, until we get to universal coverage, we do not in any way control our health care destiny because we have to many decisions that are still made for the wrong reasons. But, I think, both in the Senate Republican approach, as well as the President's, it rests on very strong evidence that we can do this better and that we are not going to sacrifice quality or care for our citizens.

Senator ROTH. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Roth.

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

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Ms. Clinton, as you know, the President's plan includes a mandate on employers, but also on individuals. Both have to share responsibility.

The Republican plan has a mandate on individuals, and not on employers. You touched on that in your statement, but I would like to have you, if you would be willing to, to expand as to why it was that the administration chose that approach. Question number one.

Question number two. The Republican proposal, which has a lot in it which is in common with the President's proposal—and I think that cannot be said enough; Senator Dole talked about starting down the road together. I think we are going to be traveling a long way together.

But one of the things they have is a tax cap that limits the deductibility of health insurance to the average cost of one-third of the policies in the area, whatever area that might be. I would like

to get you, if you would, Ms. Clinton, to expand on your views about that.

Mrs. CLINTON. Thank you, Senator. And I also appreciate all of your help and guidance in the visit to West Virginia that we had that put faces on all of these problems for us.

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

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

Secondly, because it is the most familiar and the way that most Americans are used to getting their insurance. We think it will be the least disruptive, to both people's understanding of insurance and their acceptance of individual responsibility, because it is what they are doing or have been doing.

Thirdly, the employer/employee system gives us an existing way to make sure that payments are made and can be collected. We anticipate very little additional paperwork or difficulty for employers or employees.

So, we do not think that the difficulties that one would have in moving toward a system of universal coverage will be significant at all.

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

Among those worries are that, if we have a legislatively required individual mandate, we worry that the numbers of people who currently are insured through their employment will decrease because there will no longer be any reason for many employers, who have struggled to insure their workers, to continue to do so because an individual below a certain level of income will become the government's responsibility. They will fall into the subsidy pool. It is very difficult to predict how many or at what rate that would possibly increase the number of uninsured, but we worry that that would be one of the unintended consequences.

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

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

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

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

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

The CHAIRMAN. Mrs. Clinton, may I say, Senator Rockefeller's time is up. Your time is never up. [Laughter.]

Mrs. CLINTON. Thank you, Mr. Chairman.

Well, then, on my time, Senator, I will answer the second question you posed. [Laughter.]

We also looked very hard at the proposal that is common in managed competition approaches to controlling health care costs of imposing a tax cap and limiting deductibility, and we believe that, eventually, that should be a feature in our system.

But, we have a lot of difficulty with starting it at the beginning of reform because, currently, there are millions of Americans plus their dependents—who currently have health care benefits that would be taxed if either the approach of taxing at the average cost of one-third the policies in the area, or the approach that some of the managed competition advocates propose, which is taxing at the lowest cost plan in the area were to go into effect.

We would then be in a position in the administration and the Congress, of telling millions of Americans—a very, very big percentage—that health care reform means a big tax increase.

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

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

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

When we went to the Treasury people to talk to them about how they would do that, they were just beside themselves because you would have to track that cost, plus you would have to track the in-

dividual's payment, plus you would have to have some kind of tax proof as to what that was. The complexity and administrative bureaucracy necessary to administer that is substantial.

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

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Rockefeller.

Can I just express appreciation for the sensitivity you have shown to the question of complexity of administration? That is the continuous concern of this committee with the Treasury Department, and what the form looks like.

Mrs. CLINTON. Yes.

The CHAIRMAN. And, also, to say that it would be just about 50 years ago that Robert K. Merton at Columbia University, who is still thriving, wrote his essay on the unanticipated consequences of social action.

And I was pleased to see you use that phrase, and we will be thinking about unanticipated consequences all through this, which is a necessary way to go about it. Just because you think about it does not mean you cannot come up with some answers.

Senator Danforth.

Senator DANFORTH. Mrs. Clinton, I want to ask you a general question of philosophy, and then, if I have time, follow-up on whether or not this could be accomplished, in fact.

My question is whether you would agree with me that, somehow, there should be some way of telling people that they cannot have medical care that they might want for themselves or their family, and I will give you some examples.

The so called Baby K case that has been publicized recently, a baby born with a condition called anencephaly. The brain is missing, the baby cannot think, the baby cannot feel. The baby has been kept alive, I think, for 11 months, at well over $1,000 a day, because the mother says, I want the baby kept alive.

The Siamese twin case in, I think, Pennsylvania. One baby died, the other has a 1 percent chance of survival. The more prevalent case, the low-birth weight baby, the baby under 1 pound, the likelihood is that only 15 percent of these babies will be functional. There is enormous cost of keeping them alive; an average of $150,000 each. On the other edge of life, a case I heard of yesterday, a 92-year old man who received a pacemaker. And then everything in between: the case of somebody who is dying who wants to be kept alive for another 3 months, 6 months, at a very high cost. Philosophically, before we get to the mechanism question, should somebody at some level be in a position to say no?

Mrs. CLINTON. Senator, I think there should be a discussion in this country about what is appropriate care, and that a lot of these very hard decisions that you have just outlined should be made with more thought and more concern, about both the human and the economic cost.

So, I would agree that, for both moral and ethical reasons as well as economic ones, there has to be the kind of very difficult conversation that you are suggesting.

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

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

The hospital administrator of a very large hospital came to me as a part of a group visiting, as a delegation brought in by a member of Congress. And he said that he had recently asked one of his cardiac surgeons why the cardiac surgeon had admitted a 92-year old man for a quadruple bypass.

And the cardiac surgeon had said, well, because he was referred to me by the cardiologist who refers me all of my cases, and I did not want to say no because he might send his cases to another cardiac surgeon.

And the hospital administrator said, well, do you think it was medically appropriate for you to accept this surgery? And he said, no, it was not appropriate or necessary, but that is the way the system works.

Senator DANFORTH. I think that there is maybe a harder question, and that is the question of the person or the person's family who simply wants the treatment no matter what the cost. And there is a treatment that is available, for example, to keep this baby going who cannot think.

I guess the threshold question is, under any circumstances should there be somebody out there, or something somewhere at some level that says, no? I mean, it is possible to do this. It is possible to perform whatever this procedure is. But, even though you want it, the answer to you is, no, you cannot have it.

Mrs. CLINTON. I think that if we do this health care reform right and we create the kind of security we are talking about so that people will know that they are not being denied treatment for any reason other than it is not appropriate, it will not enhance or save the quality of life, we will have a much better chance of having that kind of conversation, and physicians will, once again, have much more latitude and discretion in advising families in an honest manner about what the real costs are.

So, I think we will get to that point. But, I think, in order to get there and to bring the country along with us, we have to make some of these other changes first to establish the kind of climate in which those conversations can take place.

Senator DANFORTH. Thank you.

The CHAIRMAN. Thank you, Senator Danforth.

Senator Breaux.

OPENING STATEMENT OF HON. JOHN B. BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you very much, Mr. Chairman.

Thank you, Mrs. Clinton. Welcome to the committee. I think that what you and the President have done on this health care debate is truly remarkable. I certainly hope that what you all have accomplished becomes a pattern or a blueprint, perhaps, for future legislative action on major and controversial legislative proposals.

I think it is remarkable, first, in outlining very clearly the goals of this very complicated effort: universal access to health care, comprehensive, standardized package, and quality health care for everybody.

I think you all have done a really remarkable job in spelling that out, what we want and what the goal is. The second area, I think, that is truly remarkable is the way this process has been put together. We can learn a lot from that.

You and the President have had private meetings with Republican Senators, private meetings with Democratic Senators, and private meetings with both of us together in the same room. You have done the same thing, I think, also, on the House side.

So, I think it is truly remarkable as to what has been accomplished so far. I think that, as we move towards reaching those goals, we have to decide which path we are going to take. I think there are two options.

One, is the path of improving the marketplace; changing the rules so that competition can work better than it does right now, because right now it does not work very well.

The second path we can take is more government regulation, more government bureaucracy, either at a State level, a local level, or at the Federal level. And I think that it is difficult to try and mix the two. I think that when you try and add some regulatory rules and regulations to a system that is based on market-oriented reforms it gets very difficult to make sure how much we add without messing up competition.

That is my concern as we move down this path. I have introduced—and we have discussed this a number of times—in the last Congress, a bill that was called "managed competition," with a number of co-sponsors which was a more pure competition without the regulatory regimes. I want to work very closely with this administration on how you intend to marry these concepts, and, hopefully, we will be able to do that without restricting flexibility.

I am concerned that, by adding some regulatory requirement to the proposal and by leaving in place what I think are disincentives to changing the way people buy health care, that we make it difficult to reach the goals and make competition less possible.

Now, the point I have in the short time I have is that after the law has been enacted for only 24 months we are hoping to make some rather dramatic reductions in the cost of health care in this country. If we do not, the premium caps kick in.

I am concerned that 24 months is not nearly enough time to allow the competition to take hold, particularly in areas that do not have any effective competition now. I am concerned that there are disincentives that have been left in place that really make it more difficult for competition to succeed. The biggest disincentive is the complete employer deduction, regardless of the price of the plan, that is available for employer-provided benefits. I think that is a real disincentive to purchasing the least costly plan.

Not taxing employee benefits if they are in excess of that plan for 10 years or to the year 2000, I think, is a disincentive. Quite frankly, I think that the prescription drugs being made available without requiring Medicare recipients to change their habits by joining an alliance is a particular problem area. But I think all of these are areas that we could work on to try and reach some compromises.

My question would be, is there any possibility or any thought about trying to delay or spread out the time in which the premium caps would kick in in order to give competition the time to take hold and to actually start showing some results? I think it is 1996 in the current draft. What about the year 2000? Or is there some type of phase-in that can be considered?

Mrs. CLINTON. Senator, we would certainly work with you to consider exactly those issues. We are trying to do two things simultaneously, and I certainly understand how trying to do two things simultaneously sometimes creates, perhaps, some question as to how you can get both done. But we are trying to create incentives through the market and through enhanced competition to reorganize our health care system so that services are delivered more efficiently at high quality.

At the same time, we have to recognize that we start from very different stages of development in different parts of the country with incredibly different practice styles used by physicians that have increased costs dramatically in those regions.

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

Now, whether we can get to where we need, in 2 years, or over a longer period of time, we are very open to talking with you about that. But, to go back to the example that I talked with Senator Danforth about, this hospital administrator told me that he appreciated having some kind of premium cap out there as a backstop. Without it, he said, it would be very difficult for a hospital administrator to go to his cardiac surgeon, or ask his colleagues to go to him and make certain that the most appropriate care is provided and remind him how the budget backstop may be hit, which might possibly reduce income, if care is not provided in the most appropriate manor.

So, on psychological as well as economic grounds, some form of discipline in a marketplace that, frankly, has had none, in which blank checks have been written by both the government and private insurers until very recently, seems to us a feature that needs to be there as a backup.

But, how we get there, when it is triggered, under what circumstances, we are very open to that. We want to get to the same place, and we very much want to work with you on that.

The CHAIRMAN. Thank you, Senator Breaux.

Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

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

I just would like to point out one thing in connection with your conversation with Senator Rockefeller and the points he raised. Your plan does have an individual mandate to the extent of the 20 percent.

Mrs. CLINTON. Yes, sir.

Senator CHAFEE. In other words, the individual is responsible for paying a portion of his or her's employee insurance, whereas, ours makes the individual 100 percent, yours makes him 20 percent. So, it is a difference of degree——

Mrs. CLINTON. That is right.

Senator CHAFEE [continuing]. More than a total difference.

The other point is, referring back to what you were talking with Senator Breaux about, regarding the taxation of benefits. In our plan, we do that. Your plan, you defer that. But, as I understand it, it is your intention that down the road, that would occur.

Mrs. CLINTON. Yes, sir.

Senator CHAFEE. That would be a level called the reasonable level of benefits. Anything above that would be taxable to the employee and non-deductible by the employer.

The CHAIRMAN. That is absolutely right, Senator.

Senator CHAFEE. And the thrust of the various bills, as I see it, is to provide coverage for those who are not covered now. And this is costly, but it is worth it, we believe. However, in one instance, it seems to me that the administration has embarked on providing coverage by the government for those who are already covered. This I have great difficulty with. I am referring to page 13 of your plan summary, in dealing with retirees.

I will briefly read it. "Americans who retire before 65 and were employed for at least the amount of time used as a standard to qualify for Social Security, purchase health care through their regional alliance and pay only the employee's share of the premium for their health plan. The Federal Government pays the 80 percent of the employer share."

It seems to me that this is a very, very expensive undertaking.

What you are doing is saying that an employee who is retired, whose employer currently is providing all or a substantial portion of his or her insurance, will no longer have to do that. The government will do it. I see that being very costly.

Furthermore, we get into this point you have made with Senator Moynihan, our Chairman, of unanticipated consequences of social action. Many more employers, I believe, will choose to have their employees go this route. I mean, what a bonanza. The government

is going to step in and pay the employers 80 percent. Could you explain why you chose that?

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

This is a policy decision that is certainly one that we will be debating and discussing. It comes out of several sources of concern. The first is there is a growing tendency for businesses that have contractual obligations to retirees for them to abrogate or limit those health benefits in some fashion, whether it is an outright abrogation of the contract, or some attempt to negotiate below whatever the level of promised benefits were.

So that, in fact, there are more and more people in this time period before they are eligible for Medicare who are finding themselves without health coverage and who are not employed because they had taken early retirement, or reached the requisite retirement age. This is becoming a problem for the general society that we believe we are going to have to deal with.

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

We think that, for example, those industries—largely the older manufacturing industries—that assume these responsibilities are beginning to make a comeback. They are increasing their productivity, they are competing with the Japanese, the Europeans, and others, but they are doing so, still, with one hand tied behind their back because of the extraordinary health care costs which they have borne which, in many instances, they have borne not just for their own employees and retirees, but indirectly for other businesses that have shifted the costs onto them because they were willing to pick up those costs. And we consider that that kind of benefit which has inured to the entire population in indirect ways ought to be borne by that entire population.

And, finally, we have costed this out, as I expressed to Senator Packwood. It is about $4.5 billion. But we think that it is an investment in our competitiveness and our manufacturing base, as well as picking up the cost of people who are falling into the uninsured that is worth making.

But, obviously, we are more than open to talking with you and to exploring your concerns and making sure that the policy makes sense and that the underlying economic assumptions make sense.

Senator CHAFEE. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Chafee. Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman. And, again, I want to thank you for holding this hearing and bringing us together around this issue because, obviously, this is the focus for the rest of the year, and much of next, as well.

I want to thank you, Mrs. Clinton, for the leadership that you have shown. I think that your competence just shines out. I think that has made a difference in the way people are approaching this issue, and I think that is a real contribution to the country.

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

As I understand it, one of the goals of this plan is to change those incentives so that we begin to control costs. Obviously, when you change incentives in the system, that then creates a potential vulnerability of providing too little care, doing too few tests, doing too few procedures.

What is your reaction to those who say, I am very concerned that we are going to wind up with a system in which the incentives run toward doing too little rather than too much?

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

I pull this out at every hearing and I keep it with me because I think it is the best example of what I am talking about. If you take a look at this Consumer Guide to Coronary Artery Bypass Graft Surgery that is put out by the Pennsylvania Health Care Cost Containment Council, it makes a point that I think is very important.

This document has all of the costs of providing coronary bypass surgery in all of the hospitals in Pennsylvania that perform the surgery. The cost runs from $21,000 to $84,000.

The information has tracked the quality indicators as to what happens to the patients who receive this surgery, including how many die from this surgery, and they have done so by comparing the population and demographic statistics of the patient so that we compare apples and apples.

If you look at this, the hospital that is doing coronary bypass surgeries at $21,000 has better quality than many of the hospitals performing surgeries at much, much higher costs.

Now, if more hospitals in Pennsylvania learned how the hospital is doing it for $21,000, you would actually have more coronary bypass surgeries able to be done in Pennsylvania at less cost than is now happening. And that is repeated all over the country.

The second example I would just like, briefly, to mention was explained in a speech that I heard when I was in Minnesota with Senator Durenberger.

A physician there, who was the Chief of Quality and the head of one of the very large health networks in Minnesota, talked about how one of the health care providers in Minnesota has created a new test to determine whether a lump in a woman's breast is or is not cancerous without having to have a surgical biopsy.

And this physician said that this procedure is much cheaper, less invasive, and can be done more quickly than surgical alternatives that often leave women having to wait and having sleepless nights until she has her surgery. Why is it not being done? Because it would require, in this doctor's words, "surgeons giving up up to $40,000 in income to radiologists."

So, there is no incentive in the current system to move toward a procedure that has been proven to be less costly and more effective that can determine whether a woman might need surgery for breast cancer.

There is no system that will move hospitals in Pennsylvania, or move surgeons in Minnesota, or elsewhere, to make these different choices. But there is no question that these different choices would preserve and even enhance quality if we could structure our health care system so those choices were made instead of other ones.

Senator CONRAD. All right. I think I am right at the end of my time, Mr. Chairman. And, in the interest of allowing others their full time, I will yield back what I have.

The CHAIRMAN. You are very generous, Senator Conrad. Thank you.

Senator Durenberger.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you. I thank my colleague from North Dakota, and thank you very much, Mrs. Clinton, for sharing your time, your talent, and your commitment with us.

Thank you, also, for mentioning Minnesota with some frequency, which leads me to a point that you and I talked about in another committee. That is, that everything that is going on in Minnesota is because people want it to go on, not that the government insisted on it. Not a thing that you have heard from Mrs. Clinton today, nor that you have heard from me over the years is because Minnesota State Government said it ought to happen.

It is because people who are providers of care, consumers of care, insurance plans, creative doctors, creative multi-specialty groups have decided that the relationship between the consumer and the provider of care is critical to improving quality and lowering costs.

This committee is a very awesome place, because we have $903 billion in medical spending this year, 14 percent of the GNP; 42 percent of it comes from government, most of that the Federal Government, and practically all of it is generated by the policies made by us and our predecessors. And that is an incredibly awesome responsibility.

Economic policy, tax policy, Medicare, Medicaid, go on up and down the line. Most of the driving forces in the income security system originate in this committee. So, I think that is why your time spent here is incredibly valuable.

There are two observations I would like to make about the so called tax cap, and your response to that, and the FEHBP. Health care reform has to mean that the taxpayers of this country cannot have the government subsidize extravagant buying. And that is your husband's sixth principle, responsibility. We cannot just have

responsibility for the doctors and the hospitals, we have to have responsibility for everybody. And people have to start taking that responsibility.

The FEHBP. If we are going to cop out to the postal service plan, or any existing plan, to not take on the driving force in this community that causes the health care costs in this community to be higher than anywhere in the country—Medicare, in the District of Columbia, is at the top in the country, 33 percent above the national average, not because people are more ill—take that out of it—but just because of the way health care is practiced here in the District of Columbia. It is 33 percent higher here above the national average; Hawaii is 43 percent below the national average; and Oregon is down there, and Wyoming, and Utah, and a bunch of other States.

Those of us who are buying in the private sector here probably pay 60 percent, 100 percent, 200 percent above the national average what you pay anywhere else, in this community.

So, unless we take that responsibility principle seriously and we deal with the big help alliance, or whatever you want to call it around here, that might change the way medicine is practiced, the FEHBP, and do that right up front where everybody can see it, everybody can take responsibility, I do not think we are going to make it.

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

So, perhaps, I need you to share with us why we cannot do Medicare reform right now, why you and the President cannot come to us with a plan to include Medicare in comprehensive reform—since Minnesota has had tougher Medicare risk contracts going since 1986, and we know what is happening out there. The people who are doing efficient health care in our communities through tougher risk contracts continue to be penalized.

I will give you an example. New York. This proves that there are savings in the market, but it also proves how dumb government is, i.e., HCFA. [Laughter.]

In 1994, the tougher risk contractors in New York who currently charge Medicare $569 to get into one of these plans will go up 15 percent. In Minneapolis and St. Paul, where the charge for the very same service, for the very same kind of people, is only $351, they are going down. That is for the benefit of everybody here who is making the current policy.

Now, if we have all these demonstrations around the country, if they are that successful, why do we not just go to changing Medicare right now? Give the elderly the same kind of comprehensive benefit that we are promising everybody else, put it through one of these accountable health plans. We have the model of the tougher risk contracts operating in many of our communities. Why not just do it?

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

As you know, in this committee better than most, dealing with Medicare, and explaining it, and making sure the public understands what you are trying to do is a big task. But, if we could come up with a bipartisan approach that would explain how we are actually making Medicare better, then I think we ought to take a hard look at trying to do that.

I have no problem with doing that at all, because you are absolutely right. There is no explanation, other than the way care is delivered and organized, to explain these differences in cost.

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

The CHAIRMAN. Thank you, Senator Durenberger. Ms. Clinton, may I say, this being the U.S. Senate, it is all right to pick on New York. [Laughter.]

Mrs. CLINTON. I love New York, Mr. Chairman. It's New York, NY, as far as I am concerned.

The CHAIRMAN. Senator Bradley.

OPENING STATEMENT OF HON. BILL BRADLEY, A U.S. SENATOR FROM NEW JERSEY

Senator BRADLEY. Thank you very much, Mr. Chairman. Let me say, first of all, Mrs. Clinton, I think you are providing an enormous public service to the country. I am personally grateful. And I think there are millions of people who are very pleased that you are doing what you are doing.

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

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

On violence, one of the most startling numbers that I have come across in recent years is that if you want to be a gun dealer in America, it costs you between $30 and $75 to get a license. There are 276,000 gun dealers in America. There are more gun dealers in America than there are gas stations. That, to me, is a remarkable number and I think it is directly related to the accessibility that guns have in the country today. And if we simply put a 25

percent sales tax on the sale of a gun and raise the dealers' fees from $30–$75 to $2,500, we would raise $600 million. That would be a tax directly on the purveyors of violence in terms of the sales of the means of violence.

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

Mrs. CLINTON. Well, Senator, with respect to the tobacco tax, we agree with you that tobacco should be taxed as part of this package, largely for health reasons, and particularly to try to deter smoking among young people. And we are still trying to make sure we know exactly how much revenue we will need, but the tax will be between 75 cents and $1.00 additional to what is already the Federal tax.

Speaking personally—and that is all I can do with respect to your second proposal—I am all for that. I just do not know what else we are going to do to try to figure out how to get some handle on this violence. One of my best friends, a woman I have gone to school with since grade school who is a full-time homemaker, has three children in a suburb of Chicago, is just outraged because a gun dealer has opened a store in a strip mall across the street from the local high school.

And the parents, mothers like her, have picketed. They have tried to talk with this person, they have even tried to find alternative places for him to go so that he could still be in business, and he is just absolutely pleased as he can be to be in a gun shop across the street from the high school. He thinks it will increase his trade remarkably. I share my friend's outrage. She is somebody who is not political and does not march or picket. But there is just something wrong when it is that easy to sell guns to high school students after school. And this is a suburb, and we know what happens, now, in every part of our country with that kind of availability of weapons in the hands of teenagers. I know Senator Chafee has been concerned about this issue for a long time, and it has to be addressed. We will look at your proposal and be happy to talk with you about it. I am speaking personally, but I feel very strongly about that.

Senator BRADLEY. Well, let me say that there is no more important personal endorsement in the country today, and I thank you very much. [Laughter.]

The CHAIRMAN. Thank you, Senator Bradley.

May I just interject a thought, Mrs. Clinton? Epidemiologists have begun to think in terms of personal violence, hand gun violence, and consequences—trying to think, as epidemiologists will, in terms of vectors and so forth.

The point can be made that guns do not kill people, bullets kill people. We have a two century supply of hand guns in this country. There have been 50 million sold since Jim Brady was shot, alone. We only have about a 4-year supply of ammunition.

And the Federal Government, through the Bureau of Alcohol, Tobacco and Firearms, which does not seem to know this, but it is the fact, has the right to tax the sale and manufacture of bullets, of ammunition. That is right there in statute. And I think they do

issue—for $30 you can manufacture 300 million rounds of 9 millimeter ammunition, and you do not have to report back.

Senator PACKWOOD. Could I give you an addendum to that?

The CHAIRMAN. Certainly.

Senator PACKWOOD. I quoted your figure when I was in Oregon last week in some hearing, and I said, whether or not gun registration works, I am not sure, but there is a relatively short supply of ammunition which could be easily run out. I said, there is not a century's supply of ammunition in this country. And the witness says, there is in my basement. [Laughter.]

The CHAIRMAN. May the sometime gunnery officer of the United States Ship *Quirinus* say, if it is in his basement, it will not be worth a damn in about 10 years' time. [Laughter.]

The Secretary of the Navy will assure that powder degenerates very fast; 45-caliber pistols do not. I will stop right there. But you took that note down, did you not?

Mrs. CLINTON. Yes, I did. [Laughter.]

The CHAIRMAN. Senator Riegle.

Senator RIEGLE. Thank you very much, Mr. Chairman. Let me just say to our very distinguished guest, you are just giving terrific leadership to this country and you have raised a level of hope for people across the Nation that something good can happen.

And, by giving it this intense personal leadership as you have, and I have had a chance to watch that at close range, as we all have, it has just really been extraordinary, and I thank you for everybody in Michigan, and everybody across the country.

I want to make two points. One, is that on this committee, now, there are four of us who have announced that we will not be seeking re-election in 1994. So, Senator Wallop, and Senator Danforth, Senator Durenberger and I are in that group.

So, we are not only relieved of the time and the effort that it takes to be engaged in a campaign, but it gives us the chance to work across the partisan aisle, which we really must do to succeed in this effort. And you have been so diligent in your efforts to talk with members on both sides.

And we have talked privately, and we talked down at the White House the other day with the President when all of us were there, this is the only way we can get this done. The only conceivable way that we can enact health care over the next year is by working on a bipartisan basis.

And I want to just say again, Senator Chafee, the Ranking Member on the Subcommittee on Health for Families and the Uninsured that I am chairman of, and to the colleagues on that side, I intend to do this in a fully bipartisan way. I have also said that to our colleagues over on the Labor and Human Resources Committee. Bill Roth and I came here together 27 years ago in the same party, so it is easy for us to work together, despite an occasional difference here or there. So, you have got a pledge from me that, for my part, we are going to work across this party aisle and try to get this done. Senator Dole has said as much, and I have complimented him for doing that.

Let me just talk about the comprehensiveness of the program and how quickly we are able to phase it in. We have talked before about the fact that we have this very important model for us in Ha-

waii where we have had, now, comprehensive health care for about 20 years. And the cost of health care, as a percent of the Hawaiian economy, is about 8 percent; the rest of the country is 14 percent.

So, we know that after that 20-year experience, that we are getting this huge financial dividend, plus the health outcomes are much better. But, when you go over that 20-year history, it takes the first 10 years before those cost lines really break apart and you really start to get the big financial benefits and savings of good primary care and good preventive care.

Now, our problem here is going to be, how quickly do we phase this in? And the problem is going to be, we are going to try to measure the results of a 5-year budget timeframe and we are basically going to be measuring public costs, because that is what we deal with.

So, we are going to have to do something special to factor in the private savings and the impact out there, and then we have got to think about what the timeframe is over which we really measure the returns of this program.

If we try to just take and finance it based on the returns over 5 years, when you look at Hawaii, that is not going to be a long enough time period in which to really understand how these savings will accrue as we avoid a lot of diseases, we avoid a lot of problems of people with high-cost care, and so forth.

So, I am wondering what your thoughts are as to how we sort of reconcile that, in terms of how we think through this question of how we cost this out so that we do not fool ourselves and, in a sense, undershoot on the front end when we have got to make, in a sense, the investment in good health, in order to save the huge dollars later on down the line.

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

It has been one of the issues that I have really struggled over as I have tried to understand it, and I just hope that this committee, which certainly has so much credibility on these issues, will continue to stress that even though something may not be scorable in Washington, DC, budget talk, does not mean it is not real. We know that prevention will work if we can get prevention in place.

Senator RIEGLE. Right.

Mrs. CLINTON. It is absolutely one of the clearest commitments we can make to getting costs under control. But we also know that some people will claim, well, utilization will go up a little. If everybody is going to get prevention, utilization will go up. Well, utilization should go up. We want it to go up.

The average citizen of Hawaii has more doctor visits than the average citizen of the other 49 States. But, because they are doctor visits for primary and preventive care, as more likely to occur there than here, their overall costs are less.

So, yes, we will have some increased costs in the beginning to get this system set up. And what we are going to have to figure out how to do is, in the constraints that this budget imposes on your

deliberations and on your ability to deal with your colleagues, we have to explain that.

And we have the other problem, which we believe competition will create savings as practice styles change, as administrative loads go down, and all the things you know so well, but we cannot get those scored either because they are not considered within the budget world that exists here to be savings that can be actually laid out for people to see and realize. So, we have to be willing to make a strong stand for investment and stick to it because we know it will pay off if we do.

Senator RIEGLE. I thank you. And I will just say, Mr. Chairman, I know my time is up. Maybe one of the things we can do is, when we lay out the cost numbers, do it with the 5-year projections, the 10, the 15, maybe even the 20-year projections, recognizing that that is what experience has taught us, so we do not fool ourselves on how we really get this job done and save the money at the same time.

The CHAIRMAN. A good proposal. Let us, indeed, undertake to do it. Thank you, Senator Riegle.

Senator Daschle.

Senator GRASSLEY. Mr. Chairman, do I get a chance?

The CHAIRMAN. Yes, sir. You are after Senator Daschle.

OPENING STATEMENT OF HON. THOMAS A. DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Thank you, Mr. Chairman. Mrs. Clinton, Senator Grassley and I may ask the last two questions you get this week, and I want to commend you for the quality of your answers. The clarity and command of the facts that you have demonstrated all week is admirable, and I appreciate very much your contribution to the debate.

Somebody recommended today that you be offered a sweatshirt that says, "I Survived." I think it ought to be "I Flourished," because all week long you certainly have done just that.

You have answered, in characteristic fashion, my concerns about many aspects of how the plan would operate in rural America. But I was home this last weekend, and three concerns were raised that perhaps you might be able to address. The first is from insurance holders who have been told by some that this is going to radically change the way they buy insurance; the second, by State officials who expressed concern that we may be dealing with yet another unfunded mandate as we change the structure in the relationship between the Federal Government and the States in addressing government responsibility; and the third has to do with those who benefit from home health care, and other services that are especially prevalent in rural America. I would appreciate it if you could address those three concerns.

Mrs. CLINTON. Thank you very much, Senator. And thank you for all of your help in getting this project underway, and particularly for the Health Care University work that you did.

With respect to insurance holders, we are trying to design this so that those who are currently insured will see very little change. Every year, they will be given the opportunity to choose what health plan they wish to sign up with. They will then have a cost

that is assigned to that health plan based on how the health plan has costed out its services.

Under our system then, the employer and the employee will be making a contribution to the alliance and the individual will see very little difference in terms of making payments into the alliance, as opposed to making payments into the insurance company.

The most important feature will actually be enhanced, and that is the individual insured will have the choice as to what plan to use his insurance dollars for. That decision will not be made by his employer if he has insurance through an employer. So, we really are trying to keep this system as much like what most Americans know right now, and we believe that we can do that.

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

The States feel very strongly, and with good cause, they have had more than their share of unfunded mandates. And, the most difficult to deal with has been health care, particularly in the Medicaid program, where now, for the first time, States are spending more on Medicaid than they are spending on higher education.

So, we understand that that is a legitimate fear on the parts of States, and we intend to give States flexibility and responsibilities that they have largely asked us to give them, but not the kind of costs that come from unfunded mandates.

Then, finally, with respect to alternative health care, particularly home health care, this is one of the difficulties that we have where, on the one hand, I think there are legitimate questions raised about whether we should start a new program like long-term care.

On the other hand, if we do not provide some support for long-term care, particularly for home health care, we may well spend more money unwisely on inappropriate institutionally-based care.

So, we want to be providing a better array of alternatives to citizens, particularly in the long-term care area through home-based care and community-based care, and we think that investing in that now will reap dividends down the road, both in economics and human terms. So, that is how we would like to begin to address what are rightfully seen as alternative, but cost-effective ways of taking care of people.

Senator DASCHLE. Thank you, Mrs. Clinton. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Daschle.

Senator Grassley.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Mrs. Clinton, Senator Durenberger asked you about Medicare being included, and I want to hit it from a little different angle. Your plan calls for States having the option of taking over Medicare.

My Governor, former Governor Ray, as well, is president of the Blue Cross/Blue Shield, our hospital association, and lots of others as well believe that you are never really going to have health care

reform unless Medicare is put into it. So, maybe in my State we might opt for that.

So, I have some questions about how this might work, and they are based on the fear that we have 65–70 percent of our people in the hospitals who are Medicare recipients, and we do not get reimbursed even on the cost for those services.

First, could you tell us how the amount of Medicare money coming to a State from the Federal level would be calculated? Would it be on a per capita amount based on historical reimbursement patterns, or would it be on some sort of new reimbursement methodology?

And, if it would be a new methodology, how would it work in general? Now, I ask this question, as you probably know, because Iowa has one of the lowest cost and charge structures for health care in the country and people in our State believe now, and have believed for years that Medicare does not pay its fair share of the cost, not of the charges, of treating Medicare beneficiaries.

Our providers believe that Medicare does not pay more than 70 or 80 percent of what it costs to treat a patient, and I have already mentioned that these costs are at the bottom for my State, of all the States. So, a reimbursement pattern that freezes in what is now an inadequate reimbursement level would not be fair for my State. One additional point, and then I will let you answer.

If the State were to take this over, and, under your plan, Medicare spending was slowing down, would the slow-downs that are at the Federal level also apply on the same basis to what the States might have if they assume that cost?

Mrs. CLINTON. Senator, those are really important questions. And the way that I would have to answer them is, it will depend upon how we finally decide to deal with Medicare in this legislation. The way the plan is currently proposed, we would be starting from the historical levels that currently exist.

And I share your concern. I come from Arkansas. I think Arkansas' rate is even below Iowa's rate. And it is something that has been a particular burden on rural States like ours, because you start with a differential where Medicare pays less than the private sector, and then you add burdens by making it very difficult for a lot of States and localities to even reach what is a fair differential because we do not get reimbursed at the same rate as others. I am very conscious of this.

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

It concerns me because, already, now, you have got situations where Medicare patients are being taken care of extremely well in Iowa, or Arkansas, or Minnesota, at one-half or one-third the cost of what is being paid for Medicare patients elsewhere. We want to bring the costs in those other States down. That is the whole theory behind what we are doing.

But we worry that if we started by saying, just off the bat, okay, State X, you have been reimbursed at two or three times what Iowa has gotten, you are not going to get that anymore, that that would cause too much of a disruption in the existing system.

So, we want to try to bring it down gradually. We also want to try to figure out how to do what Senator Durenberger is saying, which is, through the States, as is our proposal, you would begin to move people into more cost-effective settings. You would begin to provide more care to more Medicare recipients for a better value for the dollar. So, we have looked at it on a State-by-State basis as opposed to a national reform, but we are open to looking at both your questions and Senator Durenberger's questions, because the bottom line is, we know that Medicare recipients in Iowa are being well taken care of, and they are being given care at less cost than other States, and we need to reward Iowa for doing a good job instead of penalizing Iowa, which is what we currently do.

So, we had thought the best way to proceed was to give more authority to the States, which is what the States have asked us; I know both Governor Ray and your current Governor, because they think, frankly, they can do a better job than the Federal Government. But we need to look at both a State approach, which is what we favor, and the national approach that Senator Durenberger has alluded to, and we will be glad to do that.

The CHAIRMAN. Thank you, Senator Grassley.

[The prepared statement of Senator Grassley appears in the appendix.]

The CHAIRMAN. I would note that the hour of 1:00 o'clock is approaching and there is only so much we can ask of our witness.

Senator Mitchell has been patiently waiting to ask some questions.

Senator MITCHELL. Thank you, Mr. Chairman.

Mrs. Clinton, my question builds upon that of Senator Grassley and your response to it, and relates to some of the criticism that has been made of the President's plan. Following the President's address last week, in the official response to that address, it was criticized as "a one size fits all Federal health care system."

We each represent different States. I, and others on this committee represent States which are called rural, with relatively sparse populations, living primarily in small towns spread over large areas of land.

The people of Maine want some assurance that this will not be a one size fits all Federal health care system; that, while there will be a basic package of benefits which will provide health care security to all Americans and will travel with that American wherever he or she goes, that the method of delivering health care will be substantially left to the States, provided they meet the threshold requirement of security for all Americans.

Is this criticism accurate? Will there be a one size fits all Federal health care system; will Maine have to do what New York does, and California have to do what West Virginia does, or will the States have flexibility in the delivery of health care?

Mrs. CLINTON. Senator, we are trying very hard to design it so that States do have flexibility within a Federal framework. This

will be, I think, one of the difficult challenges you will face in the Congress.

There are States that are very anxious to take on the challenge of health care reform. Some have already passed legislation they want to see implemented, some have a track record of doing something successful, like Hawaii, for example, and many are just chomping at the bit for the Congress to give them the kind of framework in which they can proceed.

There are other States that do not want anything to do with health care reform. They do not see it as their responsibility. They want the Federal Government to find a way to address the problem, as long as it does not impose excessive burden on the States.

We believe that there ought to be a Federal framework with State flexibility, and that States ought to be given the opportunity to design their delivery systems to meet the population needs of their States.

The Congress will have to decide how to make sure every State meets its basic obligations so that if any State is unwilling to make decisions about health care, then the Federal Government will have to be sure that the people in that State are protected. But, other than that, we want there to be State flexibility to the extent we possibly can design it.

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

Mrs. CLINTON. Senator, I think there are a number of features that, in Senator Baucus' words earlier, will be greatly beneficial and enhance the delivery of health care in rural areas.

I have driven through western Maine. I know that people are sparsely populated in those beautiful forests. And we want to be sure that we have a system of delivering health care in rural areas that is firmly grounded in a solid financing mechanism and that identifies providers in those small communities as essential so that they are given additional financial support to be there when the people need them. In addition we want to provide the kind of incentives for physicians and nurses to practice in rural areas by forgiving loans and by extending loan pay-backs, and where we use technology better than we have to get health care services into remote and rural areas.

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

Senator MITCHELL. Mrs. Clinton, finally, on the question of how the reform is financed. I have here a chart which appears in the materials prepared by the administration covering the period 1994–2000, a 7-year period. Some of the critics of the President's plan have used this chart to suggest that there will be $700 billion in "new government spending," or $600 billion in "new government spending."

I am going to ask, Mr. Chairman, that the chart be placed in the record at an appropriate point. But, as I read this chart, I interpret

it that there will be approximately $350 billion over 7 years for such new benefits; the remaining $350 billion will be merely transference of current Medicare and Medicaid recipients into the alliances and for deficit reduction. Is that your understanding, as well?

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

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

Mrs. CLINTON. Yes, sir.

Senator MITCHELL. Thank you.

The CHAIRMAN. Thank you. And we will place that in the record. We will be happy to do it.

[The chart appears in the appendix.]

The CHAIRMAN. There is a deficit reduction of $91 billion in alliance coverage. We will probably get revised numbers before we get the final legislation.

Mrs. CLINTON. In fact, we are taking in all of the advice and suggestions that all of the members are giving us and revising the plan as we speak. But these are the broad outlines.

The CHAIRMAN. Thank you. Thank you, Senator Mitchell. And, now, the one Senator who has not been heard but who has waited very patiently, Senator Boren.

OPENING STATEMENT OF HON. DAVID L. BOREN, A U.S. SENATOR FROM OKLAHOMA

Senator BOREN. Thank you very much, Mr. Chairman. Mrs. Clinton, I will try to be brief. We appreciate the amount of time you have shared with us, and appreciate the hard work and personal commitment that you have brought to this issue, and we also appreciate the decision of the President to tackle this head on.

I think we all realize we have a lot of problems in this country because administrations of both parties and the members of both parties of the Congress have wanted to shy away from tough issues that are very difficult to resolve. And I think the President deserves a lot of credit for being willing to take this one on head on and face up to it.

I suppose my biggest concern, because I share all the goals that have been announced in terms of the President's program, is to make sure that we are adequately paying for it.

I do not think there has been anything that has caused Americans to become more cynical about government than the fact that we have over-promised and under-delivered. We have certainly nearly always missed our estimates so that the deficits have been higher than anticipated. That has happened to us in budget, after budget, after budget.

So, I think it is understandable that some Americans have skepticism as to whether or not we are promising too much and providing too little revenue to sustain it.

One of the criticisms raised is the $51 billion projected figure that would come from anticipated new revenues due to increased wages and profits. I wonder if, in making that estimate, was it considered that some companies, rather than paying either higher wages or disbursing profits, might choose to reinvest their money in tax-exempt ways. For example, if they reinvested money in equipment they would be granted depreciation. I wonder, more broadly, what happens if we find that we have under-estimated the costs and over-estimated anticipated revenues? What happens if we do get a gap in the money available in the outflow?

Is there some mechanism anticipated in the plan for dealing with that? Small businesses tell me, for example, "well, we are due to get this subsidy, but what if the plan costs more than anticipated, or what if the revenues do not come in to pay for it as we anticipate, will we see that subsidy cut back?"

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

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

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

But it is the kind of change in policy that we think is not uncommon to this committee because, for example, if you were to make a policy change to shift funds from non-taxable compensation to taxable income, or to deal with pension income in a different way, you would run the same kind of modeling in the Treasury that we have done to come up with this figure. So, I think that the Finance Committee, particularly, will understand how we arrived at that.

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

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

First, in all of the cost projections that we have given you and that we have worked internally, we have tried to be conservative. We have not, for example, included any of the savings that we think will accrue because of competition and because of changes that physicians and hospitals will engage in on their own that will result, as I said earlier, in more coronary bypass surgeries being done closer to $21,000 instead of $84,000. None of those figures are in these cost estimates.

We believe—and we believe we have very strong support for this—that this proposal will realize a very significant amount of savings. So, we think that helps to cushion whatever gap there is.

In addition to that, we have included padding, if you will. We have tried to be as conservative as possible, for example, in looking at how much the benefits package would cost. We have tried to run through all kinds of scenarios—what will happen if there is an earthquake in California followed by a plague—and we have tried to make sure that we have sufficient dollars allocated for that so that there is the opportunity for this gap to be filled.

We do not anticipate that, with the combination of the revenue that we have already laid out, with the savings that, to some degree or other, everyone is confident will come if we pursue this plan, and with the kind of additional funding we have put in to cushion any eventuality that we can at least foresee at this point, that there should be grounds for concern about any individual or business having to step up and fill the gap.

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

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

Senator BOREN. Thank you very much.

The CHAIRMAN. Thank you, Senator Boren.

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

Mrs. CLINTON. Do you all ever take a lunch break? [Laughter.]

The CHAIRMAN. I think, on that practical note, I would like to express the great gratitude of the committee. I think we all would. What do you say we give her a little hand here?

[Applause.]

Mrs. CLINTON. Thank you.

The CHAIRMAN. Thank you very much. And the committee stands adjourned.

[Whereupon, at 1:06 p.m. the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR BOB DOLE

Mr. Chairman: I congratulate you on convening what I hope will be the first of a long series of hearings on what may well be one of the most difficult domestic issues to face us in this century.

I also join you in welcoming Mrs. Clinton, who has proven to be an extraordinary spokesperson on behalf of this Administration and on behalf of the plan she has helped to craft.

Mr. Chairman, this debate is not about whether we want to reform our health care system—it is about how best to do it without putting at risk the aspects of our health care system that have made it the envy of the world.

I believe I can speak for all Republicans in the Senate in saying we enter this discussion with every intention of being positive, active participants. We have not taken anything off the table or suggested any pre-conditions to our discussions, and I would urge the Administration to take the same approach.

I would also urge the administration to avoid classifying anyone who might have concerns about this plan as a so-called "special interest." Doctors, hospital administrators, pharmacists, and insurance companies are not the enemy. Their voices—like the voices of all Americans—need to be heard and respected throughout this process.

We have before us a daunting task in trying to craft a bipartisan bill—however, I can think of no Committee Chairman or Ranking Member better suited to this challenge. Senators Moynihan and Packwood have each led efforts to resolve some of the more complicated, seemingly unresolvable legislative battles we have confronted—from welfare reform, to re-writing the tax code. I believe with our help, we can again achieve a bipartisan consensus.

There is much upon which we can agree, yet there are also strong disagreements over critical aspects of the Administration's proposal and the proposal the Senate Republican Health Care Task Force has outlined.

Employer mandates, purchasing monopolies, price controls, risks to quality and choice, and the creation of new entitlements are all issues that must be addressed—and I am sure they will be by the First Lady and others.

But in this process of legislative give and take, let us not forget what this issue is all about—its about the health of our people. For there is no issue that more directly affects them than access to health care.

It is for this reason that we must talk honestly with the American people. There can be no "rosy scenarios." There can be no "smoke and mirrors." There can be no juggling of the books. Whatever plan is adopted will require some Americans to sacrifice. These sacrifices must be explained clearly and on the record.

Mr. Chairman, it's no secret that in the days following World War II, I had more than a passing acquaintance with health care. I know what it's like to not be able to afford your medical bills. And I know it's an experience that no American should have to go through.

There can be no doubt that we begin this process united in our goal of ensuring that every American has access to the best health care system in the world.

And as we work to reach this goal, we should remember the often cited Hippocratic principle that guides our health care providers—DO NO HARM.

In solving the very real problems before us, let us not bury the American people under an avalanche of bureaucracy and confusion.

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Thank you, Mr. Chairman, and welcome to the Committee on Finance, Mrs. Clinton.

You and President Clinton are to be congratulated for making health care reform a high priority. You are to be congratulated for putting together a comprehensive plan in a short time. It probably doesn't seem like a short time to you, but it was.

And you should be congratulated for holding our feet to the fire on this issue. Congress, and the country must now come to grips with the problems that afflict our health care system.

You have transformed the reform debate in our country by providing a focus for the public debate and the work that we in the Congress will do together with you in the coming year.

Surely you have it right in insisting that we provide universal access to health care for all our citizens.

Surely you also have it right in insisting that we must get cost inflation in health care under control. We simply can't continue to live with double digit increases in health care costs.

I share the sentiment that we now have what is probably a historic opportunity to bring about important and beneficial change in our health care system.

However, as much as none of us want to hinder the movement toward reform, it is important to speak frankly about the plan and its shortcomings. After all, how will be get this plan in reasonable perspective if we don't offer criticism? How will we help the American public understand the really monumental changes being proposed if we don't speak frankly about our concerns?

I would be less than candid if I did not tell you that there are many aspects of your plan that I find troubling. Some I find merely disappointing.

I am concerned about the financing for the plan. I am concerned about the very great powers that would be vested in new governmental or quasi-governmental organizations. I am concerned about the potential impact on small businesses that the plan might have. I am concerned about how the Medicare program would be treated in the plan. Both of these—the small business impact and treatment of the Medicare program—are very important for my State of Iowa.

I am concerned about the global budget proposal, even though I know from your earlier testimony this week that global budgets are intended only as a fall-back cost containment mechanism.

I am concerned about whether the organized delivery systems might have some potential to ration care. I am concerned about whether the physicians in the organized delivery systems will retain sufficient autonomy to continue to act as the patient's, rather than the company's, advocate.

By now, you will be pleased to hear that I am only disappointed with the medical malpractice reform and the anti-trust reforms proposed in the proposal. Surely you could have gone farther with these.

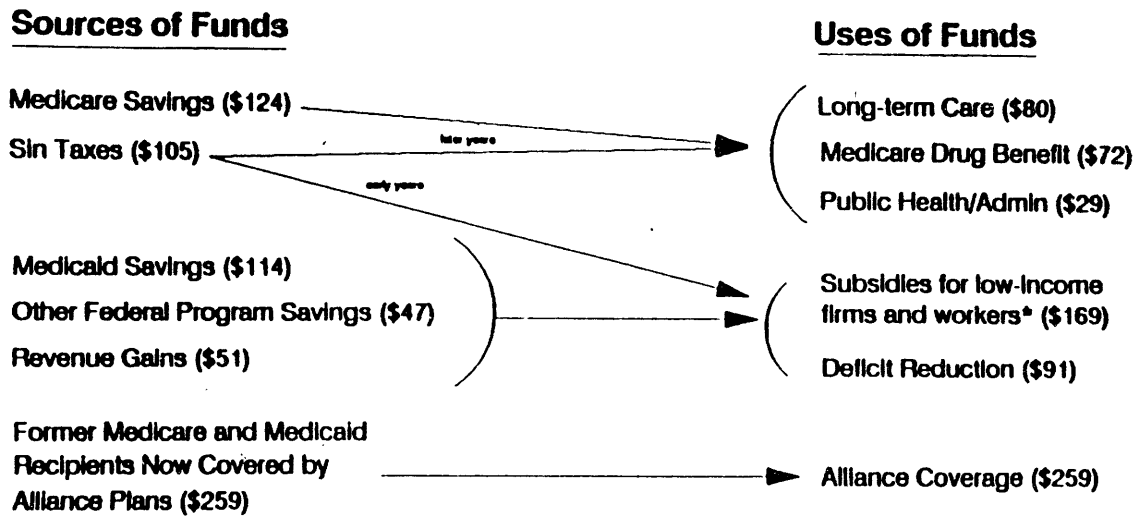
I think you have probably heard all of these concerns in your earlier hearings this week.

It seems to me that they constitute a partial list of the key issues that we will be arguing over in the weeks and months to come.

I want to help make health care reform work for the American people. I want to help to do it right. And I think most of my fellow Senators, and you and President Clinton, are also sincerely committed to doing it right.

I hope that we can.

How Reform Is Financed
($ billion, 1994-2000)



* Includes self-employed tax deduction.

Estimates are preliminary and do not incorporate interactive effects.

[Submitted by Senator Mitchell]

PREPARED STATEMENT OF SENATOR DANIEL PATRICK MOYNIHAN

Over 50 years ago Franklin Delano Roosevelt's Committee on Economic Security, chaired by Frances Perkins, undertook a study of national health care reform. Fearing that certain opposition from the medical establishment might threaten passage of the remainder of the Social Security Act, Roosevelt left health insurance out of the bill. Since then, we have been struggling to fill the gap. Over the past several decades, we have seen Presidents Truman, Johnson, Nixon and now President Clinton issue calls for national health care reform.

In 1943, President Truman—building upon the work of New York Senator Robert Wagner, Representative John D. Dingell, Sr., and Senator James Murray—began his campaign for a mandatory universal health care system. By 1945, he had recommended a comprehensive health program, declaring in a November 19, 1945 special message to the Congress that "Everyone should have ready access to all necessary medical, hospital and related services." He also unequivocally stated that "People should remain free to choose their own physicians and hospitals." Nearly twenty years later, President Johnson on February 10, 1964, asked Congress to establish a hospital insurance program for the elderly and Federal-State programs of medical assistance for the poor. Calling it "a logical extension of the principle—established in 1935 and confirmed time after time by the Congress—that provision should be made for later years during the course of a lifetime of employment" President Johnson persuaded Congress to enact the Medicare program. He signed it, and the Medicaid program, into law on July 30, 1965. President Nixon, less than 10 years later, on February 18, 1971, announced a national health insurance program in which "the public and private sectors would join in a new partnership to provide adequate health insurance for the American people." At the same time, he warned of dramatically increasing health care costs, noting that "For growing numbers of Americans, the cost of care is becoming prohibitive. And even those who can afford most care may find themselves impoverished by a catastrophic medical expenditure . . . ".

We have made progress towards addressing these problems. Our nation possesses one of the best health care systems in the world. We have created Medicare and Medicaid for the elderly and the indigent to protect them against the terror of illness. Yet much progress remains to be made. As a nation we continue to be threatened by the tremendous costs of health care and the rising numbers of uninsured. Over 13% of this country's Gross National Product is consumed by health care expenditures. And over 37 million Americans are uninsured. We simply cannot continue to allow these recurring problems from impeding America's progress.

These pressing issues have once again galvanized the American public and her legislators. This is an historic moment. We have both a consensus and a tremendous will to address a problem that threatens not only the most valuable resources of our nation—our American citizens, but our ability to compete in a global economy. We must address these problems. In the words of the President, "Our history and heritage tell us we can meet this challenge . . . And when our work is done, we will know that we have answered the call of history and met the challenge of our time."

COMMUNICATIONS

STATEMENT OF THE HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

INTRODUCTION

The Healthcare Financial Management Association (HFMA) is pleased to have this opportunity to present its views on healthcare reform as it relates to administrative processes. HFMA represents more than 31,500 professionals involved in the financial management of healthcare institutions, including hospitals, managed care providers, and group practices. HFMA's membership also includes public accountants, consultants, insurance companies, governmental agencies, and other organizations. Given the geographic and professional diversity of its members, HFMA is in a unique position to identify the problems associated with the current claims and patient accounting processes.

HFMA members are involved in all aspects of healthcare administration. For over 20 years, HFMA has actively pursued the goals of uniformity and simplification, including founding and participating in the National Uniform Billing Committee (NUBC) and Accredited Standards Committee X12's Insurance Subcommittee and Healthcare Task Force (which HFMA has co-chaired).

HFMA believes that administrative simplification and the use of uniform data sets and process is one of the keys necessary for significant healthcare reform. This element is essential if costs are going to be extracted from either the current system or any other proposed system.

THE CLINTON HEALTH CARE REFORM PROPOSAL

HFMA is pleased that administrative simplification has become a prominent issue in the Administration's healthcare reform proposal. Many of the broad concepts contained in the President's plan are compatible with the positions of HFMA. There are, however, certain elements which are of concern.

Of primary concern to our membership is that the Administration's plan calls for standardized forms. As we understand it, this would imply that the nation's healthcare system would continue to rely on processing via paper, as opposed to electronic data interchange. HFMA urges that there be a mandate for standardized formats and transaction standards, thereby creating paperless billing processes. This will significantly streamline the current system and result in substantial savings.

Of equal concern is the Administration's provision for state flexibility, including the use of minimum standards and data sets. HFMA strongly believes that this flexibility would likely undermine the benefits of administrative simplification, including the savings that could be achieved through this reform. All providers and third-party payers must be required to use the same formats, utilize the same maximum defined data sets, and use the same electronic processes. If states or plans are given the flexibility to change or augment a format, extend a data set, or use a different process, then uniformity—and thus savings—is precluded.

In addition to state modifications, use of minimum standards would allow third-party payers to require additional input on their forms. It is these additional input requests that cause administrative burden and unnecessary costs. This is particularly true as historically every payer has desired something different.

It is important to note that uniformity and standardization does not mean that formats, standards, and data sets can never be changed. Rather, it points to the need for an independent body, such as the commission proposed by the Administration, to carefully review and permit uniform changes to such standards. This commission could also allow for local experimentation to achieve innovation without creating additional burden to the system.

HFMA COST STUDY

It is widely held that inefficiencies in the current administrative processes are a major contributor to the high cost of healthcare. To substantiate this theory, HFMA contracted with Lewin-VHI, a nationally recognized independent consulting firm, to research the potential cost savings once simplification is realized. The study found:

- Administrative costs in 1991 totaled approximately $126 billion, or 17 percent of total health expenditures.
- Administrative costs can be broken down into three components: $45 billion was spent by hospitals; $43 billion was spent by physicians; and $38 billion was spent by payers.

The study also examined the cost and savings potential of a legislative proposal developed by HFMA. A summary of this proposal is attached. Lewin-VHI concluded in their findings:

- It would cost approximately $800 million per year to implement HFMA's proposed administrative simplification processes.
- *Implementation of HFMA's proposal would save $3.4 to $6.0 billion annually.*

At this point, the Clinton Administration's proposal seems to embrace many of the concepts incorporated in HFMA's initiative. Therefore, it is reasonable to assume substantial savings could be achieved by such administrative simplification reforms.

MANDATED CHANGES ARE NECESSARY

For over two decades, healthcare providers and third-party payers have worked toward administrative uniformity. While it is generally agreed that this is essential, efforts to achieve it thus far have been inconsistent. The primary cause of this is that use of the standardized formats created by the various healthcare groups are voluntary. HFMA believes that total uniformity of healthcare administrative processes and systems will not be accomplished unless mandated under law. The change in law must require all providers and third-party payers (public and private) to adopt uniform, standard, electronic processes and data definitions. Without such a requirement, the healthcare administrative process will remain complex and costly.

HFMA's analysis of the administrative burdens currently challenging the healthcare industry are summarized by the following points:

- Standard uniform transaction formats and processes for healthcare claims are readily available, but not used consistently by all participants of the healthcare delivery system.
- Within most data transaction systems, any request for additional information that is not included on the original electronic form results in the submission of paper documents, thereby negating the advantages of an electronic transmission.
- Current development of electronic data interchange standards have included data transmission standards, but there is no uniform convention for the use of these standards and no agreement on a uniformly defined maximum data set. Any improvement in electronic processing by the industry must require uniformity or the industry will be compelled to maintain costly multiple systems.

ACTIVITIES OF THE INDUSTRY TO ACHIEVE UNIFORMITY

Over the past 20 years, as a participant on NUBC and ANSI X12, HFMA worked closely with other healthcare representatives and the government to achieve uniformity. The NUBC established the UB–82, a uniform bill form and accompanying data set. It has recently been replaced by the UB–92. While the Association cannot predict the value of the UB–92, the use of the UB–82 has been limited in generating uniformity.

The UB–82, implemented in 1983, was designed to provide a uniform format for the submission of hospital-based claims. Although it satisfied the goals of a uniform bill, some payers began almost immediately requiring additional information that was not contained on the uniform bill. As a result there are currently about 50 different versions of the UB-82, representing the variances of each state uniform billing committee. In addition, as many as 420 different electronic versions of the UB–82, representing various payer versions of this data set also exist. *Thus, the uniform bill is not used uniformly and providers must submit supplementary data on demand or they will not be paid.*

Some of the factors that lead payers to detour from standard requirements and forms are:

- ERISA-based self-insurance plans, which are exempt from any state legislative initiatives attempting to alleviate a state-specific problem;
- Medicaid, whose date requirements and standards are governed by each state differently; and
- Workman's compensation, which has differences similar to Medicaid.

CONCLUSION

HFMA advocates comprehensive healthcare reform and is pleased that administrative simplification is a part of emerging reform proposals. It is the Association's position, however, that simplification must be enacted with mandated, maximum, standardized formats and processes. These formats and processes must be defined and overseen by a commission, which includes industry-based representation. A reasonable timetable must also be allowed. Such requirements will facilitate the use of electronic claims processing and void the need for paper documentation.

The Healthcare Financial Management Association appreciates the opportunity to present its views on healthcare reform as it relates to administrative simplification and savings associated therein. Our members, who are engaged daily in the management of healthcare financial operations, are available to provide guidance to the Committee as decisions are made on simplifying the system. By taking the steps necessary to create a standardized claims processing system, administrative burdens will be lowered. The results will be diminishing costs created by duplicative efforts and paper processing.

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