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# PRESIDENT'S HEALTH CARE REFORM LEGISLATION

## HEARING

BEFORE THE

## COMMITTEE ON FINANCE
## UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

OCTOBER 28 AND NOVEMBER 3, AND 4, 1993

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### COMMITTEE PRESS RELEASE



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### OPENING STATEMENT

# PRESIDENT'S HEALTH CARE REFORM LEGISLATION

THURSDAY, OCTOBER 28, 1993

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

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Present: Senators Baucus, Bradley, Riegle, Daschle, Breaux, Conrad, Packwood, Roth, Danforth, Chafee, Grassley, and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H–41, October 22, 1993]

FINANCE COMMITTEE TO HOLD HEARING ON SUBMISSION OF PRESIDENT'S HEALTH CARE PLAN; SECRETARY SHALALA 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 next Thursday on the President's health care reform legislation, which is expected to be submitted to Congress the previous day, Wednesday, October 27. Health and Human Services Secretary Donna E. Shalala will testify before the Committee.

The hearing will begin at *10:00 a.m. on Thursday, October, 28, 1993,* in room SD–215 of the Dirksen Senate Office Building.

"We are looking forward to receiving the Administration's health care reform proposal Wednesday and hearing from Secretary Shalala the following day," Senator Moynihan said. "After holding a series of hearings on problem areas in our health care system, the Committee will now begin looking in detail at the Administration's plan to improve the system."

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

The CHAIRMAN. A very good morning to our distinguished guest, witness, and our audience this morning. As I am sure Senator Packwood agrees reality time has arrived, for here we have the Health Security Act.

Senator PACKWOOD. I am not strong enough to carry it, Mr. Chairman.

The CHAIRMAN. But if it drops on you, you are guaranteed coverage. [Laughter.]

This is the first day of formal hearings on the Health Security Act, which the President has now sent to the Congress in very attractive ceremonies that were held yesterday. The bill has not been introduced. So it is not properly before our committee, but the subject clearly is.

We are going to have a year of work and well before this time next year, I hope we will be wrapping up the bill. We plan to proceed with great attention to detail. Detail is what we are talking about now. I am not going to make any more by way of an introductory statement than to welcome Dr. Shalala.

I see Dr. Feder is here. We welcome you, Dr. Feder. Are you in the administration now?

Dr. FEDER. Yes, sir. I have been for some time.

The CHAIRMAN. What are you in the administration?

Dr. FEDER. I am the Principal Deputy Assistant Secretary for Planning and Evaluation working with the Secretary.

The CHAIRMAN. At HHS. Congratulations.

Dr. FEDER. Thank you, sir.

The CHAIRMAN. Dr. Vladeck, who is the head of HCFA, which always sounds like one of those ailments that we get cured of. But we welcome you, sir.

Dr. VLADECK. Thank you, sir.

The CHAIRMAN. And Dr. Thorpe.

Do you have a statement?

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

Senator PACKWOOD. Madam Secretary, as you are well aware, I am one of the Republicans that has not been overly critical of the President's plan, and I am not now. I think what the President and Mrs. Clinton have attempted to do has been a herculean effort.

It has been done as well and as thoughtfully as any administration that I have seen in the past work on this problem, including the Nixon Administration 20 years ago when I introduced a bill for the President and I am happy to claim partial credit for it, that does not vary all that substantially from what you are trying to do.

Needless to say, are we concerned about costs? Sure. You are. The President and Mrs. Clinton are. All of us do not want to get into any open-ended obligations and we have all been burned in the past, thinking we knew what the costs were and have missed every time. There is no way you can guarantee or we can guarantee that what we write on paper is going to be the way it is going to work out.

God did not make any of us so apprisient that we know the future. Fortunately, it would be kind of dull if God was able to do that.

But I am going to work with you. I am convinced we will get a bipartisan health insurance plan that will have overwhelming Republican and Democratic support. While there are some modest questions I have about your plan, and we are all concerned again about costs, and about bureaucratic overlay, at the end of the day I think we will have a plan that we can mutually be proud of and we will pass on a bipartisan basis.

I might say, Mr. Chairman—and I am going to issue my apology now—something has come up of obvious immediate importance to me and is going to require me to be at a meeting at 10:15.

The CHAIRMAN. Sure. I think it was noteworthy and very agreeable that President Clinton yesterday noted that President Nixon

had sent a health care proposal to the Congress and I believe you introduced it.

Senator PACKWOOD. I introduced it and it was an employer mandate plan. It had minimum benefits in it. It had some co-insurance and deductibles and indicated how employers/employees would pay for it.

As I say, the outlines of it are very similar to the President and Mrs. Clinton's plan.

The CHAIRMAN. If we had adopted the Family Assistance Plan a century ago, we probably would not be here today.

Senator PACKWOOD. Well, you know, the irony, and then we will let Madam Secretary get on, the irony on both the Nixon Health Bill and the Family Assistance Plan is that it was killed by mutual opposition from the right and the left.

The CHAIRMAN. Yes.

Senator PACKWOOD. In both cases. It is the old strange bed fellows part that some liberals had some terrible objections to both plans and some conservatives had some terrible objections to both plans, and that was enough.

The CHAIRMAN. Well, you went to NYU and you know that rule in New York, when you are caught between left and right, the only way to go is down. [Laughter.]

Senator PACKWOOD. Thank you, Mr. Chairman.

Excuse me, Madam Secretary.

The CHAIRMAN. Madam Secretary, we welcome you. Would you proceed just exactly as you choose. You have a very lengthy statement, for which we are very appreciative. You proceed with it just as you like.

**STATEMENT OF HON. DONNA E. SHALALA, PH.D., SECRETARY OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY DR. JUDY FEDER, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DR. KEN THORPE, DEPUTY ASSISTANT SECRETARY FOR HEALTH POLICY, AND DR. BRUCE VLADECK, ADMINISTRATOR, HCFA**

Secretary SHALALA. Thank you very much, Mr. Chairman. I am delighted to be here bringing the plan along. Let me just quickly make sure that I have properly introduced all my colleagues.

Ken Thorpe is the Deputy Assistant Secretary for Health Policy in the Office of the Assistant Secretary for Planning and Evaluation. The Secretary of that office is David Ellwood, who you well know.

Judy has already introduced herself. Let me say that Ken and Judy have been the key policy architects of the President's plan. They have spent almost full-time working on the issue long before the President took office because they were the key players involved in the campaign in the development of health policy and now hold those senior positions, the senior health policy positions, at the department.

Bruce Vladeck comes to us from the New York Hospital Fund and was in a previous life also a public official, Associate Director for Health in the State of New Jersey. So he brings both public and private experience as do my two colleagues from universities.

I brought them with me today, because I believe that between us we actually can answer most of the detailed questions about the plan. And since this is our first formal presentation as an administration, I am also going to cut down my own presentation, submit the long testimony for the record, and move to a shorter version of it. Then I will go through a series of charts.

The CHAIRMAN. Fine. We will put your full statement in the record. And as I said, proceed just as you wish.

[The prepared statement of Secretary Shalala appears in the appendix.]

Secretary SHALALA. Thank you. As I indicated, it is a pleasure to be here this morning to discuss the President's Health Security Act. It is indeed, as indicated by the ceremony yesterday, a momentous occasion and the next step in a process that I believe will lead to a better, stronger and more secure health system for all the people we serve.

Mr. Chairman, it is only fitting that this process begin with you. As the national guardian of our Social Security system, you know better than anyone the importance of taking this next step towards providing our Nation with health care security.

It is heartening to note that more than 28 Members of the Senate have already asked to co-sponsor the President's plan, when our distinguished majority leader introduces it.

We are especially pleased and grateful for your support, Mr. Chairman, as well as six other members of this committee. In addition, we already have requests from 43 members of the House to co-sponsor the bill in that chamber, including all of the chairmen of the major health committees and their health related subcommittees.

The President's proposal seeks to fix what is wrong with our health care system and to preserve what is right. It seems to strengthen all elements of the system, so that those Americans who fall ill, and those who want to preserve and improve their health, can rely on a high quality system that is affordable, portable and permanent.

We in the administration have worked for many months to craft a proposal that addresses the serious deficiencies in our current system. We have consulted with hundreds of experts, including nearly all members of the Congress. We have gone directly to the people of this country to hear their complaints, their hopes and their dreams.

What we have found is that the American health care system has lost sight of the patients it is designed to serve. We must change the system, so that it is clearly understood, and so that it cares for all Americans when they need it.

During the last 5 weeks, we have gone over the numbers in our plan, scrubbed them and rescrubbed them, and I guess I would prefer more formal terms—that is rigorously reviewed them—so that we can explain with confidence to you and to the American people how this plan will work.

Let me assure you, there are no rosy scenarios here. There are no magic asterisks. There are conservative numbers that we believe will stand the test of public scrutiny.

As you can see from our first chart, under the President's plan 76 percent——

The CHAIRMAN. I have to say to you, Madam Secretary, there is a quadrant that looks suspiciously rosy from here. [Laughter.]

Secretary SHALALA. I think it is orange. [Laughter.]

The CHAIRMAN. Well, it is just going to be that kind of a day. I can tell.

Secretary SHALALA. We try to avoid those colors. I think a high percentage of men are color blind. [Laughter.]

The CHAIRMAN. There you are.

Secretary SHALALA. It is somewhere in my briefing books.

Seventy-six percent of the financing of the health care system will comes from employers, employees, and other individuals making their contributions to the cost of the premiums. The remaining 24 percent will come from government.

The CHAIRMAN. Our audience cannot see. It is 59 percent from business; 17 percent from households; and 24 percent from government. Is that right?

Secretary SHALALA. Yes.

The CHAIRMAN. That is important and a basic proposition.

Secretary SHALALA. We can account for every dollar we spend. The Federal share of health spending, as you will see from the next chart, will amount to $389 billion over the 5-year period of 1996 to the year 2000.

The next chart shows that we generate that money in the following way. I would like to go through it very carefully at this point.

The CHAIRMAN. Sure.

Secretary SHALALA. $124 billion will come from savings achieved in the Medicare Program. Mr. Chairman, I am well aware that you have raised some very tough questions about whether this is achievable. Let me assure you that we are prepared today to go through each of our recommendations in that area. But let me just give a feel in my testimony for a couple of the numbers that we expect that we can achieve.

One-quarter of the total of the Medicare savings will come from extending the policies that were adopted earlier this year in the Budget Reconciliation Act. If you will remember, in the very difficult negotiations——

The CHAIRMAN. We are not likely soon to forget.

Secretary SHALALA. Yes.

Well, many of those recommendations in the $56 billion were extended for 1, 2, or 3 years. What we have done is extended them further. But they are issues that already have been reviewed by the Congress and, therefore, the substance is well known in terms of the adjustments.

Another quarter comes from reducing subsidies built into Medicare to account for the uninsured. So that gives you a sense of what 50 percent of the Medicare numbers will be. We are prepared today, and Dr. Vladeck is here, is we could actually go through the entire $124 billion to actually give you a sense of what those numbers are.

I think that is very important, because we have not just thrown on a cap. We have actually looked through the program, hopefully

protected the beneficiaries, and proposed a series of recommendations.

Let me keep moving down the numbers and describe the Medicaid savings that are identified here. $65 billion will be saved in the Medicaid Program by enrolling the remaining Medicaid beneficiaries in private health plans and reducing the disproportionate share hospital payments.

We have not taken the entire amount of money out of disproportionate share, but we are assuming that once everyone is covered most of the disproportionate share money, which is now provided through the Medicaid Program would no longer be needed.

We believe we will save another $40 billion in other Federal programs, including the government employees, military and veterans health care programs as they come into the new program. And another $71 billion in Federal revenue will come as a result of slower growth in tax-exempt health spending and other kinds of changes. We can go through that in detail for you today, too.

And finally, we can gain $89 billion by increasing the Federal excise tax on cigarettes from 24 cents to 99 cents a pack and imposing a 1 percent of total payroll assessment on companies that form corporate alliances. These companies choose to be outside of the general regional alliance, and have to have 5,000 employees or more.

Mr. Chairman, I should note that this chart does not reflect the transfers of funds from Medicare and Medicaid as some of these beneficiaries receive coverage in an alliance. We could explain that further, too. This is the total sources though outside of a Medicaid recipient coming directly into the program.

In the 5 weeks since the President addressed the Congress, we have spent much of our time listening to law makers here on Capitol Hill, and to legislators, and to Governors in our State capitals. We have listened to doctors, nurses, and hospital administrators, and we have listened to the American people since the President's speech.

I personally have traveled to Los Angeles, CA, to Burlington, VT, to Billings, MT, to Bangore, ME, to Detroit, MI, to Portland, OR and to Louisville, KY.

What we have heard has helped us to improve our plan. But let me make one thing clear. The one thing that has not changed is the core set of beliefs that have guided us from the start. The President has laid out six principles that are at the core of our proposal and must be at the center of any health reform bill enacted by the Congress.

They are security, simplicity, savings, choice, quality and responsibility. If any of these principles is dominant, it is security. Under our current system, no American has true security. Most workers who lose their jobs lose their insurance in this country. People who change jobs often lose their insurance or almost certainly have to change their coverage.

Families stricken by illness face the added burden of trying to make sure their coverage will not disappear. And conscientious businesses and individuals who attempt to buy insurance often are priced out of the market. To solve this problem, the President's plan builds on the existing structure of health insurance, but

makes sure that all of our citizens are covered by a quality health plan they can afford.

To achieve that, the plan asks States to create regional health alliances to help consumers and employers purchase the coverage they need. It asks employers to pay at least 80 percent of the average premium cost for a plan in their area. And it asks workers to pick up the remainder.

Every health plan will offer a comprehensive set of benefits to provide all Americans with the kind of care that our health professionals tell us is best. It is a package that has a strong emphasis on prevention. It is a package that covers inpatient and outpatient care. It is a package that offers specialty and primary care. It is a package that improves on our mental health and substance abuse treatment coverage to help remove the stigma attached to those conditions.

We recognize that these new requirements may pose a temporary challenge for some smaller companies, particularly those that currently do not offer coverage. As the next chart shows, we provide significant discounts for employers that will hold the cost of coverage to no more than 3.5 percent of payroll for small low-wage firms, going up to 7.9 percent of payroll for companies that have more than 75 employees.

The majority of Americans should have no trouble paying the 20 percent individual share. They now pay that or much more today. But for those with low incomes and for retired workers between the ages of 55 and 65, the Federal Government will provide discounts.

To further reduce the cost of coverage——

The CHAIRMAN. Would you just help one who is not easily——

Secretary SHALALA. Yes, sir. This is the percentage of Americans that are currently uninsured.

The CHAIRMAN. But the term "discount," what does that mean?

Secretary SHALALA. Well, rather than sending a check directly for each individual, the Alliance will get subsidies for these individuals.

The CHAIRMAN. What is a subsidy?

Secretary SHALALA. A direct payment——

The CHAIRMAN. Do you mean money?

Secretary SHALALA. It is money.

The CHAIRMAN. Okay. Good.

Secretary SHALALA. The discount simply allows the individual not to put out the cash and then get the money back. Rather, they will pay less to the Alliance for their premium. So we are using the term discount. This is all money.

The CHAIRMAN. Good. Good.

Secretary SHALALA. To further reduce the cost of coverage, the plan reforms the insurance market to eliminate underwriting practices that weed out the sick and cover only the healthy.

No insurance company will be allowed to turn away anyone seeking insurance because of a pre-existing medical condition. And by returning to the historic method of community rating, we will make sure that individuals in small businesses are protected from sharp——

The CHAIRMAN. Can I ask, was community rating always the practice and then was changed in a way that has to be reformed? Reform means to restore to its earlier state.

Secretary SHALALA. That is right. We originally had community rating in this country.

The CHAIRMAN. Is that the only kind of rating we had?

Dr. VLADECK. Prior to the immediate post-World War II period, almost all private health insurance in the United States was community rated.

The CHAIRMAN. Good. That is a good point to make.

Secretary SHALALA. So by returning to community rating, we will make sure that individuals in small businesses are protected from sharp premium increases.

Together, we think that these changes will result in universal coverage of our population. In contrast, as the next chart shows, if we do nothing, the number of uninsured will grow from 37 million to 55 million by the end of the decade; and that is reflected in these percentages—ordinarily one out of five Americans.

Another important element of security is predictability. Today individuals and business owners cannot accurately predict what their insurance will cost them. Under the President's plan, all players will know in advance what their coverage costs and be able to plan accordingly.

Health plans will actually set four types of premiums. One covering single individuals; one covering couples; one covering single-parent families; and one covering two-parent families. For 60 percent of Americans, these costs will be lower than what is spent today.

For most of the remaining people, the cost will be slightly higher, but they will get better benefits. Only a few will pay more without gaining additional benefits. But for every American——

The CHAIRMAN. May we ask, those few, we will hear from those few.

Secretary SHALALA. Yes.

The CHAIRMAN. How few of them are there? [Laughter.]

Secretary SHALALA. About 15 percent. About 15 percent, many of them are high income.

The CHAIRMAN. One American in seven?

Secretary SHALALA. Yes.

The CHAIRMAN. With high incomes, such as——

Secretary SHALALA. No, it is also—remember, there are large numbers of people who are uninsured, too, who will be paying for the first time.

The CHAIRMAN. But let us hold on this for a moment.

Secretary SHALALA. Okay. We can go through the actual numbers if you would like us to.

The CHAIRMAN. Yes, I think that would help. We are into the number stage.

Secretary SHALALA. That is fine. We would be happy to.

Dr. THORPE. Among the population that currently has health insurance, about 6 in 10 will pay less and receive similar benefits. And a lot of the paying less has to do with the savings built into the system—lower administrative costs, a more efficient system.

Of the remainder, about half of them would pay a little bit more to get better benefits. So these are individuals that have benefits that are not as comprehensive as what is included in the President's plan. So they would pay a little bit more, but they would have the comprehensive set of benefits.

The remaining 20 percent would pay a little bit more, largely due to the fact of moving to community rating. These are individuals that are paying less now, largely because they have negotiated special deals with insurance companies because they are younger and have not incurred health expenses. Insurance companies have sought them out.

The CHAIRMAN. Or have they simply entered plans which are limited to persons of their circumstance, compared to individuals that negotiate a plan with an insurance company? But there are plans that say, if you are 25 to 35, that is what you mean?

Dr. THORPE. That would be the remaining group.

Secretary SHALALA. We actually have broken those numbers down by the number of dollars they pay. So we know the percentage that will pay $100 more a year or $200 more a year. So we can actually be pretty specific in this area.

The CHAIRMAN. Good. Let us have that.

Secretary SHALALA. Yes.

The CHAIRMAN. Because we are just told, and I would have the committee note, that we have just been told that the 40 percent of persons who now have insurance—and I would assume that in the whole population, that is getting close to 100 million people, is it not? Yes, 40 percent of the population would be close to 100 million people; 100 million people will have their premiums, their costs, go up, and of those, 50 million roughly would have their benefits improved and the rest would not because they would be in an insurance setting.

Dr. THORPE. Let me just clarify that if you look among those that have a slight increase that the increase among the people——

The CHAIRMAN. Just the facts, no slight.

Dr. THORPE. The increase would be as following, so I can give you the specifics.

The CHAIRMAN. Yes.

Dr. THORPE. This is based on the yearly basis of those that would pay some more, 96 percent would pay under $500 per year. They would pay a maximum of $500 per year more.

The CHAIRMAN. Fine.

Dr. THORPE. But most of them are on the $100 more per year range.

The CHAIRMAN. We will really want to know that. This committee has dealt with very slight changes in Social Security, with very large responses.

Dr. THORPE. The second point that I want to make is that these numbers are assuming the first year of implementation before the savings have kicked in. So if you look at what these individuals are paying today and what they would pay in the year 2000 versus what they will pay in the year 2000 under the President's plan, that 40 percent number, which I do not have with me, but it is substantially less and I will quantify substantially for you.

Secretary SHALALA. Senator, I hope that what this demonstrates is how much detailed work we have done now so that we can answer questions and how sophisticated, the analysis is with all the caveats about estimates and everything else.

Let me also say that for those that are paying more, because both you and I and everyone else will be talking about the plan, the President's plan does provide a kind of piece of mind that no actuary can price. That if you do have to pay a little bit more, you also get with that the portability of the plan and the security of knowing that your plan will never go away.

I think there is some indication that Americans are willing to pay a little bit more if they get that kind of security with their plan, as well as some more stability in terms of premiums going up, which is what has really both impacted on businesses, but also on individuals and their inability to predict that.

Let me talk a little about the estimated national average premium costs, which were calculated in 1994 dollars, to give you some sense for what we think the national—if we had a national premium, we will, of course, be calculating these by alliance—$1,932 for a single person; $3,865 for a couple without children; $3,893 for a single-parent family; and $4,360 for a two-parent family with children.

These are display numbers, obviously, to give us some feel for if we calculated the premium in 1994, what we think a national premium would be.

Now these amounts, obviously, are going to vary from state-to-state and from community to community. But the national averages do give us a good idea of how reform will change our current system for the better. In order to preserve security, we have to control the cost of health care.

Through changes in the competitive market, the President's plan places restraints on growth that will still allow spending to increase, but by an amount much closer to the rise in other consumer prices.

To ensure that these changes achieve the necessary savings, the plan creates a backstop system of enforceable premium caps to make sure that no one will pay more for coverage than is appropriate. The President's plan extends the concept of cost containment to all payers, public and private.

By applying reasonable limits to the growth of Medicare, we will curb the rate of that program's annual growth—you will see it on the next chart—from almost 11 percent to 8.4 percent at the end of the decade. And in this chart, Senator, we have built in the new drug benefit.

If the new drug benefit was not there, of course, with reform we would probably be around 7 percent. Ken?

Dr. THORPE. 7.4 percent.

Secretary SHALALA. 7.4 percent. So the new drug benefit adds a percent to the average annual growth rate. But that gives you a sense of the impact of the slowing down of the growth that we are recommending in the Medicare program and the new prescription drug benefit as we put those savings back into the Medicare Program.

Without such coverage, many of our senior citizens are delaying the purchase of prescribed medications, independently changing their dosages to make prescriptions last longer and even trading unused portions of prescriptions among neighbors.

Mr. Chairman, of all of the things that we can do to improve American's health, we feel very strongly that stabilizing a drug benefit for the elderly will improve their health, knowing what we know about the number of elderly that end up in the hospitals because they have not been taking their drugs or get sicker because they have not been taking their drugs, or trade off every month trying to decide whether they will buy food or drugs.

The CHAIRMAN. We have some data on that.

Secretary SHALALA. Yes.

The CHAIRMAN. And you let us have it, I am sure, Dr. Feder.

[The information requested follows:]

RE: DATA REGARDING SENIORS AND PRESCRIPTION DRUGS

There are several studies which support the conclusion that the lack of a prescription drug benefit has a negative impact on the health and well-being of seniors.

A June 1992 AARP-sponsored study conducted by Chilton Research Services found that of Americans over 45 who do not fill their prescriptions, 14 percent did not do so because of the cost of the drug. Although most seniors do not have to cut back on food or fuel to pay for prescription drugs, 10 percent reported that they do cut back on necessary items. Having to cut back on necessities affects groups at different rates: low income households (26%); those in fair/poor health (19%); nonwhites (17%); females (13%); and households with continuous or regular prescription drug users (12%).

Furthermore, there is evidence that limited access to prescription drugs increases the risk of institutionalization of the elderly. An October 10, 1991 study in the *New England Journal of Medicine* by Stephen B. Soumerai, et al., showed that when reimbursements for medications were limited, there was a 35 percent decline in the use of study drugs; furthermore, the relative risk of admission to a nursing home was 2.2. The study concluded that "limiting reimbursement for effective drugs puts frail, low-income, elderly patients at increased risk of institutionalization in nursing homes and may increase Medicaid costs."

Secretary SHALALA. The President's plan also ensures access in mainstream medical system for our Medicaid population. We will give them health security cards that will make them indistinguishable from other Americans. They will enroll in a mainstream medical system that gives them the same benefits enjoyed by everyone else, plus additional services traditionally provided through Medicaid to allow access to the health care system. In that I am talking about some of the wrap-around benefits that have been fit with the Medicaid Program.

We all know that the current system is too confusing, too intimidating, and too expensive. We force our health professionals to waste their time filling out multiple forms and filing multiple claims. The President's plan will do away with more than 1,500 often conflicting claim forms now in use and substitute a single form that will be easy to understand and easy to complete.

Another key to security is simplicity. The system we propose will make it easy for consumers to gain access, to get the care and counseling they need, and to go on with their daily lives as the next chart shows. Now this chart actually demonstrates, if you are in a small business, are an individual, or even if you are in a large business that chooses to come in the general health alliance, basically

what you do. The alliance organizes the health plans and you get a choice of health plans. At least one of them will be fee-for-service.

If you opt out your 5,000 or more and form your own alliance, you will select three health plans that your employees will choose from. One of them must be fee-for-service. But again, it will be the same process.

The CHAIRMAN. Could we just inquire? The 5,000 or more category, does that include governmental units?

Secretary SHALALA. No.

The CHAIRMAN. So that would just be private firms?

Secretary SHALALA. Yes.

The CHAIRMAN. Would it be universities?

Secretary SHALALA. Private universities will be included in the 5,000 or more category public universities will not.

Dr. FEDER. Essentially, all public employees and privates below 5,000 are in the alliance.

Secretary SHALALA. This is a good question. A private university, which has 5,000 or more employees—Harvard University, for example would be treated like a corporate and could opt out of the system and set up its own alliance. That would not be true of the University of Wisconsin, which is part of the State Government system in Wisconsin.

The CHAIRMAN. And Cornell University, which is really mostly private but happens, in fact, although nobody knows it, to be our land grant university in New York State You will find the answer to that.

Senator GRASSLEY. Mr. Chairman, did your question include Federal employees?

The CHAIRMAN. Yes, I assume it did. I was told that Federal employees do not opt out, they are public.

Secretary SHALALA. They are public. Federal employees do not opt out of the system. They join the alliance in their region.

The CHAIRMAN. Then one question more. How many corporate firms are there with 5,000 or more employees? There cannot be that many.

Dr. THORPE. I do not have the firm count. I know there is 19 million workers out of a pool of about 123 million workers that are in firms of 5,000 and above.

The CHAIRMAN. Telephone companies and such, utilities, would be a large portion, I would think.

Secretary SHALALA. Well, GM and IBM.

The CHAIRMAN. You would be surprised how much smaller they are than they were. But go ahead. We would like to get that number.

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

*Question.* How many corporate firms are there with 5,000 or more employees?
*Answer.* 1,200.

The CHAIRMAN. Senator Roth?

Senator ROTH. In many people's opinion, the Federal Employee Health Benefit Plan is working very well. It covers millions of people. I think 8 or 9 million altogether. The premiums are much lower than private sector plans. Why do we dismantle that program? Why do we not use that as a building block?

Secretary SHALALA. Well, in some sense we are using them as a building block because it is out of our experience with programs like the Federal program and the Calpers program that we believe that alliances, making choices the way the Federal program does of plans, ought to be extended to every other American. So in Washington, D.C. the Federal program will disappear inside of a similar, but larger alliance.

I think, Judy, do you want to add something to that?

Dr. FEDER. No, I think that our concern here has been to treat Federal employees as part of the community in which they live.

Senator ROTH. But why do you not include the post office then?

Dr. FEDER. The postal workers, have had a distinct bargaining relationship with the government.

Senator ROTH. But, there are also other union plans with negotiated terms. What about them?

Dr. FEDER. The relationships have been different. We have incorporated that specific difference in it.

Senator ROTH. Is it politics that makes the difference?

Dr. FEDER. The historical difference is there and we have incorporated that historical difference.

The CHAIRMAN. I might say to Senator Roth that obviously we will have to have a special morning on this subject, and we will. No, there are differences. The postal employees organized as a union in the 1880's. And in the 1960's they got recognition from President Kennedy and there is a century-long relationship.

Treasury employees have been organized, typically employees at HHS have AFGE, some portions, some do, so do not.

Senator ROTH. The real point I was trying to make, Mr. Chairman, is that FEHBP seems to be working very well. It seems to me that it could be utilized as a building block in which you would open it up to small business and could cover millions of more workers without creating a new bureaucracy.

The CHAIRMAN. I have a sense that we may be present at the beginning of the Roth bill. But we will get to that, sir.

Senator ROTH. Thank you, Mr. Chairman.

Secretary SHALALA. We believe that the new system is structured from the consumer's viewpoint. It is clear and concise that for most people it will not be much different than the way they get health care now.

An important element of that system will be the new health alliances. They will provide consumers and business owners real clout in the often daunting negotiations with insurers. Through the alliances, small firms and individuals will gain access to high-quality coverage at the same price as big firms and under the same rules.

The alliances also will guarantee choice by making sure that a variety of plans are available, including a fee-for-service plan and a point of service option in every part of the country. Once coverage is purchased, the alliances become consumer protection watchdogs that help with any question or problems that arise.

Once empowered, consumers and businesses must be ready to take responsibility for their coverage and their care. And the President's plan offers Americans a great deal. And in return, we also believe it asks something of everyone.

Employers and employees are asked to contribute to the cost of their coverage. In return, all companies play by the same rules and all Americans have coverage, the same kind of coverage that cannot be taken away.

The President's new plan asks health care professionals to provide high-quality care to all Americans at a reasonable cost. And in return the plan ensures paying customers and allows providers to spend their time with patients, not with paperwork.

It asks State and Local Governments to maintain their current efforts, particularly for the poor and the disabled; and in return states get the maximum flexibility to design their systems to meet their local needs.

In conclusion, Mr. Chairman, I believe we have come to a historic crossroads, one that allows us as public servants to leave behind the tangible evidence of our work and our caring, to fulfill one of the great unfinished agendas of our Nation and to create a sense of lasting security for all Americans on one of the most personal of issues, health care.

Working together, we can create a system of health care that provides every American with health coverage that can never be taken away. We can devise a system that is easy to understand by all Americans. And we can come up with a way to save our resources and to spend them wisely.

In doing so, we must protect and improve the quality of our Nation's health system. We must expand, rather than contract, the right to choose a health plan and a health provider. And we must ask all Americans to act responsibly and to be responsible. We can do this. We should do this. And together I know we will do this. Thank you very much.

The CHAIRMAN. By golly, the way you have us going, you convey conviction. You impart conviction. We are so pleased to have you and this distinguished group. Let us go to questions now.

I will ask each of us to keep to 5 minutes, and if I may, I will start. Just to be clear, I think, Dr. Thorpe, we found your 40 percent. It is in the Secretary's testimony—the Urban Institute's TRM micro-simulation model. It shows that 60 percent spend less under reform; 40 percent more under reform.

It has the variation from $100 to $500 to $1,000. So we have that and we will get it broken down into actual intervals. If 40 percent of insured Americans are going to pay more, we are going to have to persuade some of those that they are going to get more; and others on balance it is their civic duty. We are not always very good at that.

But because we are not very good at it does not mean it will not happen. But now a good portion of the uninsured will pay more, will they not? Dr. Feder indicates that. I can think of a young man in New York City who is related to me, who being 33 years of age, thinks he is immortal and incapable of any injury whatever and has no health insurance. He is going to have to get it now, right?

Secretary SHALALA. Yes.

The CHAIRMAN. He will not be pleased. He will be better off, but he will not be pleased. So we face the prospect that perhaps half the population will find itself paying more in health premiums. That is about right, is it not?

Dr. THORPE. Well, that is correct if the plan was implemented in 1996 and when it is folded in during 1996. I think the important point to make, however, Mr. Chairman, is that during the next 5 years, after implementation, that the number of people who pay more from those figures shrinks very quickly.

The main reason is that the rate of increases in their premiums are going to be much lower than they otherwise would have met.

The CHAIRMAN. The rate of increase and decrease.

Dr. THORPE. That is exactly right.

The CHAIRMAN. Well, fine. Give us a spreadsheet on that. We will look forward to those numbers.

[The information appears in the appendix.]

Secretary SHALALA. Senator, one of the points, though, is they are paying more for premiums. We have not calculated what, if they had an emergency in their family last year, they were uninsured, what they paid in their out-of-pocket expenses.

That is why this health care is so personal, because everybody is going to translate the premium in the light of what they spent last year and what their actual expenses are for health care. But there is always going to be the 33-year-old in New York who believes he is immortal.

In fact, there is a large group of young Americans who believe they are immortal, who do not think they ought to be paying out of relatively low wages for health care.

The CHAIRMAN. Sure. Well, we will get those numbers and we will scrub them and work at them as the doctors say.

I have just one question I wanted to put to you because it was raised on the House side. It is of importance to you and to us all, which is how this National Health Board is going to operate. We are told that a major decision was made rather recently that it would not be an independent agency in the manner of the Federal Reserve Board, but it would be in the executive branch and I presume in the Department of Health and Human Services.

Secretary SHALALA. No, sir.

The CHAIRMAN. Is that settled?

Secretary SHALALA. Actually, in the legislation there was a change to make the National Health Board an agency reporting to the President, accountable to the President of the United States, not within the Department of Health and Human Services.

The CHAIRMAN. That is what our bill is.

Secretary SHALALA. Yes.

The CHAIRMAN. I have to tell you, I am one of the few Senators who has not read the bill yet. [Laughter.]

But by week's end, I am going to get to it.

Senator BAUCUS. Have you put the disk on your computer?

The CHAIRMAN. I do not even have a computer. These youth—— [Laughter.]

No, I still read the New York Times. [Laughter.]

And on the subject of the Health Board, just to give us a feel, when you spoke before the Committee on Ways and Means, Dr. Adam Clymer reports that when asked about the Health Board you said it would be, "a relatively minor oversight group," with a staff of about 100.

But we have here a copy of a document from the Department of Health and Human Services in which your Deputy General Counsel, Anna Durrand, reports to the working group on the interim board, and says it will have a budget of $2 billion the first year and $2 billion the second. It will have an Office of Public Affairs, Office of Legislative Affairs, Office of the General Counsel, Office of the Inspector General, a Pharmaceutical Review Commission, a National Quality Committee, Office of Quality, Office of Quality Measurement and Dissemination, Office of Research and Evaluation. Now that is more than 100 people.

Secretary SHALALA. Yes, Senator. The word minor was an inappropriate word. I was talking about a small staff on the National Board. We have been talking all along about a staff of about 100 with some contracting out for certain of the responsibilities, including, for instance, that Board will have responsibility for developing methodology.

The CHAIRMAN. My time is up.

Secretary SHALALA. Okay. Fine.

The CHAIRMAN. But you will give us a paper on this.

Secretary SHALALA. Yes.

The CHAIRMAN. Because public administration is part of our job here.

Secretary SHALALA. Absolutely.

The CHAIRMAN. We are interested in that.

[The information requested follows:]

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
*Washington, DC, November 8, 1993.*

Hon. DANIEL P. MOYNIHAN, *Chairman,*
*Committee on Finance,*
*U.S. Senate,*
*Washington, DC*

Dear Mr. Chairman: During the course of the Finance Committee hearing on October 28 on the President's Health Security Act, you raised questions about the cost of the National Health Board. In particular, you referred to a memorandum by Anna Durand, Deputy General Counsel at the Department of Health and Human Services (HHS). I would like to take this opportunity to comment on that document.

As a point of clarification, the figures you cited were not a part of Ms. Durand's memorandum. You apparently received two separate documents. Both documents were the product of staff-level work groups that met in August (long before the structure of the National Health Board and the parameters of the Health Security Act were finalized) to assess, on a preliminary basis, what might be required of HHS to implement the President's health care reform plan once it was enacted. The figures in those very preliminary initial staff assessments have not been revised to reflect the many changes to the bill since the time the work groups compiled their reports. The work groups did not forward any final reports to senior Department officials for review pending finalization of the legislation.

I believe it is important to note that none of the materials produced by the work groups have been cleared through HHS. In addition, the Office of Management and Budget has not reviewed the budget figures cited in the memorandum.

Needless to say, I would be pleased to share with you any official estimates regarding the cost of the National Health Board as they are developed by the Administration.

Sincerely,

DONNA E. SHALALA.

The CHAIRMAN. Senator Breaux, you were here next.

Senator BREAUX. Thank you, Mr. Chairman.

I wanted to welcome our witnesses. Let me start by congratulating the administration for doing an excellent job of putting their package together. I have said before that the process that was used, I think, can become a process for future difficult legislative challenges in the Congress because there was a great deal of consultation in a bipartisan fashion—private meetings were held with Republican Senators, and private meetings were held with Democratic Senators, and private meetings were held with all of us together.

I think that that process is one that can be utilized, not only in this effort, but in future efforts of other major legislative endeavors.

You have also identified—the administration has—the goals that we all share. We are talking about universal health care at an affordable price and maintaining the quality health care that we all can appreciate.

How we get there is where some of us have some differences. I have introduced the managed competition bill, which I did last Congress, and I have always felt that in reaching the agreed upon goals there are two paths we can take.

One path is improving the marketplace. We do that by reforming the tax code and by setting up purchasing cooperatives to give consumers better access. We do that by standardizing benefit packages and doing insurance reforms. We do that by anti-trust reforms. We do that by medical malpractice reforms. We could do a number of things to improve the marketplace.

A second path, in my opinion, that can be used to try and reach these goals is through what I would call greater governmental regulation—mandates from the government to do certain things. In that area I would put premium caps, employer mandates, global budgeting, boards to review the pricing of drugs, et cetera.

But what I want to ask you is, what path does this proposal represent?

Secretary SHALALA. Well, I think it certainly represents a path that tries to reform the marketplace. I mean, there is no question that eliminating pre-existing conditions, helping to organize using alliances to help organize the market so that consumers have choices and so that those choices and the competition between the plans help us to hold down costs.

It also simultaneously has some back-up systems. That is, if the competition does not work to keep premium costs down, we do recommend caps that we hope will never be used because we have the same kind of confidence that you have in the ability of competition to hold down costs over time.

In addition though to market reforms, which do not get us universal coverage—they may provide some better access for certain groups if they have the money. We have added a requirement for employers to make contributions to their workers.

Building on the private system, I do not think of this as a government system, but rather a private system being helped by the government because we essentially have at this system private health plans which are going to provide health services.

Senator BREAUX. I appreciate that. But is it not correct, in fairness, to say that the things that are outlined in what I would call

a market-based system, a managed care bill, that we have in your proposal, that those features that are outlined in the package?

Secretary SHALALA. Yes.

Senator BREAUX. Also the things that are in what I would call a government regulated approach are also in the package. Now we can argue that they are not there right away. But we have premium caps. We have global budgeting. We have an employer mandate.

Secretary SHALALA. We do not believe there is global budgeting. We believe premium caps are a substitute for what some people describe as global budgeting.

Senator BREAUX. And we have drug price review boards.

Secretary SHALALA. Yes, in which we would review the prices and make public that review of the prices of breakthrough drugs.

Senator BREAUX. That is my concern. We are going to get into the details, Mr. Chairman, later.

Secretary SHALALA. Right.

Senator BREAUX. But philosophically I think that the package has a little bit of managed competition and has a little bit of what I would call perhaps single payer, for lack of better terminology. My concern is that when you put competing philosophies in the same package that things contradict each other. Of course, that is a subject for a lot of debate later.

Let me ask you about the comprehensive health plan. In our bill, we have a National Health Board, comprised of medical experts, that will design the comprehensive health package. As I understand it, the administration's proposal says that not medical experts, but us, political experts, supposedly, will make the decisions of what is in the comprehensive health plan.

Now we were looking through part of it in the legislation and we have some great things in here that I am sure should be covered. But just as an example, we are talking about on dental health care, space maintenance, we talked about individuals from 3 to 13 years, that the plan will not include space maintainers that are placed within 6 months of the expected eruption of the permanent posterior tooth concerned.

I do not know whether that is a good idea or not. I will never know whether that is a good idea or not. I have no idea what you are talking about in making that recommendation. It may be a great, wonderful thing that everybody needs between the ages of 3 and 13, but I am not qualified to make that decision.

Why is that recommendation of how we get to the comprehensive plan better than a National Health Board of medical experts making that recommendation?

Secretary SHALALA. Senator, the recommendations in the President's plan were in fact made by health experts. The difference between your proposal and our proposal, I would suggest, is not significant, other than the Congress of the United States taking the advice of medical experts who have put together the comprehensive benefit package so that Americans can see what they are going to get as part of this National health care reform effort.

It has been medical experts that have put together that package and Congress can well take their advice because it would be the same kinds of people that would sit on your National board to

make the recommendations. and the same kinds of people that will sit on our National board to make any changes in that comprehensive benefit package.

It is really a judgment call on whether you believe that it is worthwhile for Americans to see the content of the health part of the plan as opposed to waiting to see that until after the plan is passed. But I would suggest that the same kinds of people are doing it in both plans.

Senator BREAUX. Thank you.

The CHAIRMAN. Thank you, Senator. We are all going to learn a lot and it is going to be fun. I mean, I think a space maintainer is what we call braces. Is that not right? Does anybody know?

Senator BREAUX. Who knows?

The CHAIRMAN. Well, we had better know because it cannot be placed within 6 months of the expected eruption of the permanent posterior tooth concerned. [Laughter.]

Secretary SHALALA. Senator, I am certain we could provide that answer for the record. But my doctorate is in political science.

The CHAIRMAN. I know. Well, Dr. Feder says it——

Dr. FEDER. Our experts behind us tell us that that does mean braces.

The CHAIRMAN. A space maintainer means braces.

Secretary SHALALA. Let the record show that there are no dentists sitting behind us.

The CHAIRMAN. Now, listen, we are not making fun. We are just sort of saying we are going to have to learn a lot.

Secretary SHALALA. It is braces.

The CHAIRMAN. Yes, braces.

Secretary SHALALA. Which many of us have had.

The CHAIRMAN. It is what we call them and we had better use the dental term in this.

Secretary SHALALA. Yes, sir.

The CHAIRMAN. Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman.

Thank you, Secretary Shalala. I thought your presentation this morning was excellent.

Secretary SHALALA. Thank you.

Senator CONRAD. I must say I actually feel I learned something. It was not about braces. Let me ask you. Perhaps you have seen the ad running on television lately that shows a husband and wife at the kitchen table and they are saying that, as I recall, the husband is reading the newspaper and he says the President is saying we have to have health care reform and they both agree that he is exactly right about that, but a little concerned about some of the details.

The woman turns. She has a book that suggests it is the Clinton Health Care Plan and she says, "it says in here that they are going to cap the amount that can be spent in a year." And the husband then says, "Well, gee, what happens if our health care alliance runs out of money?" And the wife then says, "Well, there must be a better way," and kind of looks off into space; and the next line is, "there is a better way. Call this 1-800 number and we have the better way."

I am very interested to know, what is the answer to the question that they pose of, if there is a cap on expenditures that can be made in the country for the year on health care, what happens if their health care alliance runs out of money?

Secretary SHALALA. I have not seen the ad. I actually do not know the details of the ad. I know the answer to the question, but not the details of the ad.

Dr. VLADECK. Senator, there are actually two parts to the ad. The first says that you will only be allowed to enroll in a government-approved health plan, which is already the case. States already regulate the offering of health insurance as they do other kinds.

The CHAIRMAN. Right. Sure.

Dr. VLADECK. The bill proposes to strengthen and modify the State role in the regulation of private insurance. But that is a role the States have played since the turn of the century.

In terms of the cap, the cap is not on overall health expenditures. The cap we are proposing is on a premium that is set in advance. If a health plan runs out of money under the President's proposal, as is the case now, the State insurance regulators are responsible through the mechanism of a guarantee fund to ensure that providers are paid what they are owed, and that individual beneficiaries are protected and provided with the opportunity to enroll in new plans.

Senator CONRAD. So the fact is, nobody under this plan, nobody would be in a situation in which if their alliance ran out of money they would be denied coverage?

Dr. VLADECK. That is correct.

Secretary SHALALA. And the risk fund, of course, is set up as part of this legislation.

Senator CONRAD. And the cap that you are talking about is a cap on premiums?

Secretary SHALALA. We are talking about a cap on the growth of premiums over a period of time, yes.

Senator CONRAD. Well, I think that is an important answer to get out to the American public because that has to scare people. It has to scare people to think, gee, their health care alliance may run out of money and they would be denied care. The answer you have given here is very clear—that is not the case.

Let me go to a second question, which is very important in my State. Secretary Shalala, you were kind enough to come to my State.

The CHAIRMAN. Senator Conrad, before we do that, do you happen to know who paid for that advertisement?

Senator CONRAD. HIAA is my understanding.

The CHAIRMAN. The Health Insurance Association of America?

Senator CONRAD. Yes.

The CHAIRMAN. Well, they ought to be ashamed of themselves. I put that on the record. They ought to be ashamed of themselves. I have seen the ad. I never found the——

Senator CONRAD. Well, let me go, if I could, go to a question—and again, I appreciated, Secretary Shalala, your coming to North Dakota and coming to our HMO that we have there, Rugby, a very successful HMO and also participating in a series of forums.

The question that I think is foremost on the minds of people in North Dakota, especially in small rural towns is, when we talk about saving $124 billion out of Medicare, what is going to happen to those hospitals that have a disproportionate share of Medicare patients now, and Medicare is only paying 73 or 74 percent of the actual cost that they are experiencing?

I have hospitals, as you know—we were in one—70 percent of their patients are Medicare eligible. And many of these hospitals are operating very close to the margin now. When they see this number of $124 billion they say to me, Senator, this is going to put us under. What is the answer to those people?

Secretary SHALALA. Senator, to back up for a moment, there are a couple of things that will happen to rural hospitals that will be very helpful. For one thing, of all of the parts of the country, it is rural areas that have the least percentage of people who have coverage.

So those that do have coverage in rural areas tend to be Medicare recipients. That is why the hospitals are so dependent on Medicare. What the President's plan will do is to cover the rest of the people in the rural areas. So suddenly the hospital and the other kinds of health providers that have just been holding on, often by their fingernails in rural areas, will have a larger number of people who have health coverage. So expanding coverage to 100 percent so that everyone has health coverage will help.

Second, we are going to do a number of things that will be helpful to rural areas. I must say, I am grateful to both you and to Senator Baucus for the opportunity to visit your States and to get a much better hands-on feel for the special problems of rural areas.

We will identify those hospitals or other kinds of rural health centers as essential providers, which means that the plans will have to contract with them and will have to reimbursement them when they serve patients. We are looking at reimbursement rates that are higher than they currently get because we believe that rural hospitals have been underfunded and under reimbursed for people that live in rural areas.

Other measure to help rural areas include: investments in rural providers, not simply physicians, but nurses making certain that they can afford to go to medical school and helping them to pay off their medical and nursing school debts; a doubling of the number of Health Service Corps members so we increase the number of professionals; provisions to help rural areas to build linkages with regional health centers; and efforts to increase the number of primary care providers.

We have actually a rural strategy in this plan that we would be happy at some point to show you in much more detail. But I believe the plan is very sensitive to rural areas and to the different kinds of rural areas such as the more frontier areas that Senator Baucus represents.

The CHAIRMAN. We will have a special session on that. But now for the urban point of view, Senator Grassley. [Laughter.]

Secretary SHALALA. Sorry. I did not see you or I would have talked about my visit to Iowa.

Senator GRASSLEY. You bet. Well, I would have asked exactly the same question that Senator Conrad asked. I would throw in one

other factor and then I want your reaction to this factor. That is, unlike or maybe like North Dakota, I do not know, but I know what the figure is for our State. We have just 8 percent as opposed to 15 percent of our population that do not have health insurance.

So you say that hospitals in rural areas are going to benefit because more people are going to covered, more people have to pay so you have a bigger pool to make it up out of. I do not see that in my State. I do not see because we have a higher percentage of people covered that we have that pool. And we are going to be hurt then by the cuts and we are not going to be benefited by the increased revenue.

Secretary SHALALA. Senator, I sat in a farm house in rural Iowa with Mrs. Clinton about 3 or 4 months ago and heard stories of families that yes, indeed, have coverage, but whose coverage had maxed out because of a chronically ill or a terribly ill member of their family who had limited acute care coverage, but no primary care, that the kind of coverage they had was very limited.

Under the President's health care plan, I think every single one of those families would have better coverage, more investment in the areas, more security. There were farm families there in which one farmer said to me that he had to sell a cow to pay for his premium.

He had no stability in his coverage. And when his wife got sick, the premium suddenly went up. So I think in addition to the list of things, that the 8 percent represents the uninsured, but the underinsured, the lack of a range of coverage, I also think will put more of an investment in rural areas.

Senator GRASSLEY. I would not dispute what you say about the quality of health insurance. I would only say that perhaps that is a little bit of an apples and oranges comparison where I was trying to compare apples, our 8 percent, with your apples, 15 percent nationwide, and consequently there is less benefit from us and more overall harm.

A second question deals with the role of risk adjusters and how they work in with your purchasing alliances and also the fact that your purchasing alliances are exclusive except for 5,000 employees or more.

Why should not other types of insurance providers be able to offer insurance if they conform to community rating or modified community rating and very definitely have to have open enrollment.

As I understand it, if we have a workable risk adjustment mechanism, there would be no need for those insurers to engage in cherry-picking. They could then compete for business on an equal basis with the alliances and with other insurers who want to offer health insurance.

Basically why the exclusivity if we have comprehensive and workable rate adjustment?

Secretary SHALALA. I wish I was as confident as you are, Senator, in what we know about risk adjustment. I think that our feeling was that if we move to multiple alliances that we would be reducing the power of consumers in terms of making choices.

The fundamental point about the President's strategy is to increase the pool, not to decrease the pool. I think that our general

concern would be that what we know now about risk adjusting, that multiple alliances would make a risk selection a lot more possible.

In addition to that, multiple alliances would confuse the system. What we are trying to do is to reduce the amount of fragmentation and confusion for the consumer. For a consumer, being in one alliance and having a choice of plans is much easier. As you move to multiple alliances, you are almost going back to the current system. I do not know if my colleagues want to——

Senator GRASSLEY. Well, under your plan you do have to have risk adjustment?

Secretary SHALALA. Yes.

Senator GRASSLEY. So we know we have to have it. You question whether or not my assumption that we might have it would solve the problem, so you would not have to have exclusivity.

Secretary SHALALA. I guess my sense is that our knowledge of this is a lot more imperfect and we are safer with a single alliance in this situation. But I have a couple of risk adjustment experts here.

Bruce?

Dr. VLADECK. Senator, even if you are perfectly able to adjust for risk, there may well be marketing advantages in terms of giving everyone in the community equal access to the same deal for health insurance that are avoided only by having everyone in the same health plan.

It seems to us that most of the reasons why folks would want to opt out of a single regional alliance would probably be because of some perception on their part that they could beat the system one way or another and we do not see what the advantage of the consumers would be from the proliferational alliances.

Senator GRASSLEY. For your consideration, Mr. Chairman, and any further discussion, we need to think in terms of the fact that the President's plan says we have to have risk adjustment. If we have to have risk adjustment, will we have to have it on time. And if we have risk adjustment then, does that not detract from the necessity of exclusivity? I think that is a major point that we ought to deal with in the future and I would like to have you think about it. You do not have to answer.

The CHAIRMAN. It shows more confidence than I think may be in order. But we will have a hearing on this, absolutely.

May I say that Senator Grassley has raised a powerful point and necessary point, sometimes a difficult one to do, which is the regional impact of our legislation. For the last half century, the last 60 years, the social legislation that has made its way through the United States Senate has had to pay a special tariff to get by the committee chairmen of the south and west. It is an elemental fact. Read the memoirs of any President.

The distribution of wealth from the northeast to the south and west began under the New Deal as policy. We have Schwartz's new book on this and the wonderful passage of Lyndon Johnson in the 1930's being told by some Texas businessman that he thought these New Deal business programs were taking away his independence. And Johnson saying, "do not worry about it, you know, nobody in Texas pays taxes. It all comes from the northeast and we

just do not want any of this power running through the checking account of some Wall Street firm, et cetera, et cetera."

Now here again we have the same pattern, Madam Secretary. Senator Riegle, who is the Chairman of our Subcommittee on Health for Families and the Uninsured asked the GAO (the General Accounting Office) to give him a study of this. I see Dr. Feder nodding. You have obviously seen it. It confirms exactly what Senator Grassley says.

Eight percent of the population of the State of Michigan is uninsured; 26 percent of the population of Texas. I think it is 9 percent for Iowa, below 10 percent. You know, that northeast quadrangle, you have Minnesota, Iowa, Wisconsin, Michigan, Ohio, Pennsylvania, Massachusetts and Rhode Island are under 10 percent; and then the rest of the lower are from 25 to 26.

That is a redistribution question that we are going to have to address.

Secretary SHALALA. And a classic issue of American federalism.

The CHAIRMAN. Yes. But here for the first time in 143 years the Chairman of the Committee on Finance is from New York. [Laughter.]

Secretary SHALALA. And, Senator, you have over the years demonstrated the overburden that New York bears and the way the formulas work in relationship to New York. I think somewhere in that legislation is a requirement that we take a very careful look at this issue.

The CHAIRMAN. Good.

Secretary SHALALA. We would be happy to come back and discuss it. It is an issue that I am personally interested in. I have over the years read your own yearly analysis of the impact on New York.

The CHAIRMAN. Thank you.

And somewhere between Iowa and Arkansas comes the great State of Missouri, which is from 15 to 19 percent uninsured.

Senator DANFORTH. I do not know about the second part of that statement, but the first part was perfectly accurate, Mr. Chairman.

Madam Secretary, I take it that if a health alliance runs out of money it can borrow from the Treasury.

Secretary SHALALA. No.

Senator DANFORTH. Well, I am looking at your——

Secretary SHALALA. Wait. I am sorry. You said a health alliance. Pardon me. The answer is yes.

Senator DANFORTH. Now is that an open-ended authority to borrow from the Treasury?

Secretary SHALALA. Let me turn to Dr. Vladeck.

Senator DANFORTH. I think the answer is yes.

Secretary SHALALA. The borrowing arrangement is short-term. There is a short-term cash flow of borrowings that have to be repaid within a 2-year period. I am sorry. I had to click in on that section.

Senator DANFORTH. Is that a considerable exposure for the Treasury?

Secretary SHALALA. You will have the Secretary of the Treasury here on Tuesday. I think I can answer for him though that they reviewed that very carefully. I think that their estimates indicate

that they could handle that. They do see it, as I understand it, as a short-term borrowing opportunity for the alliances.

But he will be here before your committee on Tuesday. But that is the section that I remember.

Senator DANFORTH. All right. Yesterday in the morning paper there was the story about the new caps that have been developed. I am not sure I understand what they are. Are these caps on the subsidies that are provided for small business and low income people?

Secretary SHALALA. Yes.

Senator DANFORTH. And that is the full extent of the caps?

Secretary SHALALA. Yes.

Senator DANFORTH. So these are not caps on any benefits?

Secretary SHALALA. No. These are the caps on the government subsidies. There are caps on the government subsidies for low income people and for small businesses—employees and employers.

Senator DANFORTH. The subsidy to buy into the program.

Secretary SHALALA. Yes.

Senator DANFORTH. But it is not a subsidy on——

Secretary SHALALA. We have described it as a discount. But it is, in fact, money and it is a subsidy.

Senator DANFORTH. It is not a cap on Medicare?

Secretary SHALALA. No.

Senator DANFORTH. And it is not a cap on the new long-term benefit?

Secretary SHALALA. No. The new long-term benefit is a program. It is not an entitlement.

Senator DANFORTH. But it is not a cap on whatever it is?

Secretary SHALALA. No. What has been described—the newspaper article you are talking about was, in fact, the cap on the discount subsidies that are available for those groups of people.

Senator DANFORTH. Now, if even so defined, what happens if the cap is reached is the President goes to the Congress and says here is what I want you to do.

Secretary SHALALA. Exactly.

Senator DANFORTH. So that we politicians could then say, well, the popular thing to do when people want a subsidy is give them a subsidy, could we not?

Secretary SHALALA. Yes.

Senator DANFORTH. It would not seem to me to be much of a cap. Am I being too cynical in saying that?

Secretary SHALALA. Oh, I would never describe you like that, Senator. Let me suggest to you that we had some experience with this in the Social Security Program in the 1980's, which the Senator led the effort when the Disability Program needed help and the Congress replenished the fund.

I believe that we are trying within the legislation to build in financial controls so that we can anticipate if we have not built in enough of a cushion. If, for instance, there is a downturn in the economy and there is an increase in the number of people who are unemployed, when we go through our numbers we can describe to you how much of a cushion we have built in.

So we think it is unlikely that we will reach the subsidy caps. But if we do, then the President does, indeed, notify the Congress,

make a recommendation and the Congress has a number of options at that time—to reduce the benefits, to increase the subsidies.

Senator DANFORTH. Okay. Can I just tell you what my concern is?

Secretary SHALALA. Sure.

Senator DANFORTH. And then you address the concern for me.

Secretary SHALALA. Of course.

Senator DANFORTH. In 1965 when Medicare was enacted, the Washington Post reports, the expected cost of Medicare in 1991 was $9 billion. In fact, in 1991 the cost was not $9 billion it was over $100 billion. It was not even close. The predictions were not even close to the cost of what health care was going to be.

Now my concern is that we are going to create a program that is a rerun with what happened in Medicare and that if we miss we really caused a very, very substantial problem for our children and our grandchildren. And that that is why some of us believe we should have the savings in hand before we spend the savings on new benefits.

I think to say that we have a cap on the subsidy for small business or for low-income people to buy the insurance unless Congress acts, while we do not have a benefit cap on the benefit programs, and we have the ability of the alliances to borrow from the Treasury creates a tremendous potential exposure. However you would like to address that.

Secretary SHALALA. Senator, I think that you are worrying about exactly the issues that all of us should worry about as we take a step forward in this National Health Security Act.

Let me say a couple of things about the design of the Medicare Program and we were way off in the estimates. And we do not have a clear explanation. One of the fascinating things to me coming into the department—I will be very candid with you—is I said, how did we get so far off with the estimates.

You would think that with all the analysts in the department and the capability that we would have a clear explanation for why we were so far off from the origins of the program. We do know some things about the program. It was designed in a way because Wilbur Cohen was scared to death that he would not be able to attract physicians.

So there were very generous benefits to get physicians to participate in the Medicare Program, for example. We changed who participates in the Medicare Program. We added the disability group over the course of that time. So who we started with and who we ended with actually are different groups. So we did do some things.

In addition to that, we absolutely under estimated utilization and how the system would be gained. It took us a number of years to get adjustments into the system. I mean, I can give you a long list of what we think the explanations are. We are now in the process of trying to find out what happened because we need to learn from that experience.

Dr. Vladeck, one of the country's experts, has made some recommendations. So I absolutely admit that we were way off.

We also did not have the same capacity at this time. I would suggest that we have at this time in terms of our ability to do analysis

and the same level of sophistication, but I would not feel protected by the policy wonks in new computers and better models.

In fact, I would suggest that in this plan is protections built in up and down for cost containment, that what this plan is about is universal coverage and security. But we only get that security if we have real cost controls, real protections, and real financial management and protections up and down the system.

The fact is that everyone is at risk if that is not built into the plan. I think that we can demonstrate to you that within the plan we have actually built in those protections. And over the next few months as we discuss it, I think, that we will be able to demonstrate that.

Senator DANFORTH. Thank you.

The CHAIRMAN. Thank you, Senator Danforth. I think that we would all agree that what Senator Danforth has raised to us is one of the central questions.

I know that Senator Baucus shares that concern and was going to ask the same questions. Perhaps he will rephrase it because we cannot ask it too often.

Senator BAUCUS. Well, thank you very much, Mr. Chairman.

Frankly, Madam Secretary, that is the central question I have at this point. Before moving to it, though, I do want to thank you for coming to Montana. It demonstrated a deep awareness and sensitivity towards addressing rural problems and the fears that many people in rural areas have—access and doctor shortages and so forth.

Secretary SHALALA. I not only learned a lot in that visit, but I had fun.

Senator BAUCUS. Oh, good. And, frankly, I think there are many provisions in the administration's plan which demonstrate that rural America would be better off under the plan than the status quo. There are major improvements.

But back to the points raised by Senator Danforth. It is my sense in listening to all this and trying to make what sense I can out of this 1,300 page program, that we are essentially going to be back where we are. That is, because Congress has the authority to raise the caps under the plan, just as Congress has had the authority in the past adjust a lot of the Medicare provisions that there is no self-containment.

That is, there is just no full cost containment package, which means that the balloon is going to pop up in the area where there is the least resistance and often Congress provides the least political resistance. We are going to find we are back in the soup again.

For example, Mr. Magaziner said, according to this problem, I quote, "We thought about walling it off," and adding that, "after several attempts the administration concluded it would be impossible."

What are some of the walls that you considered and why are they "impossible"? This is like the base closing phenomenon. Congress does not do a good job of closing bases. We are only able to close bases when we set up a commission. It is somewhat analogous to the Federal Reserve system, where they said okay this is it, Congress, it is all or nothing. You cannot pick and choose.

We figured out a way to police ourselves with base closings and I think we have to find some other way to police ourselves here. We can't just pass the buck over to Congress and say, okay, Congress, you decide. I just do not think that is going to work here.

So what are some of the walls you considered and why did you reject them?

Secretary SHALALA. Senator, again, I think that this is the central point of the plan—both your point and Senator Danforth's. So we would like to take a couple of minutes here.

We actually did not reject protections. What I would like Dr. Thorpe to do is actually list for you the protections that are built in and why we do not think that we are going to reach those caps. And if we might, just take a few minutes to go through because it is such a central issue.

The CHAIRMAN. Take all the time you need.

Secretary SHALALA. Thank you.

The CHAIRMAN. We are very grateful that you are here. You have the question in front of you.

Dr. Thorpe?

Dr. THORPE. Well, as the secretary pointed out, the likelihood that in any year that we would come close to these caps is very, very small. Let me try to outline both the structural safeguards that are in the plan, as well as the estimation safeguards that we have taken to make sure that those numbers are really very high.

First structurally. The President's plan was built into it year by year a two-part cost containment strategy. One is through purchasing in managed competition.

Second, we do have a fail safe backup system to assure that the year-to-year growth in health insurance premiums remains within what we have laid out as a target.

The CHAIRMAN. That is good military engineering talk—fail safe backup system. Name it.

Dr. THORPE. The fail safe backup system is the following. If the actual growth in premiums rises above what the average premium target is designed to be, then there is an automatic reduction in those premiums and a commensurate automatic reduction in payments to providers. It is not negotiable. It is automatic. It is a structural safeguard built into the plan.

So that is just the first piece of this which is very important. Built right into this are those structural features.

The second point, and this is an estimation issue that we spent a considerable amount of time on deriving what those subsidy caps would be, the actual numbers. We have done two things with those that I think are very important.

First, the technology, as the Secretary has discussed, of coming up with estimates of what it costs to provide insurance to individuals and what the associated Federal costs are, have advanced substantially in the last 10 years. I think that it is with a lot of confidence we know the costs of providing insurance to an uninsured individual.

What we did in estimating the Federal component of this was, in our best estimate we built in several conservative assumptions just to come up with our best estimate. Let me give you three ex-

amples because I think it is important for us all to understand how these numbers were derived.

First, we had several estimates of the premiums associated with this benefit package, both within the department and from some outside groups. We used the highest premium estimate.

Second, as you will see in the plan, families have a choice of receiving coverage in either the regional alliance or from a corporate alliance. There are 10 million families in this country where you have a worker—one works in a regional alliance; one works in a corporate alliance.

If the corporate alliance is chosen, there are no Federal subsidies that go to the corporate alliance. We could very well have made an assumption that indeed some families would go to the corporate alliance. We decided not to and put them all in the regional alliance where subsidies would be paid out as clearly a conservative estimate and it is not going to happen.

A third point is that as you will see in the proposal that discounts are available to firms under the size of 75. All firms under 5,000 are capped at 7.9. But we have an additional schedule for firms under 75. In our base estimates, we assumed that all firms under 100 would be eligible for this special discount schedule.

That is three examples of just in our basic estimate of what we put into the numbers. To be even more conservative, however, we have done something different. Over and above what I think is starting off to be a conservative estimate, we built in an additional 13 to 15 percent cushion onto that number and wrote that number into the legislation. This cushion is sitting there to make sure that changes in the economy and the unemployment rate would not adversely affect the amount of money available.

Let me give you one quick last example. We did some analysis looking at how the subsidies would change if there is a 2 percentage point increase in the unemployment rate, a very substantial downturn in economic conditions. That would have increased the amount of subsidies required in a given year by $4 billion.

Now just so that you will know, on a typical year we have built in about a $12 billion cushion over and above that conservative number that I have already described. Now having a 2 percentage point swing downward in unemployment is a very substantial swing.

The CHAIRMAN. A swing upward.

Dr. THORPE. A swing upward. So just to give you some sense that we have been conservative in our base estimates, we built in an additional factor of 15 percent and really went through the worse possible cases we could think of of what would happen that would have a drawn down of these subsidies. We think that the likelihood of ever getting to that point, given the way that we have developed the analysis and the numbers, is very, very small.

Secretary SHALALA. Senator, we appreciate the time that you are willing to give us on this subject. Obviously, you will have a separate hearing. But I think that we wanted to take the time to indicate how serious we take those questions and how seriously we took them into account, we believe, as we developed the numbers and the subsidy schemes and the protections for all of us in the system.

The CHAIRMAN. May I just say, I think Dr. Thorpe gave us a very careful answer as he brought out these matters and we will, indeed, persist with it.

Senator Baucus, is that——

Senator BAUCUS. I think it is clear that the administration made many estimates that tend to be on the conservative side and I commend you for it. My problem though is that the country, the medical community, is still going to know that there is a process by which you can go to Congress or that can amass public opinion to go to Congress for more dollars, that, basically, Congress can raise these caps.

Even though there are provisions designed to prevent that from being necessary, everybody is going to know, doctors are going to know, hospital administrators are going to know, that collectively, these caps are not real caps because Congress can raise them and Congress probably will if the system is getting more expensive. That is my concern.

The CHAIRMAN. Could I just make a point, and I wonder if you would not agree, that the Medicaid experience was certainly discomforting Wilbur Cohen, God rest his soul is not here to tell us exactly what happened, but something did happen. So we have had the experience.

We would not have an excuse to say, we had no way to know or imagine, and we must have learned from it. It has not been a different experience with the Social Security benefits, which were previously raised at intervals by Congress and the intervals were invariably the second year of a Congressional session when the elections were at hand.

Then in 1972 we decided enough of that and we moved to indexing, which has been a stable relationship ever since. But the species learns intermittently——

Senator BAUCUS. We will hopefully be surprised.

The CHAIRMAN. Senator Daschle, you have been very patient there, sir.

Senator DASCHLE. Thank you, Mr. Chairman.

Just to follow-up, I think that Senator Baucus has expressed a very legitimate concern and one that we have to keep questioning. Obviously when it comes to limits on Federal spending we are the last resort. We are that entity to whom the American people turn.

So that is not going to change. I suppose we can devise ingenious ways to insulate ourselves from that kind of a political pressure, but it will always be there. I do not think we should delude ourselves that we can somehow avoid that responsibility.

Dr. Shalala, I want to commend you for your testimony and its specificity. I see that 1,300 page document and I must say, I do not know that any other bill before the Congress can boast of that specificity and elaborate detail.

I think before we begin this debate we must demand of all plans the same specificity, the same elaborate detail to allow us to compare effectively the advantages and disadvantages of all the proposals before us. I am concerned about that.

I am not sure I am telling you anything new here, but I do not think that anybody on this committee or anybody in the Congress is your biggest opponent. I think your biggest opponent is the mis-

information perpetrated by so many outside groups and others who do not want to see health care reform passed. That is what we have to deal with—misinformation.

There is going to be a lot of it—some of it inadvertent, a lot of it as part of an elaborate plan to defeat this legislation. I think the American people have to be forewarned. They are going to hear a lot of misinformation. They are going to hear a lot of hyperbole. I heard some again this morning about socialized medicine and all of the old rag-tag descriptions given to health care reform.

The American people need to be on guard that that misinformation could be the most damaging aspect of this debate. So it is very important we sift through it all and come through, as you are this morning, with the specificity about the various plans and answers that address the questions that arise with regard to ramifications of the plan.

The other advice I have for all of our witnesses is that I hope when they do come before us they can always answer the question "compared to what?" I think it is good to know what this plan does, but it would even be better to know what this plan does compared to other plans being presented and compared to the current system.

I think your chart, for example, with regard to the premium spending for families and how it affects various income groups is extremely helpful. What this chart says is that for those whose incomes are below $100,000 premiums are going to be lower than what they are paying today.

What it says is that if your income is above $100,000 you may spend more. That is good information. That tells us how your plan will affect us compared to the current system. But I think it is also very important for us to know specifically what other plans do with regard to premiums.

I would be interested in knowing, and I will ask you this question in just a minute, whether any other plans allow for community rating. I would also like to know how other plans are specifically financed.

And in that regard I must say I am very disappointed with the Washington Post this morning as they attempted to compare all the other plans with the Clinton proposal. I hope they do much better than this in the future.

For example, with regard to financing, the subject of this hearing, the Post in elaborate detail talks specifically about the Clinton health care plan. It talks about the 7.9 percent limit on the amount of payroll spent in health premiums. It talks about the fact that employees would pay 20 percent of the premium. It talks about a 75-cent tax on cigarettes, and a 1-percent payroll tax on corporate alliances. That is a good description of the financing of the Clinton health plan.

But here is what it says about Senator Chafee's plan. It says that they are going to finance their plan by limiting tax deductions for premiums beyond a certain amount, and by cuts in Medicare and Medicaid. Does that mean they are going to finance their entire plan with limits on the tax deduction and Medicare and Medicaid cuts?

I mean, that is the kind of partial explanation that creates a distorted understanding of what we are doing here. So I think it is

very important that as we look at the press and as we look at hearings like this we compare side-by-side, principle-by-principle each one of these issues.

I would just ask you—I know the yellow light is on——

The CHAIRMAN. No, do not worry about that.

Senator DASCHLE. If you could on the issue of community rating, give us some indication as to how other plans compare to the Health Security Act.

Secretary SHALALA. None of the other plans are as comprehensive in their community rating as we are in our plan. But Senator Chafee's and Senator Breaux's plans do allow for age rating and other kinds of factors. We would be happy at some point to come back and do these kinds of comparisons. We obviously have done it for ourselves as we look through the plans.

I should also say that we have offered our analytical capacity to help the Congress actually look at the plans in comparison, if that would be helpful, and if it would be helpful to the sponsors to help them provide the kind of analytical detail they will need to provide as we move through this process.

Senator DASCHLE. Well, it would certainly be very helpful to me and I am sure to most members of the committee. I would think that we would want to have that kind of analytical detail on each of these issues because short of that, it is impossible for us to make a very good comparison.

This is the subject of our discussion today. The Chairman has led us remarkably well in this regard in giving us the best information possible thus far. Therefore, I think we will be in an even better position to compare plans in the future. I thank you, Mr. Chairman.

The CHAIRMAN. I thank you, Senator.

Now to set the record straight on the Chafee plan, we turn to the author thereof.

Senator CHAFEE. Thank you, Mr. Chairman.

On our plan we get the community rating at the end of 5 years, but even with that we do have some bans for age and for sex, which we think makes sense.

Let me just set forth what I believe to be a couple of truths. First, that every entitlement program costs more than anticipated, no matter what the reserves that you set aside or the extra amount that you figure is necessary.

Secondly, it is not possible to cut back on entitlements. Anybody who advances on into an entitlement and says we will see how it works out and then we will reduce it if necessary is in a never-never land.

Now the third point I would like to make is that whenever we are—and one of the things I have discovered from being in this field and I certainly will not suggest I am an expert, but one of the things I have learned is that medicine is evolving at a tremendously rapid rate.

What appears to be a saving because the costs of the operation reduced, the hospitalization time is cut back does not yield to saving because more people avail themselves of that particular operation.

Example, heart bypass surgery, 20 years ago very expensive, quite dangerous, required hospitalization for some time. Over the period since then better techniques, better trained surgeons, reduced hospital time, less risk and between 1980 and 1985 the number of heart bypass surgery operations in this country tripled. That probably is good.

More people are able to lead healthy, useful lives than in the past. But the suggestion that these advances in medicine are going to yield savings to the total system just plain do not work out that way. It is very, very hard, at least in my experience, to calculate what is going to happen.

Now I would like to ask you a couple of specific questions that Senator Daschle indicated that how can it be that the Republican Senators task force program, sometimes called the Chafee Program—I am going out to Kansas tomorrow and it will be the Dole Program out there. [Laughter.]

Depending how it flies, at least the first part. But one of the differences is that we do not get embarked on some of the entitlements that the Clinton plan does.

For example, if you look on page 11 of the Madam Secretary's testimony, you will see, and finally for retired workers between the age of 55 and 65 the Federal Government will eventually pay the full 80 percent premium—employer share of the premium.

Now what possessed you to get into that area? Is this to make General Motors happy? I am sure it does. They would be crazy if they were not happy with it. And likewise Ford, U.S. Steel, every one of those companies that people can take early retirement. And so we the taxpayers or the taxpayers in Cranston, Rhode Island are going to be paying for the health premiums of people who choose to take early retirement. Could you explain that?

Secretary SHALALA. Senator, yes. A couple of explanations of that and then I hope we will have a chance to comment on your more general points about advances in medicine and the economics of health care and why it is that health care does not seem to operate like other businesses when it comes to technological breakthrough. The retirement——

The CHAIRMAN. Madam Secretary, may I interrupt just a moment to say——

Secretary SHALALA. Yes.

The CHAIRMAN. I have to go to the floor. There is the Unemployment Compensation Extension Bill. Senator Daschle is very generously going to chair the hearing now. I will miss your answer, but I would like to remind you of an old rule, which is what is good for General Motors is good for America. [Laughter.]

Secretary SHALALA. Thank you very much.

Senator, let me say that all of us at the table and my colleagues in the Department come here with great admiration for your work over the years in health care and the kind of leadership that you have provided. So I want to begin by saying that we look forward to working with you as we move through the next few months.

The issue of the President's recommendation on retired workers is an important one and we do see this as part of our economic strategy that this, in fact, helps the aging industries in this coun-

try and helps to make them more competitive by helping them to pay for their retirees.

Actually, the amounts of money we will be spending is not as large as someone suggests because if these workers, these retired workers, were simply put into the system as unemployed people, we would end up paying for them in a universal system at the same time.

These are particular people in our society that once retired, many increasingly involuntarily, from our aging industries that are very vulnerable. They often lose their health insurance when they go into retirement. They have some difficulty in getting other jobs because of their ages and they often are very vulnerable in terms of the employment market, in terms of their own health.

And both the contributions to the economy that this investment would make, making those particular companies more competitive, as well as our own sensitivity to the particular population that will be affected and by their special problems, led the President to recommend that we do this program.

We also obviously know that there will be discussions about the incentives that we are sending here for businesses and we certainly do not want to encourage any kind of push out from American companies. We are very anxious as we structure and review this particular proposal that we work with all of you to make sure that we do not do that.

Senator CHAFEE. I want to thank you. I have one more quick question, if I might. But I want to say that I think this is a classic case of an inability to predict with any kind of accuracy how many people you will be paying the premiums for.

I believe in your latest version you have made it means tested. Am I correct in that?

Dr. FEDER. No.

Senator CHAFEE. Oh, anybody?

Dr. FEDER. There is no income cap, I do not believe, on the protections for retirees.

Senator CHAFEE. Oh. So if I were——

Dr. FEDER. Senator, we are going to check on that and we will come back to it.

Senator CHAFEE. Yes.

Secretary SHALALA. We have gone through various drafts. And as you can understand, I think that this group knows 99 percent of this bill, but we had better be absolutely accurate.

Senator CHAFEE. I think it is mean tested. Otherwise, Wayne Gretsky would be eligible for having his health premiums paid for.

Dr. VLADECK. Senator, I do not believe he is a citizen. [Laughter.]

Senator CHAFEE. All right. Lem Uyr then. Well, I guess my time is up. I will have another question.

Senator DASCHLE. Senator Hatch?

Senator HATCH. Thank you.

Welcome, Madam Secretary.

Secretary SHALALA. Thank you, Senator.

Senator HATCH. And welcome to all of your cohorts here. I have to admit that I did not have the opportunity to read all of War and Peace last evening. But as far as big bills go, this one is certainly going to set a precedent. I admire you and I admire President and

Mrs. Clinton for the efforts that they made to elevate these issues to the status that they have.

Now, you mentioned in your statement you visited several States recently—Maine, Oregon, Montana, Michigan, Vermont and Kentucky. I would also invite you to visit Utah.

Secretary SHALALA. I actually was in Utah, but that was before the President made his speech.

Senator HATCH. I invite you to come to Utah, because I think you would be pleasantly surprised by our innovation in health care and by what we are doing that is right. But some of our health care professionals could explain to you why too much government involvement in health care is not a good thing.

Last Thursday, for example, two of our pre-eminent hospitals just received word that the Justice Department dropped an antitrust investigation that has been going on for quite a while at a cost of millions of dollars and spanning years. That money could have been going for health care and not lawyers' fees.

I do not blame this administration for that. That started under the Bush Administration, even at a time when President Bush was talking about "coordinated care."

I know you do not handle antitrust and frankly that is one reason why I considered giving HHS the lead for health care in the bill that I am drafting. But I say this to illustrate a broader point.

The President's plan does not "build on the existing structure of health insurance." It totally revamps that system. I think we have to be perfectly clear about that. I am concerned about that. I think others are also. Because I do not ever recall seeing our government attempt to restructure one-seventh of the total economy before. I have to say, I am not too optimistic about the prospects of doing that. We are a long way from doing that.

But let me just ask one question because I will not keep you. As you know, I have been a long-time supporter of both home health care and community-based patient care and long-term care programs in general. For that reason, I am very interested in how the administration addresses those important issues. So let me just ask two questions for you on that topic.

I understand that the new legislation will put an overall cap on government health care spending. Now in the home and community based program, how would the administration's plan control access and spending under the cap? And second, what happens if Medicaid spending for long term care exceeds the cap?

Secretary SHALALA. Let me say that the home and long term care program that we are recommending is not part of Medicaid or part of Medicare. It is a new program and not an entitlement program. It will be grants to the States and they will manage the program.

Senator HATCH. But that still does not answer the question—how would the new legislation impose the overall cap on government health spending, especially in home and community based programs?

Dr. VLADECK. Well, Senator, the existing Medicaid long-term care benefits, both for nursing homes and home and community-based services are not capped in the President's proposal.

Senator HATCH. They will not be capped?

Secretary SHALALA. No, they will not be capped. I am sorry. I thought you were talking about the new program. We are continuing the Medicaid long-term care program and have not made changes in that program so it will continue to be a program the way it has been in the past.

Senator HATCH. Do you feel that you can keep costs under control by continuing in that manner with the totality of your health care plan?

Secretary SHALALA. Judy?

Dr. FEDER. Senator, there is a relationship between those programs and the new program that the Secretary was referring to. We are establishing an expanded home and community-based care program that is an entitlement to the States, not individuals. So it itself is capped. That makes available a new source of services for people at home, which can contribute to the overall better use of resources in the system.

Secretary SHALALA. In addition to that, Senator, the universal health care coverage program helps those that are disabled who really can work be able to work because they will get their health care as part of the program. So for disabled that have been using other kinds of programs that were available to them only if they were below certain income groups, we think that the new health plan will help the disabled get back into the work force. So we do not have welfare a lot, for example.

Senator HATCH. That is great if it will. Just to change the subject for one more question, several States have already undertaken significant reforms. In fact, in two, California and Florida, mandatory purchasing alliances were rejected.

Now given their experience, why has the administration opted in favor of mandatory alliances?

Secretary SHALALA. Well, we believe that this is the best way to finance a system. Referring to your first point, and that is whether this is a private system, we would suggest that we are, in fact, building on the existing system.

The existing system is employers and employees paying for premiums. We see the President's proposal as simply expanding the current system that is pretty tried and true, but adding subsidies so that those who have not been able to afford either small businesses or individuals to buy premiums, adding subsidies so they can come into the system.

I do not know the Florida system experience well enough. But I think that Bruce may. But if my experience is correct, part of the problem with the small businesses and their ability to pay for the premiums, does someone here know the Florida experience?

Dr. VLADECK. Well, the Florida does not have experience yet. It has a statute that has been passed and they are just beginning to implement it.

I think the concerns that we expressed earlier—I guess in response to Senator Grassley's questions—are very much the same. There are two virtues to having as large an alliance as possible. One is the aggregation of market power on the purchaser's side of being as great as possible. It is fragmentation or limitation alliances preclude.

Second, we can disagree about exactly when and to what extent our capacity fully adjusts for risk and to limit risk selection behaviors on the part of either lawyers or insurers will be fully developed. But at the current time it is very hard to prevent people from selecting out because they think they can beat the game on a risk selection basis.

Senator HATCH. Mr. Chairman, if I could just comment a little further.

Senator DASCHLE. By all means.

Senator HATCH. I am very concerned, as is Senator Grassley, and I associate myself with his remarks, about the cuts to hospitals, especially Utah hospitals. You say in your statement that $124 billion is going to come out of Medicare and I believe about $80 billion alone will come out of hospitals.

That means for the State of Utah hospitals will account for at least $200 million of that amount. And even with offsets for uncompensated care, there is no way they can absorb that large a hit. I have to tell you, my State is in a lot better shape than many other States. So, cuts of that magnitude are unrealistic in my opinion. Naturally, I could be wrong. But they are unrealistic in my opinion.

I think that you must worry about the effects of the cuts with regard to hospitals. I think it is going to be a nightmare in the end. So you might want to give maybe a——

Secretary SHALALA. Senator, we are very concerned that we not disadvantage the Medicare system or in any way hurt our senior citizens. As for the uncompensated care, there will be no more uncompensated care, except for illegal aliens. So there will be resources put into the system. But we are very anxious as we detail the Medicare changes that we are recommending to work very closely with members of Congress because the President has no intention of hurting the system.

We would not have recommended changes of that scope unless simultaneously there was going to be a slowdown in the growth in the private sector on the private side because we would simply cost shift over and create terrible problems in the system.

So we look forward to working with all of you on the Medicare recommendations. Some of them are things that can come out simply because everyone is going to be covered and there is no need for huge investments and disproportionate share any longer. And some of them are, in fact, asking providers and physicians to reduce their increases.

Overall, I think, we have been talking about reducing growth from about three times the cost of inflation to just under two times the cost of inflation.

Senator HATCH. My major concern is: what if you are wrong? If you are, you can have a sudden skid of this whole program that would just kill it right off the bat. And I mean kill it in the eyes of everybody. We all lived through consideration of the catastrophic care legislation. We passed this wonderful bill and then went home and got beaten up. Then, we came back and repealed it without even trying to refine it or improve it in a way that might have been very beneficial for our constituents.

So I am very concerned about it. Of course it is just one little nuance of concern compared to some of the other concerns I have

about the bill as a whole. But thank you. I appreciate your appearing here today, all of you.

Secretary SHALALA. You are welcome.

Senator DASCHLE. Orrin, I thought that this projection was similar to what the Republican Medicare and Medicaid projections were in the budget resolution this year. Do you happen to remember?

Senator HATCH. I do not remember, but let me tell you, that does not make it any more right.

Senator DASCHLE. I know it does not.

Senator HATCH. I believe that even Republicans have made some serious mistakes. In fact, I can point to some of them.

Senator DASCHLE. I did not know if you knew the number.

Secretary SHALALA. Senator Daschle, could we make a correction? Senator Chafee knows the bill better than we do. There is an income limit for early retirees. We bow to the Senator.

Senator CHAFEE. You do not know what the limit is, do you, offhand?

Dr. FEDER. It begins at about $90,000, varies for individuals and couples. But that is the income limitation.

Senator CHAFEE. $90,000?

Dr. FEDER. Yes, Senator.

Senator CHAFEE. Did everybody hear that? Anybody whose income is below $90,000 a year the Federal Government will pay their health insurance premiums?

Dr. FEDER. We are talking about the early retirees, Senator, and we are talking about a group many of whom have protections from their employers and we are talking about sharing that as a social responsibility.

Senator DASCHLE. Senator Bradley?

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

Good morning.

Secretary SHALALA. Good morning.

Senator BRADLEY. In the documents released yesterday it showed that there were $20 billion in increased income taxes. I was just curious, what is the basis of the $20 billion?

Secretary SHALALA. Ken, do you know what that is? That is the taxes that we get back because we are not going to allow the——

Dr. THORPE. There is a provision in there that would remove health insurance from cafeteria plans. I am not sure if that is——

Secretary SHALALA. And that is an increase in the Treasury. I think that is what it is.

Dr. THORPE. That is an increase in revenue of about $30 billion over the time period. But basically it would not allow individuals and companies to shelter health insurance contributions from taxable income.

Senator BRADLEY. So the result is that individuals pay more in income tax because they are not sheltering?

Dr. THORPE. Right. It would treat health insurance contributions in that way. That is correct.

Senator BRADLEY. Okay. I also see that corporations are going to be able to save in health care deductions enough to create about $71 billion in new revenue. What is the assurance that that number is actually going to be there?

Dr. THORPE. Well, I think that if you are looking at the entire package of revenue gains, the entire package is $71 billion. Of that there is an estimate that the Treasury Department has made that there be a $23 billion increase in revenue collections due to the fact that health insurance premiums are going to grow at a slower rate than they otherwise would have; and that those savings, if you will, would be transformed into wage increases or higher corporate profits, which are taxable.

Senator BRADLEY. So the $20 billion is included in the $71 billion?

Dr. THORPE. Right. The $71 billion includes a $30 billion increase in revenue from removing health insurance from cafeteria plans; $23 billion from increased revenue from slowing the growth of health insurance premiums; and then there is $11 billion in there which has to do with an assessment on companies that would benefit from the early retiree provisions.

Senator BRADLEY. I noticed though that the amount of money from the cigarette tax and from the large companies who form their own alliances has dropped to $89 billion from $105 billion.

Secretary SHALALA. Senator, are you talking about since the September draft and this?

Senator BRADLEY. Yes.

Secretary SHALALA. We actually are not conceding. Since we did not testify on those numbers, they were not official numbers. These are now our official numbers.

Senator BRADLEY. Okay. So we should not look at the other ones?

Secretary SHALALA. No, I would not look at those.

Senator BRADLEY. Okay.

Secretary SHALALA. In fact, I refused to testify on those numbers when we were testifying at that time because we had not finalized them.

Senator BRADLEY. Right.

Secretary SHALALA. These are the final numbers that Treasury and OMB and HHS have signed off on.

Senator BRADLEY. Very good.

Last week we had a hearing in here on the connection between social behavior and medical costs that I thought was really an eye-opening discussion in which the witnesses testified that $4 billion in health care costs comes from essentially gunshot wounds and about $20 billion from smoking and a variety of other things, from alcohol and other kinds of behavioral activity.

My question to you is, in this bill you have raised cigarette taxes, but there is nothing in there that would tax either handguns or ammunition or assault rifles, nor is there anything in there that would raise the fee for a gun dealer, even at a time when there are more gun dealers in the country than there are gas stations. And in some cities the gun dealers have increased 100 percent just in the last year.

So my question to you is, are you opposed to that or is that something that you could support if the Congress moved in that direction?

Secretary SHALALA. I think it would be inappropriate for me to commit the President on that. Let me say that in principal we share your very strong and very eloquent views about violence in

this country. The administration has supported, obviously, the Brady Bill. We have every interest in getting guns out of the hands of those that should not have them and reducing the amount of violence and irresponsible behavior. We look forward to working with you on this issue and on others.

Senator BRADLEY. Great. I appreciate that. Could I ask you just a kind of threshold question concerning the whole series of behaviors that the witnesses illuminated for the committee?

Secretary SHALALA. Yes.

Senator BRADLEY. Do you think increased taxes on these kinds of self-destructive behaviors actually would reduce the incidence of the behavior?

Secretary SHALALA. The research has given us, you know, very little information about this. We know a little bit about price elasticity for young people in smoking. And, in fact, we would be happy to share with you an international study that the Johnson Foundation did for us, that looked at price elasticity and smoking and how to reduce the number of young people that start to smoke.

We know a little bit about family planning services, school-based clinics and whether that combined with some other kinds of programs can do something about unwanted pregnancies, for example. We know some things about, I suppose, some States that have done some things in relationship to guns and whether they have had some impact or whether community policing has had some impact.

Alcoholism is something that I have dealt with when running universities and what you can do working with young people and peer pressure on moderating alcohol abuse. The President's plan at least takes a very strong first step. There are, in fact, a set of prevention strategies, that are not simply getting screening and having mammograms, but are, in fact, health education, school-based clinics, putting a tax on cigarettes, putting some programs together to give some young people in disadvantaged neighborhoods some hope that combined education and sex education and jobs will make a difference.

Other prevention strategies include education in relationship to AIDS and other kinds of sexually transmitted diseases, and other kinds of outreach programs that are related to tuberculosis. We have obviously been studying—my colleague, Phil Lee, Assistant Secretary for Health has led a project study on needle exchanges.

The answer is yes and the public health part of this plan is as important from our point of view as moving to universal coverage in our kind of investment in primary care, and more importantly our investment in prevention. We see prevention beyond that kind of list in the comprehensive benefit package, but way beyond that in terms of outreach and the kind of energy we must spend on it.

Senator BRADLEY. I am glad to hear you say that.

Secretary SHALALA. Thank you.

Senator DASCHLE. There is a vote on the Senate floor. So the committee will stand in recess momentarily. Senator Riegle, Senator Danforth and Senator Chafee intend to return and ask additional questions. So with your indulgence, we will stand in recess and be back very soon.

[Whereupon, at 12:10 p.m., the hearing recessed, to resume at 12:22 p.m., this same date.]

Senator RIEGLE. Let me invite those in the room who are standing to find seats. We are going to resume. I want to raise two or three issues at this point.

Let me just say to you, Madam Secretary, how much I appreciate your leadership on this issue and on that matter a great number of other issues as well. We were marking up legislation in the Banking Committee this morning, and as Chairman of that Committee it required that I be there to orchestrate that effort.

I very much wanted to be here for the early part of this discussion, as my staff has been. I will read the exchanges with great care.

Let me go right to some specific questions and then I know Senator Chafee has some questions that he wants to raise. First, I want to say to you how strongly I support the retiree health provision. I know there are some who have expressed reservation about that. But I think that the provision is going to help our country's global competition position in many of our basic industries where we have problems of great pressure on the job base than just the financial condition in those areas of our economy.

I also think it will especially help a vulnerable population that falls in the 55 to 64 age category who have limited incomes and who have trouble getting health insurance. So I think that is an important part of your proposal. But let me go to two concerns that I have, that I wanted to just get your response to.

There have already been some questions about the cap entitlement issue. My question, it goes in the direction of how we make sure that people are, in fact, going to have guaranteed coverage. Because as you know, the President has said repeatedly and did back in September and since that he wants a program where health care is always going to be there, period, that there is no ifs, ands or buts and the bottom line is that the care will be there. There will be this sense of security regardless of the circumstance.

What I am concerned about is if the budget projections for one reason or another do not work out and we are caught in a situation where we have a capped entitlement, and yet we have requirements and needs for health spending that go beyond what the projections were, how do we reconcile this? How do we make sure that people get the services they need if we are boxed within a capped entitlement that for some reason is not sufficient to really let us meet the health needs of people out there.

Secretary SHALALA. Well, Senator Riegle, we obviously share your concern. Throughout the entire health care program, we have built in anticipation, protections, financial management reviews to make sure that we do not run out of money.

Dr. Thorpe before you came in detailed how conservative our estimates have been. Not only every time we had a choice did we go the conservative route in terms of our estimates, but we also have built in a cushion for the subsidy part of the bill of close to 15 percent. So we have protected this capped entitlement in every way we could think of.

In addition to that, the President felt very strongly that we could not any longer in this country recommend entitlements that just sort of went their own way and then we found out later, and we

started, as we have been doing in some of our major entitlements, reducing benefits or changing them in some way.

Therefore, we see the cap as a mechanism to really a pay attention, anticipate if there are going to be any problems of keeping the entitlement. We see it as if everything else fails—and we do not think everything else will fail—then the President must notify the Congress that some changes must be made. And, obviously, there will be some options there.

But before we ever get to the cap we have built in every protection we can think of and we have done that with great rigor because the fundamental commitment of this plan is a health care system that will always be there.

Senator RIEGLE. Well, I appreciate that. I appreciate what you have said. I know from your own intense personal work on this that you are convinced that these margins are sufficient, that they have been built in in the name of conservatism and to make sure that we are going to be able to deliver on the promise here.

But I think it is important having said and accepting what you have said as the best judgment that the administration has been able to make on this and what it considers to be a prudent judgment, if we find that, in fact, for reasons we cannot foresee that things do not work out quite the way we would like them to, it might even be because the program gets changed that Congress may very well write it in a form that takes away part of what you are anticipating being in there to help you stay within the financial projections.

But if for any reason we should run into the capped entitlement and you have people waiting in line needing health services, what would be the response in that kind of a situation?

Secretary SHALALA. It is up to the President to make those recommendations so that the health services do not run out, and up to the Congress to act before those health services do.

Senator RIEGLE. So one can presume that the President in terms of keeping the promise of health care that is always there would ask for the resources that were needed and then the Congress would have to, in its own best judgment, provide them if this promise is going to be kept?

Secretary SHALALA. That is the expectation.

Senator RIEGLE. Now, one other thing. That is, kids getting coverage. You and I care as much about that as probably any two people in this town. I will tell you a concern that I have. That is, with the phase-in going through the States, as I see it, we are going to have children now in our society who lack health care protection. These would be children not under some kind of a Medicaid type protection.

That some of them, depending upon where they happen to be around the country, might not, in fact, receive health care protection until the year 1998 if I am reading the phase-ins correctly in terms of how this can work.

First of all, correct me if I am wrong on that presumption, but if I am right about that, that some children may stay unprotected with health insurance as far out into the future as 1998, I am not sure that that ought to be really an acceptable condition of a plan we devise. I mean, I think that just from the point of view of meet-

ing their needs, which we must do in my view—it is just a matter of national priority—but also in terms of just the economics, I think to forego health care for children, preventive care, checkup type care, means that we are going to end up spending more money later to deal with problems that in many cases could have been prevented.

I know you feel that way, too, personally. So my question is, am I right in the presumption that the plan that is now designed would have some children not come under the coverage until 1998? Let me just start there.

Secretary SHALALA. Senator, as you know, we have two different programs that cover children. One, obviously, is the Medicaid program that is related to welfare, to those that are getting cash assistance.

There is another program that you provided leadership on, which is a program for the non-cash that really takes care of the working poor mothers and kids. That program continues. We do not phase that out until the State comes into the plan.

So whatever the Federal Government currently has in place for working poor kids and their mothers stays in place and then that is all folded in as we move to universal coverage.

Senator RIEGLE. But, you know, and with all due respect, there are——

Secretary SHALALA. There are still children that are left out.

Senator RIEGLE. Their income reflects on that. There is a woman, Cynthia Fife in Detroit whose story was in the Detroit paper. She earns just enough money not to qualify. Her child has no health insurance and that will continue now until such time if she stays in Michigan, that Michigan kicks in with a program or if she goes to another State with health care.

But my concern is that I see, you know, somehow or another we ought to be reaching out and taking hold of the children of the country and getting them into a health coverage system essentially on day one.

Secretary SHALALA. Under this plan, it would be almost impossible to do that. We would have to set up another government plan for children for a couple of years. I mean, we are talking about 15 percent of the States coming in in 1997; 40 percent by 1997; and 100 percent by 1998.

That is the period of time that we are moving towards universal coverage, which is very fast. If the Congress wanted to first phase-in of all the children in 1996, given this financing plan it would have to be a direct governmental expense. I would know of no other way to do it.

Senator RIEGLE. Right. Unfortunately, it is probably the best money we could spend.

Secretary SHALALA. Yes. I guess, Senator, we have spent our careers adding groups that are uncovered like children and special programs for children. This is where we have the opportunity to get their mommies, and daddies, and cousins and uncles, everyone covered. There is a time lag, but it is a relatively fast program.

I guess we have tried it all the other ways because we have been doing these programs incrementally. The President has made a decision that it will be universal coverage and it will be phased in by

States. All I can tell you is, we will do it as quickly as the States can move to get their programs up and moving.

Senator RIEGLE. Well, we may have to try to devise something there, maybe even something where the States in effect have to step up to that part of the problem faster.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

I would point out that you indicated enthusiasm for the retired workers' proposal and it covers all retired workers with incomes up to $90,000. So I just thought in view of your coming retirement you might be eligible for this. I do not know whether that puts you in a conflict of interest.

Senator RIEGLE. I think if we do not get this done right, there may be several retirements around here, people who are not planning to retire.

Senator CHAFEE. Well, that may well be.

Madam Secretary, I want to thank you for your kind comments about the work we have done on our side; and I want to commend you, and Dr. Feder, and others who have been working on this for a good number of years.

Let me ask you this. See if I understand the purchasing alliance situation and the mandates under it. As I understand it, all companies with less than 5,000 employees, the employees must belong to the purchasing alliance.

Secretary SHALALA. Yes.

Senator CHAFEE. And you take a state like ours, a million people, a relatively small geographic area, presumably there would be one purchasing alliance. That would be determined by the Governor; is that correct?

Secretary SHALALA. By the State Legislature. By the State.

Senator CHAFEE. By the State?

Secretary SHALALA. By the State and I assume you are a State Legislature.

Senator CHAFEE. So if the Governor should choose to set up just one purchasing alliance, but then—and I will point out that in our State we do not have any private employers with over 5,000 employees, maybe Brown University does. They are close to it perhaps. Or perhaps Rhode Island Hospital. But outside of those——

The CHAIRMAN. Would Brown qualify as a public university or private, because we had that distinction earlier?

Senator CHAFEE. But let us just assume that they have more than 5,000 employees so they would be exempt. So therefore in effect we have a million people in our State. So nearly every man, woman and child in the State of Rhode Island would be required to belong to one purchasing alliance. And, indeed, there is no option. You have to belong. Am I correct in that?

Secretary SHALALA. Yes.

Senator CHAFEE. I would point out that in our program it is not mandatory that you belong to a purchasing alliance. And, indeed, if you work for a company that has more than 100 employees you cannot belong to the State purchasing alliance. You can belong to different accountable health plans if you wish.

Now I do worry about the tremendous power that is thus concentrated in the entity. As I understand the management of this,

is not by vote of the members of the alliance, but it is by an appointed board by the Governor. Am I correct in that?

Secretary SHALALA. Yes.

Dr. FEDER. It is up to the State as to how they structure it.

Secretary SHALALA. To determine whether the Governor is going to do all the appointments or whether the Governor is going to share the appointments.

Senator CHAFEE. You could have a situation where the Governor, one, degrees that there be one purchasing alliance for the State; and, two, he appoints the Board and everybody in the State of Rhode Island thus belongs to this one entity with no recourse to go elsewhere.

That strikes me as a tremendous amount of power concentrated in one entity and gives me cause for concern. Is there anything you can do to allay my concern?

Secretary SHALALA. Senator, two points. First, it is the State that has the authority, which means that there will be within the State Legislature a debate and a discussion about whether it will be a single alliance and how the Board will be set up for the alliance. So that there will be public participation representatives at the State level who will make these decisions, not the single Governor.

Second, the alliance itself will live by certain rules. It is there as an organizer to organize the market and to make certain the information gets out on choices. The competition is within the alliance. There will be multiple plans and the power is in the hands of the consumer to choose between the plans.

Senator CHAFEE. But the alliance is not required to present to its membership any plan that it comes before?

Secretary SHALALA. Yes, it is, required to present any plan that qualifies.

Senator CHAFEE. All right.

Secretary SHALALA. The alliance can not exclude a plan that qualifies financially or in terms of comprehensive coverage.

Senator CHAFEE. So always working with a uniform benefit package?

Secretary SHALALA. Always with a package.

Senator CHAFEE. So the fiscal strength of the accountable health plan and the eligibility of it would be determined by who?

Secretary SHALALA. By the State.

Senator CHAFEE. By the State. By the alliance or by the State Health Department or whoever it might be?

Secretary SHALALA. No, the State or the State Legislature. We are assuming that it is the insurance departments who currently play these roles would do the certification. They would have to meet the standards which have to do with their fiscal health as well as their ability to deliver the comprehensive benefit package.

Senator CHAFEE. I have one more question, if I might.

Senator RIEGLE. Sure. Proceed.

Senator CHAFEE. All right. The other question that concerns me is the powers. I cannot quite understand why you have this in your bill. Turning to page 286, "The Advisory Council on breakthrough drug."

Now the Secretary, which is, I assume, the Secretary of HHS——

Secretary SHALALA. Yes.

Senator CHAFEE.—appoints an Advisory Council on breakthrough drugs that will examine the reasonableness of large prices of new drugs.

Now, Madam Secretary, that is a very, very powerful tool that you have and your Board has. You will examine the reasonableness. I do not know what standards there are for reasonableness. Oh, yes, you set them forward to the prices of other drugs in the same therapeutic class, the cost of information supplied by the manufacturer, the prices of drugs in countries specified in Section so and so.

Now this power does not apply solely to drugs that are offered by Medicare. It is the price of drugs offered by any of the accountable health plans. Am I correct in that?

Secretary SHALALA. Yes, you are. But it is not a regulatory power; it is an informational power. The Secretary would not set the price of the drugs, but would comment on the pricing of the drugs. It is not a regulatory authority.

Senator CHAFEE. But it is a very, very powerful tool. And any Secretary worth his or her salt is going to try to land base any set of prices that are not as low as the imagination of the Secretary can conceive.

Secretary SHALALA. Senator, on the contrary. You are talking to a Secretary that not only is concerned about making certain that this country is on the cutting edge in terms of its investment and basic science in drugs and vaccines in particular, but I believe this administration is sensitive to the role of the drug industry, of the fragile biotechnology industry in particular, plays in the economic health of the people of this country as well as the role they play in job creation.

Many members of this committee and of the Senate have been concerned about drug prices. This is the power of information. We intend to use it very sensitively. It will be an expert panel. It will be a panel not of people who are hostile to the pharmaceuticals in this country, but are sensitive to the need to make certain that breakthrough drugs in particular are available to people in the country and that will provide a report which the Secretary will make public.

But let me assure you that there is no Secretary of HHS that has ever been more concerned about making certain that R&D investment, that the private sector R&D investment continues in this country. That ought to very much be part of our role. We are not going to improve the health of Americans unless that industry is healthy and we have to be extremely careful as we move into these roles.

Senator CHAFEE. Well, Madam Secretary, I want to say that first of all, durable though you may be, you are not going to be Secretary of HHS in perpetuity.

The CHAIRMAN. I hope not. That is a cruel and unusual punishment. [Laughter.]

Senator CHAFEE. To have a power like this, which is not restricted to the Federal Government expenditures, there can be a valid argument made that when the Federal Government is involved in paying for the drugs that it should have a say.

But now we have a third party inserted between the seller and the purchaser, the purchaser being the accountable health plan. I know for a fact, I had the opportunity to speak to a biotech gathering the other day, and this already has had an extremely chilling effect on the venture capital that is going into the biotech industry, which as you know is completely dependent on venture capital.

And already the threat of this—of course, it is not enacted into law yet, but the suggestion. And by the way, is there something in here, and you can correct me, there is a suggestion that you can look into the pharmaceutical companies or the biotech companies books to ascertain what you think is a proper price. Is that correct or am I misinformed?

Secretary SHALALA. Yes.

Senator CHAFEE. So you can go into the books of a company to see what they ought to be charging——

Secretary SHALALA. Let me check the details of this, Senator. Certainly in inquiring and playing a role and providing information about pricing we obviously need information because one of the points that the industry has made is they need to protect their R&D investment, so that we will need information if we are going to provide a comment on appropriate pricing.

Let me also say to you, Senator, that for the drug industry in this country, this National Health Security Act is a big boom by proposing a drug benefit for every elderly person in this country. By investing not only in that drug benefit, but in universal health care that also provides a drug benefit to those under 65, we are making a major investment in the stability of the drug industry in this country and making drugs accessible to every person in this country.

I see no reason why we cannot play a role. If information is power, then so be it. But the consumers in this country and members of this body have long urged the Department to play a much stronger role, particularly on the pricing of breakthrough drugs. And a comment, it seems to me, is an appropriate role.

Senator CHAFEE. Let me just conclude on that, Mr. Chairman, by saying that I do not buy your argument. That because the suggest is that there be prescription drugs provided for the Medicare population that therefore it is perfectly all right to in effect curb prices—I know you argue with that definition—of breakthrough drugs.

Somehow that just seems to me the suggestion that since we have gone into food stamps in the country, we ought to be able to control the prices of the food industry or give information out after looking into the books of the food companies of the nation.

I think this is going to have a very severe affect on biotech and pharmaceutical research, this very provision.

Thank you, Mr. Chairman.

Senator RIEGLE. Chairman Moynihan?

The CHAIRMAN. Thank you, Mr. Chairman. Let me just say that we will be having a vote any second now on a closure vote on appropriations. Perhaps I could just say how much we have all learned from this hearing this morning. Perhaps the thing we have learned most is how much we have yet to learn. That is all right.

You are going to find a committee that is genuinely concerned about science. We have the finest pharmaceutical industry. We have the finest pharmaceutical research in the world. We lead the world in patents, even though we have a very difficult patent obstacle course.

It is not hard to kill off these things. The creative processes in chemistry are an extraordinary breakthrough. We are in the age of biology. Two generations ago we were in the age of physics. Now we have gone past the point where embryos are cloned. It is extraordinary. Issues of medical ethics arrive and also extraordinary frontiers.

The thought that somebody in this government is going to be going over the books of the industry sponsoring this chills me. But we will get back to that. I know that we will want to know a lot more in terms of the numbers, sizes of companies.

I see Dr. Thorpe agreeing. I am sure he would like to know more himself. I do not know what the Department of Commerce tells you. I suppose we have—well, we have the decennial census. But, again, how many under 100–110, over 5,000 that kind of thing.

Senator RIEGLE. Right.

The CHAIRMAN. We are just going to need to learn more. We have learned a lot. I just want to express my thanks to Dr. Vladeck, Dr. Feder, Dr. Thorpe. Secretary Shalala. It has been instructive. It has been encouraging. We are launched. With that I want to thank you and say, I am sure you have another hearing to go to.

Secretary SHALALA. We appreciate that, Senator. Could I make one correction? We will not be going through anyone's books. The companies will voluntarily be providing us some cost information. We will be working with them.

Obviously, this is an area I share your concern about that industry and about our investment in science. We need to look at this provision very carefully and I agree with that.

Senator RIEGLE. Well said. Thank you very much, Madam Secretary, and your fellow colleagues.

The committee stands in recess.

[Whereupon, at 12:50 p.m., the hearing in the above-entitled matter was adjourned.]

# PRESIDENT'S HEALTH CARE REFORM LEGISLATION

## WEDNESDAY, NOVEMBER 3, 1993

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

The hearing was convened, pursuant to notice, at 10:03 a.m., Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Present: Senators Baucus, Pryor, Rockefeller, Daschle, Breaux, Conrad, Packwood, Roth, Danforth, Chafee, Durenberger, Grassley, and Hatch.

[The press release announcing the hearing follows:]

(Press Release No. H-43, October 25, 1993)

FINANCE COMMITTEE ANNOUNCES HEARING ON PRESIDENT'S HEALTH PLAN; SECRETARY BENTSEN 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 next week regarding the Administration's health care reform legislation. Secretary of the Treasury Lloyd Bentsen will testify.

The hearing will begin at *10:00 a.m. on Wednesday, November 3, 1993,* in room SD-215 of the Dirksen Senate Office Building.

"Secretary Bentsen, as former Chairman of the Finance Committee and now as Secretary of the Treasury, has unique insight into the problems of our health care system and its costs," Senator Moynihan said. "We look forward to hearing his views and recommendations for action."

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

The CHAIRMAN. A very good morning to our most distinguished guest who returns to the domain over which he presided with such great distinction for so many years, the Secretary of Treasury, Lloyd Bentsen.

Sir, we are now, as you know, dealing with a specific legislative proposal, the Health Security Act, that has been sent us by the President. It is a very considerable one.

If you do not understand the bill, there's a book explaining the bill. If you don't understand the book, there's a pamphlet to explain the book. And, if the pamphlet fails, there is a button. And, when all else fails, there's the Secretary of the Treasury.

We have a vote called on cloture at 11:00, and Senator Packwood and I are concerned that we hear from you at length and give our colleagues and ourselves time to ask you questions in the aftermath of your testimony, so I will simply welcome you, sir. My col-

league and friend has a brief statement, then we will hear from others, and go right to you.

Secretary BENTSEN. Thank you, Mr. Chairman.

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

Senator PACKWOOD. Mr. Secretary, Mr. Chairman, delighted to have you back with us again. Let me thank you for adding two provisions in the bill, both of which you and I had an interest in when you were Chairman here.

The first, is the problem of access to health care services in rural areas. In Oregon, and, I am sure in Texas it must be true in spades, that you have many, many areas that have a shortage of health care practitioners in rural areas.

The bill includes the proposals that you supported before that Senator Pryor did and that I did, giving tax credits and medical equipment expensing to doctors, nurses and physicians assistants who locate in rural areas.

And then the long-term care proposals that you, I, Senator Dole, and others worked on last session and almost had, you have put these in the bill. These are much-needed reforms to ensure that our rural citizens have access to health care and that our low-income and moderate income citizens plan for the time when they're going to need long-term care. I think they are good additions to the bill, and I thank you for putting them in.

Secretary BENTSEN. Thank you.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. I am going to pass. I have a statement.

The CHAIRMAN. Why do we not put it in the record?

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

Senator GRASSLEY. The trouble is, it is such a good statement.

Senator DURENBERGER. Well, I will read it then. [Laughter.]

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

Senator DURENBERGER. I just think, Mr. Chairman, it is great to have the former Chairman back. And, following along with what Bob Packwood said, if you read through a lot of this legislation—and I will not cite the exception; we may in our questions—but a lot of this is Lloyd Bentsen, and a lot of it is the work we have done in a very bipartisan way through all of the years we have all been together here on the committee.

I am sure the Secretary, the Chairman, and all the rest of us feel a sense of excitement that all of this work is finally coming together, and it has Presidential leadership, and that we have quite an opportunity.

The CHAIRMAN. We do, indeed, sir. You said that. Very good. Senator Baucus.

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

Senator BAUCUS. Thank you very much, Mr. Chairman. I do have a statement that I will read.

Mr. President—Mr. Secretary, thank you very much for coming.

Secretary BENTSEN. The other one had a nice ring to it. [Laughter.]

Senator BAUCUS. I know it did. Which reminds me of an earlier conversation you and I several years back at an earlier date.

Nevertheless, we are very honored to have you here before the committee again. Frankly, you are one of the most respected members of the Senate, and certainly one of the most respected Chairmen this committee has ever had. You are always more than welcome befor this committee and privately, as I am sure you know, Mr. Secretary.

The Secretary also knows, even in my home State of Montana, with its small population and its rural population, health care costs are exploding. It is not just in the urban parts of the country, it is in rural America.

And, consequently, the high costs are hurting our economy. Even in States like Montana, we are depleting our State budget because of increased health care costs. And it lowers our wages as well, forcing over a fifth of our population in Montana to go without health insurance.

Over the last decade, just to give you a couple of statistics, health care costs in Montana rose almost 400 percent faster than wages. And families in our State spend $3,000 a year on health care, yet their average income is among the lowest in the country, at $28,000 for a family of four. And, at this rate, Montana families can expect to pay over $7,000 a year in health care by the year 2000.

Business spending on health care has skyrocketed, rising by about 300 percent in the last decade. Montana businesses can expect to pay over $1.2 billion on health care by the year 2000.

The administration's proposal addresses the fundamental problems in our health care system of access and cost. At long last, I think our country will join the ranks of every other western industrialized Nation by providing universal coverage at a reasonable price.

I am still concerned, however, about how this proposal will impact small business. We are a small business State. A lot of western States are small business States. Most employers in the State of Montana have fewer than 100 employees. And only half of the businesses in our State with fewer than 50 employees offer health insurance. About half do not.

In 1989, I served on the Pepper Commission, also with the Chairman of the Commission, Senator Rockefeller. We were charged with developing a health reform plan that would guarantee universal coverage. The commission, as you well know, recommended an employee mandate. I finally opposed the commission's recommendations because I felt they posed an unfair burden on small business. I say this not to criticize the Pepper Commission.

It is important to note an important distinction between the Clinton plan and the Pepper Commission plan. The Clinton plan has strong cost controls which prevent large premium increases. It also caps how much employers must spend on health insurance; much lower caps for small businesses.

The President, clearly, wants to make insurance affordable for small business. It is clear he has made that statement many times, as has Mrs. Clinton. I think that this plan contains many pro-business provisions. Most of the small businesses I know tell me they want to offer insurance, but simply cannot afford to spend 15–20 percent of their payroll on premiums.

The President's plan would cap how much low-wage small businesses would have to spend on health care, from as low as 3.5 percent of payroll to 7.9 percent of payroll. This is just a fraction of what it would cost them to purchase insurance today.

I also applaud the provision that would allow the self-employed to deduct 100 percent of the cost of their health insurance. Large businesses have been able to do this for a long time. It is about time our Tax Code treats small businesses fairly.

I am particularly pleased with the rural health care proposals in the bill. Almost half of our 56 counties have no physician who deliver a baby, and only eight of our counties have no physician at all. We are, clearly, sensitive to the fact that giving people in rural communities a health insurance card does not mean that they will have access to health care.

The President's proposal will seriously address our provider shortages. I am referring to the provision which would offer rural health providers tax credits and bonuses, and the telecommunications piece that would link rural providers with other health care institutions, and about the investments in new medical equipment. These provisions would greatly increase access to health care in rural communities.

Having said that, Mr. Secretary, I am still concerned about what happens if the caps are exceeded; that is, if the plan costs more than the subsidies that would be provided for small business. It is an issue, I know, that you have heard of before. I think it is a key question that many of us are still asking, and I hope that during this hearing that we can address that with some satisfaction.

The CHAIRMAN. Thank you, Senator.

Senator Hatch.

## OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Thank you, Mr. Chairman. I want to welcome back our former Chairman, now Secretary of Treasury. We have watched you through this year, and it has been a horrendous, difficult year for you. You have had many competing demands. We appreciate you.

I want to raise only just a couple of things. I am really concerned. A lot of us agree on the need for health reform, but many of us question how the President's plan achieves that goal.

And a particular concern, which Senator Baucus raised, is the employer mandate. While I recognize that subsidies would make the employer mandate less onerous, I am still concerned that there is going to be a major hardship on a lot of small businesses.

So, I will be interested to hear your assessment of the impact of this mandate on our Nation's small businesses and the employees who work for them.

Also, I am concerned that the financing provisions simply are not realistic in light of today's economic and political environment. So, I have a number of other questions on these and other issues that I will ask if time permits.

I do want to welcome you. We are glad to see you and glad to have you back. I wish you well.

Secretary BENTSEN. Thank you.

The CHAIRMAN. Thank you.

Senator Daschle.

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

Senator DASCHLE. Thank you, Mr. Chairman. Mr. Secretary, welcome, again, to the committee. I appreciate very much your willingness to come, as you have on so many occasions, to talk about this issue and provide additional guidance.

I would hope that, with respect to the examination of health reform options we always ask ourselves "compared to what?" There is no way we can evaluate reform options if we are not able to evaluate the proposals within that context.

If we do not know how a reform proposal compares to the current system, or compares to the Chafee, Breaux, or Cooper plans, for example we are forced to make our assessments in a vacuum.

So, it is very important that we have a context within which to evaluate all the information we are going to be given.

And I think that is especially true with respect to the issue raised by our colleagues this morning. Senator Baucus and Senator Hatch have rightfully raised concerns about small business. I personally believe that there are few winners in this whole plan as significant as small business. I do not know that there is any other group that will benefit more from this plan than small business, and I say that with conviction.

First of all, we recognize that 60 percent of small businesses today provide health insurance. For these businesses, there will be significant reductions in their health insurance costs. Forty percent of small businesses do not offer any coverage. For that 40 percent, they will be able to provide coverage at significantly discounted rates due to subsidies available to small businesses.

For a minimum wage worker, his contribution to health insurance costs will be about 15 cents an hour for health care that is always there under all circumstances. Small businesses are currently paying 40 percent of their premium dollars in administrative costs. We will reduce this 90 percent amount by a remarkable achievement.

For self employed individuals, we are talking about 100 percent tax deductibility. How many times in this committee have we discussed whether or not the deduction would be 25 percent, zero, or 100 percent? We now say, for the first time, it is going to be 100 percent.

And we will end employment lock. I have had so many small business people come to me and say, I would like to hire this person but I am told by my insurance company that my premiums are going to sky rocket. So the small business people don't hire that

person because he or she cannot afford the insurance premiums that come with that new employee.

Employment lock is as serious a problem as job lock. I just read an article yesterday that said over 27 percent of people around the country have job lock. That is, they do not move simply because they cannot get hired or they do not want to leave the benefits they have with their current employer. Ending both employment lock and job lock will be major gains for small businesses.

There's a tremendous opportunity for us to get the message out. Whatever the message is, it has to be in the context of, "compared to what?" Without the comparisons we really do not have any better information than we had before.

Welcome, and thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Daschle.

Senator Breaux.

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

Senator BREAUX. Well, I would like to welcome our former Chairman back to the committee once again on behalf of the administration, and welcome your testimony.

I compare your position in this debate to the position I find myself in with my senior colleague in the Senate, Senator Johnson, who is senior member of the Appropriations Committee. Bennett gets to announce all the good projects for the State of Louisiana, and I get to announce all the taxes that we have to raise to pay for them. [Laughter.]

And Donna Shalala, our good Secretary, was here announcing all the benefits of the new Health Reform Plan, and you are here today to tell us how we are going to have to pay for it. So, one is a lot more fun than the other, but we look forward to your thoughts and suggestions. I know you have worked very, very hard to come up with numbers that will make the plan work. Such effort is going to be true for almost all of the plans. I look forward to your testimony.

The CHAIRMAN. Thank you, Senator Breaux.

Finally, Senator Rockefeller.

## OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman. I simply welcome back our former Chairman, Senator Bentsen, who has been so deeply involved in health care, and the whole area of children and families. I am sure you have a lot of memories, sitting there.

I would only echo completely what Tom Daschle said with respect to comparison. I find it very ironic—I am looking at the Secretary of Treasury, but, obviously, I am talking to the press and to our colleagues in the Senate—that people spend so much time analyzing the Clinton plan because there is something to analyze because it is all laid out, the specifics are all there.

The 6 to 8 months of work by the task force and the transition work that went on before that was for a purpose. Modifications were made as modifications needed to be made. But the other plans, for the most part, reside in 10-11 page loose-leaf documents,

have very few details, and are not being scrutinized or compared to the same standard that the Clinton plan is.

So, with respect to our colleagues in the Senate, and also in terms of the press, the media needs to be focusing on the other plans, as well as the Clinton plan. As well as comparison of the mess that we are in today—the status quo.

I thank the Chairman.

The CHAIRMAN. Thank you, Senator Rockefeller. And, Mr. Secretary, good morning, sir.

## STATEMENT OF HON. LLOYD BENTSEN, SECRETARY OF THE TREASURY, WASHINGTON, DC

Secretary BENTSEN. Mr. Chairman, Senator Packwood, my distinguished colleagues, how many times have we wrestled over these problems, how many times have we addressed ourselves to them, how many times have we tested options on the floor.

I think what Senator Rockefeller just said is quite right. I have never seen a piece of legislation that has involved as much effort, time, or expertise. I have never witnessed so much communication with both sides of the aisle to try to resolve what is one of the most serious problems this country has. I have never seen as much effort go into the kind of detail, the kind of specifics that are included in this piece of legislation.

As you look at other plans, which are sincere efforts on the part of others, in fairness, hold them to the same standard of detail we have undertaken, the same level of specificity that you see in this plan. Obviously, when there is this much detail it is much easier to differ with one or more provisions.

I think every one of these plans should be analyzed using the same standards. Mr. Chairman, I have a more lengthy statement I would like to put in the record, but I will summarize this morning.

The CHAIRMAN. Of course.

[The prepared statement of Secretary Bentsen appears in the appendix.]

Secretary BENTSEN. This issue is one that has greatly interested me and so many of you on this committee. Each of us comes here hoping we can make a difference. That is what we hired out for. And this is an issue that is so basic it affects the well-being of our people. There are quite a number of things we have done in this committee to improve prenatal and neonatal heath care. Now we are talking about an all-encompassing reform effort.

Reform of the health care system is an absolute priority for this President. It is an integral part of his economic strategy. With our first step through the deficit reduction plan, we have begun to renew the basis for economic growth and rising wages in this country.

But deficit reduction, by itself, will not ensure a higher standard of living for the American people because for too long now we have seen rising health care costs act as a drag on wages and a drag on profits. So, now we turn to health reform.

From an economic standpoint, failing to act is just not an option. When employers pay their workers more but health care costs con-

tinue to rise, workers' paychecks just do not go up as they should. As an example, I like to call your attention to that first chart.

Some projections show that if nothing is done, every bit and more of projected wage increases in the coming decade could be consumed by health care costs. Talk about going backwards. This country spends 14 percent of its GDP on health care; almost twice as much as some of our major competitors.

If nothing is done, health care is projected to consume nearly 19 percent of GDP by the year 2000, and that is just unsustainable. For all this extra spending, our health is no better than that of many of our competitors, and, in many areas, it is worse. We are spending more money and not offering Americans—too many of them—health care security.

The President's Health Security Plan attacks the fundamental problems of the current system: cost, and the tragedy of Americans going without coverage. We are the only major industrialized country without universal coverage.

We have more than 37 million without coverage; between a quarter and a third of them are children. Another 22 million Americans are under-insured. That lack of universal coverage affects every one of us.

Every time someone goes to the hospital and does not pay for it, is treated in an emergency room, each of us with insurance foots the bill. That is when hospitals raise the cost of the bed, the physician, the anesthesiologist; the cost of all of these services goes up. And all of us have horror stories we can tell. Every time a business leaves its employees uninsured, those with the insurance pay the price.

Estimates show that corporate premiums are 10 percent higher than they need be in order to pay for uncompensated care. I know of two hospitals in Texas where they totaled over $80 million worth of uncompensated care last year. $80 million.

You know what happens. You have parents who decide they cannot afford to take their child to the doctor, so the child gets sicker and sicker, and finally they rush him to the emergency room. The emergency room doctors look for the gunshot wound or the stab wound and if he does not have it, they feel his forehead and say, well, he has got a fever, we will get to him after awhile. But by the time that they are able to tend to him, they have waited so long, it takes longer for the child to be treated and longer to recover and it costs a lot more.

I think universal coverage is critical to get costs under control. I can remember when my desk mate here in the Senate was Lawton Chiles. And, as Chairman of the Budget Committee, he testified at that time that he believed we had to control health care costs before extending coverage to everyone. Less than a year after becoming Governor of Florida he was back here telling this committee he had changed his mind. Universal coverage was absolutely necessary in order to contain costs. It is the only way to stop the cost shifting that takes place when everyone isn't covered.

The Health Security Act takes on that universal coverage issue. It provides security to all Americans and shifts resources to more productive uses. As a result, many businesses are going to see their

costs come down and others will be able to afford insurance for the first time.

I was listening to Senator Daschle talk about the numbers of small companies that all of us have in our States that really would like to provide health insurance if they thought they could just afford it. This proposal drives those costs down substantially for them. It will let workers enjoy real wage increases.

Universal coverage will ensure that workers no longer have to fear losing their health insurance if they change jobs or if they want to start their own businesses. I think each of us, knows of instances where we have a member of the family or we have a friend that has been offered another job, a higher paying job. But if they have a child with a pre-existing condition and risk losing their insurance they just cannot take that job. It has happened time and time again. There will not be that problem in the future.

Now, I know that 9 of every 10 Americans with health insurance get it through the workplace. So, that is why we are talking about building on the existing system of insuring individuals through employer and employee contributions. Just as we do today, employers and employees will pay premiums to cover the bulk of health insurance costs.

The President's plan not only has important benefits for individuals, but, over the long run, it can also lower what businesses must spend on health insurance. And, by the end of the decade, preliminary estimates indicate total business spending on the services secured by the Health Security Plan will fall by $10 billion.

That savings could be used to hire more workers, to increase wages, increase benefits, to invest in plants, equipment, training or research. It could also go to increased dividends or to lower prices. Every one of these possibilities can stimulate the economy and create jobs. And, through the bargaining power of health alliances, it can also level out the playing field for small businesses when it comes to premium rates.

When you can pull these small business people together, where they can bargain because of their substantial numbers then they can get to the point where health insurance costs are something equivalent of costs paid by big business.

Now, before I deal with some of the specific revenue issues, there are three general points I want to make. First, our plan is the only comprehensive proposal that spells out exactly what will be provided and exactly how it will be financed, and that is the only fiscally responsible way to do it.

During the development of the plan, the administration consulted with the Nation's best actuaries and health care experts. I feel confident we have approached the estimating process in a very responsible way.

I note there were some stories in the newspaper about my being reluctant to come up here early on to testify. I was. It was because I wanted to be sure that we had all the numbers. I wanted to be sure that we had refined them and reviewed them in detail. And this administration has done that. We have taken the time to consider them carefully. We even went to some of the outside, Big Five accounting firms for actuaries and estimators. We certainly had careful estimates.

To see our people at Treasury work these numbers night after night, day after day, to be sure we are solid in what we are saying; to ensure that even if, by some reason, we had missed on some of these projections, that we put a cap on the entitlement to the subsidies; those are the things that have been done here to try to be sure of our numbers. And, with that having been done, I am enthusiastically here in support of the plan we are presenting.

So, we clearly spell out the cost to the Federal Government and how we are going to pay for it, including the discounts to eligible businesses and individuals, long-term care and the new Medicare drug benefit.

Funding for these and for other program improvements will come largely from slowing the rate of growth in Medicaid and Medicare and a 75-cent increase in the tax on a package of cigarettes; an assessment on large companies that choose to establish corporate alliances; increased revenues as compensation shifts from non-taxable health care benefits to taxable wages.

Now, as to some of the specific revenue items in the bill. You will find that our proposal contains a number of provisions that have been of interest to this committee over the years. We propose increasing the excise tax on cigarettes by 75 cents to 99 cents a pack. We also propose raising the Federal excise tax rates on all other tobacco products.

Senators Bradley, Chafee, and others on this committee have said for years that increases in tobacco taxes will promote better health, not just for adults, but, very importantly, for our children. Like you, I am very concerned about the use of tobacco products by our children.

The Health Security Act also contains a 1 percent payroll assessment on large employers who opt to form their own health alliances. Among other things, those funds will be used to underwrite important work in health research from which every American benefits. How many times have some of us on this committee have worked on that issue?

Another major revenue major source in the package are the tax receipts that will result. This provision accounts for about $23 billion over the existing period. Let me explain we are convinced that increased competition, greater cost consciousness on the part of both consumers and providers, and other cost containment measures will lower health care costs over time.

Standard revenue estimating rules assume that, as tax-preferred employer health care costs go down, that more compensation will be paid in the form of taxable wages. And that shift will generate more income and payroll taxes, even taking into account the increased numbers of workers covered.

There are other tax provisions of the President's plan that will accomplish many of this committee's goals. For example, we want to help the self-employed better afford their contribution to health coverage. Senator Packwood has worked on that issue for many years. Members of both parties here in the committee have wanted to enact that proposal for years. It is time we get it done. And we are doing it.

We propose that self-employed individuals be able to deduct 100 percent of the cost of a comprehensive benefit package. In fact, I

guess every one of us supports getting that done as a part of this package.

In addition, we want to ensure that rural residents and those who live in the inner cities have adequate access to quality health care. This plan helps achieve that with incentives to encourage doctors and nurses to locate in those under-served areas. Senator Baucus talked about the miles and miles that people have to travel for health care in Montana. I am sure they have problems in Texas.

The administration has offered a bold and comprehensive plan to give Americans health security and to take charge of health care costs. Next year alone, before we can fully phase-in our plan, our Nation's health care bill will exceed $1 trillion. That is $1 in every $7 in this economy. That chart will show you how it hits $1 trillion next year.

The plan we have drafted accomplishes everything many of us tried to do in the last Congress, and much more. Last year, we tried to enact legislation that would have made important, but incremental progress in extending health care coverage to families.

Several of us authored those bills because at the time we thought it was as far as we could go in achieving some serious reform of the health care system. Things have changed. It has, in fact, been a sea change. Americans know that our health care system needs a comprehensive overhaul. You can see that in every poll in every newspaper that you pick up.

It is clear to me we are going to do something in this Congress. You need only to look at the legislative landscape to figure that out. No fewer than a half dozen plans are on the table. There is quite a bit of similarity among them.

For example, all but one calls for some form of competition; every plan wants to get rid of the exclusions for pre-existing conditions; every proposal offers a choice of health plans and providers; each proposes reform in our malpractice system; and most propose increasing the deduction for self-employed Americans.

So, I think we have a significant amount of common ground here. I think we have a real opportunity for bipartisan support, and I think that is critical to passing a meaningful bill.

But only the President's plan is truly universal and comprehensive. It provides universal coverage, builds on our existing system of obtaining insurance, contains a Medicare drug benefit, a long-term care benefit, cigarette taxes, a requirement that employers help pay for health insurance, and a budget to ensure that it is fiscally responsible. I have been waiting a long time for a President willing to lead that fight and take on that issue. I am proud to be part of an administration willing to seize this opportunity.

President Clinton is committed to universal coverage and comprehensive benefits with lifetime coverage, and coverage and cost protections for every American. He is committed to choice in health care. He is intent on seeing the quality of health care improve. He wants to reduce the paperwork burden for individuals and for employers.

He wants to make everyone responsible for health care, and he is intent on financing the Health Care Security Act in a responsible manner, and the President sure wants a bipartisan solution to the problem. It is an American issue, not a partisan issue.

The President and I look forward to working with the members of this committee and others in the Congress to enact a comprehensive and lasting reform of our health care system.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Secretary. That was exceptionally straightforward and illuminating testimony, and we thank you, in particular, for the table of the revenue proposals in the Health Security Act. And we thank you for emphasizing the need for a bipartisan approach. Senator Packwood and I are well-launched on this, I think, and you can see it before you in this committee.

I will take advantage of this opportunity to raise a question about a revenue source, which we have not yet discussed, which is a tax on ammunition. If you, sir, were to look at evening television and ask, what is the most urgent health emergency in our country, you would think it was bullet wounds and handgun wounds. The proposition is that guns do not kill people, bullets do. We are engaged in this protracted effort to control access to handguns. The President was speaking yesterday with former Press Secretary James Brady and Mrs. Brady, and so forth.

But it is a fact that we have taxed ammunition since the Revenue Act of 1918. You are responsible for the Bureau of Alcohol, Tobacco and Firearms, which has licensed the manufacture of ammunition since 1938. The derisory sum of $10 a year will let you produce any amount of ammunition with no reporting. The revenue, actually, obviously can be raised considerably. To some extent, it is like the proposal on tobacco. You hope your revenue goes down because your consumption goes down as well.

But, if I can just say, I think we do not follow the extent to which atrocious rounds of ammunition are being introduced to the public right now. Here is a report on a new product by the Winchester Division of the Olin Corporation called the Black Talon round.

It says, "the Talon expands to expose razor-sharp, reinforced jacket petals. These cut tissue in the wake of the penetrating core. Toward the end of the bullet travel, the Talon bullet typically turns sideways. From this point on, it penetrates soft tissue like a throwing star. Very nasty, very effective, and a real improvement in handgun ammo." I cite Handguns for Sport and Defense Magazine. It is out there. One Senator had a person arrive in her office with ammunition.

A surgeon at the Parkland Memorial Hospital in Dallas, in the Trauma/Emergency Department, described having to remove the Talon by hand, which you have to do. He says, imagine someone reaching into a bucket of mud and there is a multi-hooked fishhook down there, and the possibility of AIDS present.

We do not need that round, sir. The police do not want it; we do not want it. Someone is making money off of it. There are 1,000 rounds like it. We have banned armor-piercing ammunition. We did get that round banned here. You were part of that, sir.

Do you think we might develop a comprehensive tax system on handgun ammunition that might be part of the revenue stream for this proposal; a combination of raising revenue, and, in the end, discouraging the production, or even outlawing it?

Secretary BENTSEN. I must say, I cannot see any possible excuse for that particular piece of ammunition that you are talking about.

The CHAIRMAN. Yes. You know about guns.

Secretary BENTSEN. Oh, I do.

The CHAIRMAN. You are an old Air Force bomber pilot.

Secretary BENTSEN. Yes. I do not intend to bomb out on this one. Obviously, that is a source of revenue that could be examined, and we are willing to look at your proposal. I, as you know, was a strong supporter of the Brady Bill.

The CHAIRMAN. Yes, sir.

Secretary BENTSEN. I think that is an excellent bill. I am totally for it. We chose the tobacco tax because there is a direct relationship to health but we do not preclude the other one. We are quite willing to look at your proposal as an addition. In the past it has not been, even with the present tax percentage—frankly, I have forgotten what it is—a big source of revenue and I am not sure that it could become so. But we are quite willing to look at that, Mr. Chairman.

The CHAIRMAN. To pursue this conversation, Mrs. Clinton was here earlier, and the subject was raised and she was very positive.

Secretary BENTSEN. Yes.

The CHAIRMAN. Good.

Secretary BENTSEN. We would be delighted to look at it.

The CHAIRMAN. Thank you very much. Senator Packwood.

Senator PACKWOOD. Mr. Secretary, I hate to ask you this, but, as you may or may not be aware, when we passed the 1993 Budget Act we added a new provision that we have to have 10-year estimates, and bills reported out have to be revenue neutral in each year.

Secretary BENTSEN. Yes.

Senator PACKWOOD. First, 10-year estimates——

Secretary BENTSEN. And, I must tell you, it gives us a real problem.

Senator PACKWOOD. I do not blame you. You will recall, when we were doing the Tax Reform Bill and we were trying to do 5-year estimates, and if we are off 1 percent we were off $50 billion. But, anyway, we have done it to ourselves. We passed it, and we want 10-year estimates, and they have to be revenue neutral in each year. I am not asking you for them now. You have done an excellent job on the estimates you have here over 7 years. But, anyway, I ask only because we have to have them. And, if you can get them, fine. I would hope we would.

Secretary BENTSEN. Well, let me tell you, Senator. It is a tough job, but I share that concern with you. I have asked for those and the agencies are working on those 10-year estimates right now because I think it is an imperative, and we are going to provide you that information just as soon as it is available.

The CHAIRMAN. Ten year?

Secretary BENTSEN. Yes.

The CHAIRMAN. God bless you.

Senator PACKWOOD. I appreciate it.

I will take it with a grain of salt, not because of any efforts on your part are lacking. It is just that I doubt 10-year estimates——

Secretary BENTSEN. It is tough.

Senator PACKWOOD. I know it is.

Now, the second question—and this is more specific, and it is tough, and, I fear, real—the Bureau of Labor Statistics has indicated that a 75 cent a pack tax increase on cigarettes will raise the Consumer Price Index about 0.7 percent. They estimate that that increases our Federal spending about $4 billion a year for entitlement programs that are paid through the Consumer Price Index. Is that taken into account in your estimates?

Secretary BENTSEN. Yes, that has been taken into account.

Senator PACKWOOD. Good.

Secretary BENTSEN. I must tell you, I think that that index reflects what is now a disproportionate impact. But, nevertheless, it has been taken into account.

Senator PACKWOOD. I thank the Secretary.

That is all the questions I have, Mr. Chairman.

The CHAIRMAN. Thank you, sir. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman and Mr. Secretary, I must begin by granting the statement that you made that the President's plan or the administration's plan is the only plan that says exactly what you are going to do and exactly how you are going to pay for it. As a co-author of two other plans, I will grant you that in the beginning and I will compliment the President, Mrs. Clinton, you and everyone else for the thoroughness of your work.

I think the concern that a lot of people have is, not for the thoroughness about which you went about the proposal, but whether or not it is going to work. I have some sympathy for you, and I have some sympathy for whoever it was—Kinsley, or somebody—this morning, who says, cut the deal real quick, otherwise somebody is going to pick this thing apart and it is going to bleed from a thousand cuts.

But there are a couple of critical questions, and a variety of them that need to be asked we probably will not get a chance to ask today.

When I think about what we are doing, I think about three areas of reform. First, is system reform, changing this whole system of ours. The objective there is to raise the value of what we get, and, thus, reduce its price. And, in the Republican Senate bill, the Managed Competition bill, and the President's bill, that is achieved through something basically called Managed Competition.

The second, is coverage reform. And this is a difficult one because another word for coverage might be making sure it is affordable to everybody in the country, or providing everybody with an insurance plan that is affordable.

The only way we get at that is through insurance reform. It was at 97 to nothing twice last year on insurance reform. We need to establish or re-establish the notion that we have to get rid of experience rating, get rid of all of the things that drive the medically uninsurable out of the market, begin to make the insurance company or whatever we're going to call it go out and assume risk rather than try to avoid the risk. And that is an important first step. There is a consensus, as you point out, across all of the plans on that one.

But then it gets difficult, because then we have to go into, how do you make these plans affordable to people, with their now ap-

proximately similar prices in the same market, because people buy them on the margin?

The answer to that, is a tax subsidy, the answer to that is Medicare for the elderly and the disabled, and the answer to that is Medicaid, and the answer currently in the current marketplace is cost shifting, which is a problem that you have already pointed out.

My impression of the administration plan is that it does not really reform Medicare. It talks, as many of our plans do, about moving, for the low-income, into a more vouchered approach, but I am having a little difficulty finding the financing for it. It does not take on the tax cap, as we call it, until 10 years from now.

It continues to acknowledge the fact that General Motors can go out and settle with its employees for first-dollar coverage financed by the taxpayers, while Tom Daschle and the rest of us are struggling to make ends meet in our rural communities.

But then the administration is going to come along and say, we are going to bring you and General Motors, who are now at 16 or 18 percent of payroll on your health insurance for yourself and your retirees, somehow we are going to bring you down to 8 percent.

Yet, we are going to continue to allow negotiations of free health care for those employees. There strikes me that there is something inequitable across America about continuing that process.

So, having said that, I really do need to ask you a question about cost shifting before and cost shifting after. And just so we understand what cost shifting is—I recall these figures from Houston and I think I have shared these with you before—one of my experiences down there at one of the hospitals in the Houston area, where they say the indemnity plans have to pay about 160 percent of the hospital charges; the HMO plans pay about 110 percent of hospital charges; Medicare pays about 85 cents of hospital charges; Medicaid pays about 40 cents of hospital charges; and, of course, uncompensated care is zero. So, we know what that kind of cost shift is.

But, when part of the savings in the system, or a substantial part of the savings in the system are going to come from decreasing Medicare payments or the growth of Medicare payments, or decreasing the growth in Medicaid payment, I am left wondering how in the world we end this whole business of cost shifting.

You talked about Lawton Chiles, just to add another example. I wish I had more time to lay these on you in variety. But I know why Lawton went back to be Governor of Florida and switched his position.

It is because he discovered that, in Miami, the doctors are charging $1,874 a year for Part B payments for doctor services, whereas, in Minneapolis they are only $822 a year, and in Salt Lake City, Utah, they are probably about $650 a year.

Of course he wants universal coverage. Of course he wants the national taxpayer and the folks in Minneapolis to pick up the bill after they worked to get a better system. Of course he wants them to pick up the bill in Florida.

The CHAIRMAN. Mr. Secretary, would you like to answer that question? [Laughter.]

Senator DURENBERGER. Would I like to stop asking the questions?

Secretary BENTSEN. Well, let me state, under Medicare it will continue as it is and has been in the past, with the addition of outpatient prescription drug coverage.

Insofar as the other question is concerned, in allowing the Big Three to continue to give total coverage for awhile, what we are talking about is trying to have a transition period so we do not have a shock to the system, where people adjust to it over a period of time, and that, frankly, we get the support we need to enact a bill.

The CHAIRMAN. Thank you, Senator. We will stay with this.

Senator DURENBERGER. All right. Thank the Chairman.

Secretary BENTSEN. There is more to be answered than time.

The CHAIRMAN. There is more to be answered. And, if you would like to give us something in writing, because Senator Durenberger has been working with you on this so long.

Secretary BENTSEN. I would be delighted. Because, as he said, he laid it on me for quite awhile there. I will be delighted to.

The CHAIRMAN. Thank you, Mr. Secretary. Senator Grassley.

Senator GRASSLEY. I know that I cannot put words in your mouth, and I am not trying to. The family plan for a two-parent family with children, to my understanding, would be about $4,360. It was $4,250 and then revised upwards, I believe. I am hoping that you can answer that that is the maximum any family would have to pay, at least starting out.

Secretary BENTSEN. I would say that is the average. You cannot say any family.

Senator GRASSLEY. All right.

Secretary BENTSEN. Average.

Senator GRASSLEY. The average would be all right for me.

Secretary BENTSEN. All right.

Senator GRASSLEY. Then if a person is self-employed, they would pay whatever that family plan would cost. What happens if somebody in the family worked for another employer and the spouse works in town for somebody that provides insurance through that employer, so that one person would get their insurance paid through the employer. Is there any—and this gets at the crux of my question—possibility that a family would have to pay more than 100 percent of a premium under a family plan?

I perceive that it is possible, that if you were self-employed, paying for it out of your business, that that would be X number of dollars for that family. But, if somebody went to work outside the family to bring in extra income and was covered under another plan, that, through that other plan they might actually end up paying more for health insurance than that 100 percent maximum for that family. Is that possible? And, if it is possible, is it right that it be possible?

Secretary BENTSEN. There are two basic components that make up the total premium obligation: the "family share" and the "employer share." The family is given credit for the family share paid, through paycheck withholding, by the spouse who is employed by the employer in town. Since the family share is paid only once, the self-employed spouse isn't required to pay the alliance any addi-

tional amount for the family share. With respect to the employer share of the premium, the shelf-employed spouse pays the employer share—for an average-cost plan, this would be up to $2,479—and, in addition, the employer in town would also pay up to that same amount.

So, in total, for an average-cost plan, the family you describe would pay a single 20% family share (up to $872) plus the self-employed "employer share" (up to $2,179). This total would not exceed 100% of the premium.

Senator GRASSLEY. All right. So, I do not have to worry then, through your plan, that any family might have to pay more than 100 percent.

Secretary BENTSEN. That is correct, for the example you gave.

Senator GRASSLEY. Thank you very much.

The CHAIRMAN. Thank you, Senator.

Senator Baucus.

Senator GRASSLEY. Oh, no. I'm not done.

On another point—and I hope you believe my sincerity because I think it could be seen as partisan—an opportunity to clarify what Secretary Shalala said last week and then what Magaziner——

Secretary BENTSEN. Let me tell you something, Senator.

Senator GRASSLEY. All right.

Secretary BENTSEN. You have always been candid, and I have never charged you with being otherwise.

Senator GRASSLEY. There is a question, apparently, of whether 40 percent of the people in America will pay more in premiums, or just 15 percent will pay more in premiums as Ira Magaziner said this last weekend.

Secretary BENTSEN. Yes. Let me say on that, Senator, that the numbers that were given were numbers that were given without consideration for the out of pocket costs; the questions of deductibility, co-insurance, those things had not been put into the computation. The number is substantially less than 40 percent, but HHS is working to clarify that and we will have you more definitive numbers.

Senator GRASSLEY. So then they will clarify this chart that they gave us last week, that this chart does not take that into consideration.

Secretary BENTSEN. That is correct.

Senator GRASSLEY. The administration's plan is going to provide for what are called in the legislation discounts for small employers. The most that the smallest business with the lowest annual average wage would have to pay would be 3.5 percent of payroll.

I did notice that a few pages further on in the bill that there is a little section numbered 6125 entitled, "Employer Collection Shortfall Add-On." Am I correct in understanding that this section provides that if an alliance does not originally collect from employers the amounts that it expects to collect it can seek additional amounts from all employers and it can collect those additional amounts without regard to the discounts that apply in the original levies?

Secretary BENTSEN. Yes. Employer will pay in general 80 percent of the estimated shortfalls in collections and the employer premium

discounts will not apply to this additional collection. There is no more discount available for the additional levy.

Senator GRASSLEY. All right. I think I got your answer, except for the point about the discounts being taken into consideration. There is still a maximum discount even if there is an add-on. There will not be any more discount even if there is an add-on to it, what is going to be assessed to an employer if there is a shortfall.

Secretary BENTSEN. I think that is the way it is written.

Senator GRASSLEY. All right.

Secretary BENTSEN. Senator, I think that is the way it is written.

Senator GRASSLEY. All right. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Grassley. And, may I, in respect to that matter that Senator Grassley raised, the 40 percent figure was presented to us in testimony by your Cabinet colleague, Secretary Shalala.

Secretary BENTSEN. That is correct.

The CHAIRMAN. It was a bar chart with those that will pay more, those who will pay less. If it is does not satisfy your standards of accuracy or detail, we would appreciate another. And, in your good time, I hope we will get one.

Secretary BENTSEN. Mr. Chairman, it did not take into account the out of pocket expenses.

The CHAIRMAN. Yes.

Secretary BENTSEN. Those things were not considered. It is now being recalculated with those taken into account and those estimates will be provided to you.

The CHAIRMAN. Fine. Thank you very much. Senator Baucus.

May I first say that the Secretary must leave at noon, so we will all be mindful of that. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Secretary, I have a couple of questions. The first, deals with tax-exempt non-profit hospitals. Currently, hospitals can elect, as you well know, non-profit status if they show that they are providing a certain amount of charity care. That provision costs the Federal Government between $25–$30 billion over 5 years, and it also costs State and local governments about $15 billion over 5 years.

Now, I understand that the Health Security Act will reimburse hospitals for all the care they provide, including emergency room services, yet I understand further, that, despite eliminating the need for hospitals to provide charity care, the administration does not anticipate any revenue gain.

So, I am curious as to why we need this provision in the code providing tax-exempt status for non-profits if the Health Security Act will reimburse all hospitals for all care, including charity care, and why the administration does not anticipate any gain in revenue.

I guess what I am really getting is, what must non-profit hospitals show in the future to retain the non-profit status, even though they will be fully reimbursed for all services they provide?

The CHAIRMAN. A very good question.

Secretary BENTSEN. Well, as you correctly stated, Senator, in the past they have taken a lot of charity cases. In this situation, that is now unnecessary. But, to continue their non-profit status, we are

requiring that they assess the health care needs of the community at least annually, and develop a plan to meet those needs.

The hospital will have to conduct this needs assessment and plan development process with the participation of the representatives of the community. That is a requirement which would supplement the current law requirements, and, I think, a rather reasonable requirement.

Senator BAUCUS. Well, I hear what you are saying. But it just seemed to me, certainly on the surface, there is much less need for non-profit status if the act provides for full reimbursement to hospitals for all care that they provide. The main reason for non-profit status today is for charity care.

Secretary BENTSEN. Absolutely. I agree with that.

Senator BAUCUS. And there will be no charity care anymore.

Secretary BENTSEN. I have stated that, too.

Senator BAUCUS. Therefore, there seems no need.

Secretary BENTSEN. But, therefore, there are other things these institutions do to satisfy the needs of a community. These other functions can be given consideration, and working with community representatives to identify and address those needs, perhaps, we cannot anticipate what they can do to earn their non-profit status.

Senator BAUCUS. Will those plans that the hospitals provide to the government, whether it is Treasury or whomever, be plans that will be provided to the public?

Secretary BENTSEN. Oh, certainly.

Senator BAUCUS. Similar to Form 990, which is now supplied by tax-exempts like the Treasury.

Secretary BENTSEN. I can see no reason why it should not be public.

Senator BAUCUS. The second question regards Item No. 12 in the handout that I think the Treasury provided to the Senate. It is called, "Revenue Proposals Health Security Act." Number 12 states, "Assessment on premiums and regional alliances. Beginning October 1, 1995, a 1.5 percent assessment will be applied to premiums for comprehensive health coverage purchased through regional alliances."

Does that mean that each American will be paying the 1.5 percent tax on their premium?

Secretary BENTSEN. No. That is already figured into the premium and that 1.5 percent is pulled out of the premium paid to the regional alliance.

Senator BAUCUS. Who would pay the 1.5 percent?

Secretary BENTSEN. Well, that would be paid to the regional alliance as a part of their overall premium. It is a portion of that premium, in effect.

Senator BAUCUS. So, it is the alliance, that pulls 1.5 percent out of the premium that each individual pays.

Secretary BENTSEN. That is correct.

Senator BAUCUS. And then the alliance would then remit that amount to Uncle Sam.

Secretary BENTSEN. That is correct.

Senator BAUCUS. Now, I hear——

Secretary BENTSEN. Now, that does not necessarily have to be done that way, and that is one of the things that is being deter-

mined, whether or not it has to come back to Treasury. It could be handled through a reduced Federal contribution to the alliance. It could be handled either way, probably.

Senator BAUCUS. I raise this, in part, because it is there in your handout and I was unclear as to what that is. Also——

Secretary BENTSEN. Well, I think it is a legitimate question and one that has to be further resolved. I do not think there is a final decision on that as yet.

Senator BAUCUS. And it is supposed to raise $18 billion over 5 years. But I am also told that it is being used to fund graduate medical education. Is that correct?

Secretary BENTSEN. Part of it. Part of it goes to medical research. We have done that in the past, and we did it with induced medical education payments, under Medicare.

Senator BAUCUS. Yes.

Secretary BENTSEN. And this is a substitute for that approach.

Senator BAUCUS. Could you tell us what portion, roughly, is used to finance graduate medical education, out of the $18 billion?

Secretary BENTSEN. Oh. I will have to get you that one, Senator. I do not have that specificity on it as yet.

Senator BAUCUS. And who decides which schools or hospitals would get reimbursed; how is that going to be decided?

Secretary BENTSEN. HHS would do that.

Senator BAUCUS. Thank you.

The CHAIRMAN. Thank you, Senator Baucus. Senator Breaux.

Senator ROTH. Mr. Chairman, could I ask, since I have another committee meeting, will we be able to submit written questions?

The CHAIRMAN. Of course you can. And I know the Secretary would be happy to address them.

Secretary BENTSEN. I would be delighted. Thank you, Senator.

Senator ROTH. Thank you.

Senator BREAUX. Thank you, Mr. Chairman. S. 1579 is the Breaux-Durenberger bill, which is referred to this committee. My good friend, Senator Rockefeller, referred in the beginning, he did not know what the other plans did because we had not seen them. S. 1579 is pending in this committee and has been for quite some time. In fact, we introduced a similar bill in the last Congress.

The CHAIRMAN. It is, indeed.

Senator BREAUX. It is 260 pages that was introduced in the last Congress.

The CHAIRMAN. Not long enough. [Laughter.]

Senator BREAUX. It has been around a long time. We will not win the size battle. We are looking for efficiency. But it is here. The pages are typed and it is typed in the form of a bill, and it is easy to read.

There should be no question about what it does. We can argue about the merits of it, but it is there. The administration's bill has not been introduced yet. I hope and expect that it would be referred to this committee when it is introduced. But there is not an argument, certainly, at this point that we do not know what the other plans do, because we do.

My understanding is that Senator Wellstone's bill is also in this committee——

The CHAIRMAN. Correct.

Senator BREAUX.—and it is in the proper form, so we know what it does. Now, we do not have a CBO estimate on our bill because CBO said that we are going to wait until the administration's bill is introduced and have estimated first and then they will estimate ours in due course. They estimated the managed competition bill and we have those numbers. The bill has changed a little bit, but not a great deal.

The other bills have been introduced. They are pending before this committee, as a matter of fact.

Mr. Secretary, thanks again. You have done tremendous work in, I think, a relatively short period of time in putting the numbers together on this proposal from the administration, with which our bill has a great deal in common. We have more in common than we have in differences.

I think, and would say, and predict that sometime next year there will be meetings between administration officials and those who advocate different approaches like managed competition, and that we will come to an agreement that will be a compromise that will take the best features of all approaches and produce real health reform for this country. Such an effort would be a credit to everybody in this Congress. And that is what I am working towards.

Let me just ask one question which is one of the differences in the two approaches. On page 3, Mr. Secretary, your statement points out that employers will be required to pay 80 percent of the average premium. However, the plan limits the percentage of payroll that would be devoted to health care premiums to 7.9 of payroll for large firms.

Now, that really, in essence, is one of the principle differences between managed competition in my bill and the administration's bill. We use the Tax Code to provide incentives to encourage competition, to encourage the purchase of the least costly plans. My concern with this approach is that it does not do anything to encourage the phalanx of least costly plans, to encourage the competition to produce lowest price, highest quality plans.

My point is, that if an employer can deduct 100 percent of his premium costs, there is no incentive to purchase a less costly plan. The limit of 7.9 percent of payroll is not going to bother him if he knows that somebody else is going to pick up any excess costs if they exceed 7.9 percent of payroll. If he picks a plan that is 10 percent of his payroll, he does not pay that extra 2.1 percent.

It is my understanding that the alliance pays it; somebody else pays it. And that is one of the concerns that we have had, is that we do not use the Tax Code in the administration's plan to encourage competition, to encourage movement towards the least costly plans.

I would like to give you a chance to comment on the fact that we are not doing anything at that point to encourage employers to move to the least costly plan.

Secretary BENTSEN. Our approach is one where we are trying to get the competition—and managed competition is very much a part of this—on the basis of quality of service and cost of service, by having a standard benefit package for everybody. Since there was a standard benefit package the competition would be on cost, and

it would be, on quality. That is it. That is the way it has been presented, and that is the way it has been proposed.

And, frankly, I think it is a good standard to judge by. We have got a comprehensive benefit package if you do not have that, then you will have a deficient benefit plan. And without comprehensive benefits that kind of situation would not give the coverage that is important and necessary.

Senator BREAUX. Well, we do not have a lot of time to talk on those points. The point is, is that every plan is going to have a standard plan and it is going to provide coverage for the same features in all of the plans. And any plan that is offered has to meet those procedures, and their records have to be out there for everybody. We have no disagreement on the quality aspect.

I think one of the defects in the proposal from the administration is that we do not use the Tax Code to encourage greater competition to produce the least costly plan. If I am an employer and I know that I can deduct 100 percent of my premiums, up to 7.9 percent of my payroll, there is no incentive to look for the cheaper plan. Then if I know that if it goes beyond 7.9 percent that somebody else is going to pay for it, again, there is no incentive to seek out the least costly plan.

Secretary BENTSEN. Well, now, I do not concur with that. In the other situation we give the employee the chance to pick amongst plans, and if he has got 100 percent coverage the employer is paying 100 percent of it and he decides he wants to pick the cheaper, more modest plan, he can do so. And then the amount of money the employer saves goes in to wages for that employee.

Senator BREAUX. Well, the person who provides the insurance, the employer, does not have a problem with picking the most expensive plan. I mean, I think that is an area that hopefully we can work out something in the future.

The CHAIRMAN. We will be at that. May I point out to the committee that the vote has been called. Senator Daschle, you are next. Senator Baucus has agreed to Chair the hearing while I rush off, and we will try to give everyone a chance to question the Secretary.

Senator DASCHLE. Thank you, Mr. Chairman.

Mr. Secretary, let me just pick up on that point. I think it is a very valid question and concern that we certainly want to address. There may be a misunderstanding about what I understand the Clinton plan does in this regard. As I understand it, the employers have nothing to do with choosing plans, the employees themselves pick the plan. Is that correct?

Secretary BENTSEN. That is correct.

Senator DASCHLE. And isn't it true that the Clinton plan calls for a comprehensive benefit package—that employees and employers would be entitled to? Should they choose more elaborate coverage they would then pay a tax on that additional benefit as if it were income. Is that not correct?

Secretary BENTSEN. They would pay for that with after-tax income.

Senator DASCHLE. That is my point.

Secretary BENTSEN. That is correct.

Senator DASCHLE. They pay after-tax income——

Secretary BENTSEN. That is right.

Senator DASCHLE [continuing]. On benefits above that package. My concern about the Cooper-Breaux approach is that we appear to be putting our health in the hands of the lowest bidder.

And it concerns me that we may be encouraging people to cut corners to reduce costs. Under the Cooper-Breaux plan, each person is going to be forced to take the lowest cost plan unless he or she want to pay taxes on a plan offering better coverage. Under the Clinton plan, we are going to cover everything you need for comprehensive health care, and, only if you take auxiliary coverage will you pay with after-tax income. Is that a correct interpretation from your point of view?

Secretary BENTSEN. That is a correct interpretation. That is it.

Senator DASCHLE. Well, I think that is one of the many issues that we are going to have to sort out. As Senator Breaux has indicated, there is a very big difference between mandating an individual to obtain health care from the lowest bidder as opposed to making sure individuals can obtain a good, comprehensive benefits plan with pretax dollars.

The other thing, that is very important—and I would be interested in your observations on this——

Senator CHAFEE. Could I just say one thing here? You are always talking a uniform benefits package, however. So, when the Senator suggests you are cutting corners, no, it is always using the same benefit package. The variation—I am on your time.

Senator DASCHLE. That is all right. I will take some of yours and we can get back. [Laughter.]

Senator DASCHLE. I think it is important that we understand what we're talking about here. It is my understanding—and I could stand corrected—that the Cooper-Breaux plan does not spell out the benefits, but they would be determined by the Health Care Standards Commission. So, we really may not be comparing apples to apples here.

In the Clinton plan we have an elaborate, delineated set of benefits, including long-term care and prescription drug care, that, as I understand it, is not in the other plans. And, if it is, I hope the Senator from Rhode Island will correct me.

I think it is very important that, number one, we understand that we are talking about comprehensive benefits under Clinton's plan. We are talking about what might be called a bargain basement benefits plan under Breaux.

Second, I think it is very important that we take a look at another issue, and that is the tax deductibility question. I think the Cooper-Breaux plan imposes a "choice tax." I do not know if there is any other way to say it. If you are going to tax benefits beyond a health-to-the-lowest-bidder approach, it is a choice tax. If you want choice, you are going to pay a tax. Do we really want that?

Let me move to another issue. I was very interested in a recent study by the Rand Corporation, and I would be interested in knowing whether you had any comment on it.

The Rand study was a comprehensive study having to do with the effect of health reform on employment. There have been critics that have alleged that the Clinton plan could result in a loss of 3 million jobs. The Rand study indicated that the potential job loss was extraordinarily minimal, perhaps one-half of 1 percent.

Mr. Secretary, I would be interested in knowing whether that is consistent with your own analysis, whether you have different figures, or to what extent you have had a chance to look at the Rand study and have evaluated its veracity.

Secretary BENTSEN. Well, I think, unfortunately, I know of no economic models that can evaluate all of the employment effects of health care reform. In other areas of economics you can develop those models, and we have done it time and time again and we have tested them for decades. We have experience in the outcomes that we predict.

In predicting the effects of health care reform on employment there is an old adage, that you get out of it what you put in it. In such circumstances, I do not think I am in a position to give you a specific number.

Senator DASCHLE. Well, I can understand. I just think it is interesting that an independent study—I would think Rand is probably as reputable an organization as one might find—has concluded that job loss is one-half of 1 percent. I certainly hope that, as we go through the next several months and consider analyses of this kind that, perhaps, a Rand expert can come and further explain their predictions.

But, I thank you, Mr. Secretary. I see I am out of time.

Senator BAUCUS. Thank you very much, Senator.

Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. Mr. Chairman, I want to ask one question for the moment to Secretary Bentsen because I have to go vote, and there has to be a 2-minute Veteran's Committee meeting on the floor after that.

This has to do with the Constitutional Balanced Budget Amendment which is going to be voted on in this body in 2 weeks or so. If there is a Constitutional Balanced Budget Amendment that is passed, and there are some who say that that will happen, obviously one of the prime targets would be Medicare and Medicaid for the massive cutting that would have to take place.

My question to you, therefore, is, what would be the effect, in view of comprehensive health care reform and what we are doing with respect to Medicaid and Medicare in that bill, on the prospects of health care being passed this year, next year, or any year if we passed a Constitutional Balanced Budget Amendment?

Secretary BENTSEN. Well, I think it would impair it. In the long run, we could probably come within the budget limits as we get better control of health care costs. But, in the short run, I think there is a conflict there and a real problem.

Senator ROCKEFELLER. A conflict, I would think, which would be so immediate and so absolute that, even with the prospect of coming years, people would be reluctant to make cuts in Medicaid and Medicare.

Secretary BENTSEN. That would be my deep concern.

Senator ROCKEFELLER. And, thus, there would not be health care reform passed. I just want to put that on the record.

Mr. Chairman, I have to go downstairs in order to vote and have a quick, 2-minute meeting and I would like to reserve the balance of my time for one more question when I return.

Senator BAUCUS. You have a few more minutes. The vote will not——

Senator ROCKEFELLER. I know, but I have seven members of the Veteran's Committee waiting down there for a quorum vote.

Senator BAUCUS. Thank you. Thank you very much, Mr. Secretary. I see no Senators to ask questions. I understand the Chairman will be back very quickly.

Secretary BENTSEN. All right. Fine.

Senator BAUCUS. So, the committee is now in recess for probably about 5 minutes.

Secretary BENTSEN. Fine.

[Whereupon, at 11:22 a.m., the hearing was recessed.]

AFTER RECESS

The CHAIRMAN. I wonder, out of consideration for the Secretary's time, if we might resume now.

Mr. Secretary, the vote was prolonged, as you would expect. There is no Senator here who has not been heard. So, I will share what time we have until one such appears, with Senator Durenberger, if I may do.

Just to ask you, if you would not want to expand on this question of the status of non-profit hospitals. I will speak as a New Yorker when I say that I had never known there was anything other than a non-profit hospital. I am not familiar with the concept of a hospital that is other than basically a charitable enterprise. New York Hospital in New York City was chartered by George II, and is a charitable enterprise.

Are we facing the prospect of redefining income in such a way that our great charitable hospitals will find themselves declared to be for-profit enterprises? Because there is surely no profit in it. I know that is not your purpose, but I would want, perhaps, you to clarify it.

Secretary BENTSEN. Mr. Chairman, hospitals have been eligible for tax-exemption since the beginning of our income tax system. You are quite right on that.

The CHAIRMAN. Yes, sir.

Secretary BENTSEN. And we recognize the promotion of health as a charitable purpose, and our proposal would not change that.

The CHAIRMAN. And would not change that. And you do not contemplate any changes.

Secretary BENTSEN. We asked them to do this, in consultation with representatives of the community, to set out a plan as to how they respond to the health care needs of that community.

The CHAIRMAN. Yes.

Secretary BENTSEN. I think that is compatible with what you and I are talking about.

The CHAIRMAN. And if they run a surplus every so often it is because they need to build an endowment. No one makes any money out of hospitals.

Secretary BENTSEN. I think, in this instance, what we are talking about is something that is compatible with the objectives we are talking about in taking care of the health care needs of the community.

The CHAIRMAN. Yes.

Secretary BENTSEN. The exemption would continue under those conditions.

The CHAIRMAN. Fair enough. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, I wonder if the Secretary might take most of my 5 minutes, or whatever we might have here, and respond to what is probably not as well stated a question as I would like to have stated it.

But the thing that is puzzling me, as one who really wants this to be successful, is how we can capture $124 billion in savings from Medicare, $65 billion in savings from Medicaid, and provide a large chunk of subsidies for employed people.

How do we capture all of this in a national system, which is as disparate as Miami and Minneapolis, with the charges and all the rest? How do we capture that and then transfer it around so that, somehow or other, it takes care of the uninsured and so forth? The proposal captures a lot of savings and then uses them to expand coverage, but the people who need the coverage are not in the same place as the places where you get the savings. I am just curious.

The CHAIRMAN. Do you want to expand that last statement? That would be helpful. The people are not in the same place?

Senator DURENBERGER. Yes. We are talking about capturing savings in Medicare. Let us say Wadena, a small town in Minnesota, has 57 percent Medicare of one of the hospitals there, Tri-County Hospital; 57 percent of the people are on Medicare, 13 percent of the people are on Medicaid, and only 27 percent of the people are in some private care system.

Now, in a suburb someplace you will have somewhat the reverse of that. And, yet, we are going to try to go out to Wadena and capture savings from these Medicare/Medicaid people and then transfer them to somebody else someplace who is currently uninsured, probably one of my uninsured young sons who chooses not to be insured, or low-income persons in some other part of the country. It is a puzzle to me, how do we capture these so called savings and move them around?

It is a puzzle to me, Mr. Secretary. I was told the other day, for example, that if you take Marathon Oil out of U.S. Steel, U.S. Steel's health care costs for retirees and active employees as a percent of payroll is 23 percent. That is going to go down to 8 percent somehow or other. I do not know how it goes down, why it goes down, and who pays for it. How do we accomplish things like this on anything other than paper?

Secretary BENTSEN. Well, part of it, of course, is that we are talking about savings from managed competition. That brings about a substantial amount of savings.

Some of us feel that the amount of paperwork that is involved now, as you well know, Senator, with your studies of it, is just incredible, and that we anticipate in this bill that if we get down to one claims form and other administrative efficiencies, that we will cut back very substantially on management costs of these various systems.

So, putting all those things together helps us, I think, very substantially to bring about savings that will then be translated into more comprehensive coverage and getting everyone into the system. It is not easy; obviously not.

Senator DURENBERGER. No.

Secretary BENTSEN. If it were, it would not have taken these months and all of these hundreds of people working together to do it.

Senator DURENBERGER. And I appreciate the response. But, Mr. Secretary, you have been at this business of trying to save money in Medicare for longer than I. And the reason that I earlier gave you the figure for Miami, which is $1,872 per year, per physician in Part B, and, in Minnesota it is $822—that is Minneapolis; up in Duluth it is probably only $600—is that we are trying to do managed competition in Minnesota and we cannot get rewarded for it in a system like the proposal here which would reduce payments for Medicare in Duluth, which is already at $600.

Do you understand me? When we say we are going to reduce the growth of Medicare it means we do it across the board. Instead of letting it go up by 11 percent, we say it is only going to go up by nine, or we are going to freeze categories for this category, or that. Well, that penalty hits Duluth the same way it hits Miami. It is the way the system works.

So, my question, again, is, if you want managed competition to work in Duluth, you do not cut the reimbursement in a place in which the payments are $600, you should cut it all in Miami where it is $1,872.

Or, on Long Island, in the discussion we had earlier—and I am not picking on the Chairman—where the TEFRA risk contracts are, this year, paying $600 plus to a plan on Long Island, and $279 in Duluth, but Duluth gets cut and Long Island goes up 15 percent.

Now, there is something I do not quite understand about how we make managed competition work on one hand, and we capture the so called savings on the other.

The CHAIRMAN. What you are saying is, you do not want to penalize success.

Secretary BENTSEN. Well, I take a look at what we are proposing by adjusting Federal employees' pay across the country now, for the cost of living in different parts of the country and the differential that exists there, we adjust for those types of things and yet our tax rates are uniform. We further adjust with the small firm subsidy, and with the individual subsidy to bring about what we think is equity to all the American people.

The CHAIRMAN. Thank you, Senator.

Senator DURENBERGER. Thank you for the opportunity.

The CHAIRMAN. Mr. Secretary, we are going to ask you for more specific numbers—or as specific as you can get—on the regional distribution of the uninsured. This came up with Secretary Shalala.

Secretary BENTSEN. Yes. All right. Fine.

The CHAIRMAN. It is an old, familiar pattern. It has its problems.

Secretary BENTSEN. It sure is. And I can think of my own State and what we have there, a very high percentage of uninsured. One of the very highest.

The CHAIRMAN. As, again, in Rhode Island.

Secretary BENTSEN. The Senator was very kind. He left me alone on that. He went to Florida. But we understand the differences.

The CHAIRMAN. Right.

Secretary BENTSEN. We have worked on these problems.

The CHAIRMAN. Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman. Mr. Secretary, it is good to have you before the committee once again.

Secretary BENTSEN. It is good to be here.

Senator PRYOR. I want to compliment you on talking about an issue and a part of the overall comprehensive health care plan, as offered to the Congress by the President and the First Lady, and compliment you on emphasizing what it is going to cost us——

Secretary BENTSEN. Cost what?

Senator PRYOR. What it is going to cost us to do nothing if we continue doing nothing.

Secretary BENTSEN. Yes.

Senator PRYOR. I think, as you did in your statement this morning, we need to constantly emphasize what is going to be happening to us when our health care costs in this country go from 14 percent of GDP to 19 percent by the year 2000, just 7 years. It seems like all the headlines these days are what the Clinton plan is going to cost. I hope we will start seeing some headlines about what it is going to cost each American family, every one of us, if we continue to do nothing.

Secretary BENTSEN. I think you are right. And I think the other side of it, if we do nothing and then this goes to 19 percent of the GDP at the same time our international competitors have stayed below 10, you can see what it costs us in jobs and standard of living in this country.

Senator PRYOR. Well, it seemed to me—and I think this figure may have gone up another $100 in the last 30 days—that $1,100 per automobile, I believe, that comes from Detroit or from major automobile manufacturers in this country is attributed to the cost of health care. We are probably looking at $2,200 by the year 2000 for each automobile, which, in my opinion, this is going to be an area where we end up being totally uncompetitive.

I just am glad to see you stress this. I think all of us ought to really begin talking about this a great, great deal more.

There is one concern that I have with one of the plans—and I will call it, for the time being, the Cooper plan, introduced in the House. I am not certain if Senator Breaux and Senator Durenberger have included it in their proposal—that is, the delegation of new authority to the Internal Revenue Service to monitor the various alliances throughout the country.

I understand this authority would be to have the IRS monitor these alliances to determine if, in fact, a particular plan is the lowest price, therefore, enabling that company to get a deduction in the Tax Code.

Now, the Clinton plan proposes to let this step be accomplished by a national board. The Cooper plan says this should be accomplished by the Internal Revenue Service. And I think that we have a real difference there, in philosophical terms, as to who is to make that determination. And, Mr. Secretary, I wonder if you had a comment on that, or if you have looked at the Cooper plan. You may want to submit that in writing.

Secretary BENTSEN. What I would say, Senator, to the extent that the Cooper plan does that and requires the Internal Revenue Service to play a significant role in valuing the coverage or the ben-

efits or monitoring the health plans to determine whether a particular plan is the lowest cost plan in an area, I would have concern that it is not their background, it is not their area of expertise. We think it is desirable to minimize the role of the IRS in valuing the benefits and collecting the tax based on such valuations.

Senator PRYOR. I think, at last count, the IRS had about 117,000 employees. I am just wondering how much of that work force would have to be basically designated for this particular function, which is a new function for the Internal Revenue Service. It gives me some concern and I just wanted to make that observation.

Secretary BENTSEN. Well, when we are talking about the Vice President's plan to save in overall management costs and services costs, and we are looking at the further computerization of services in the IRS and having to make capital investments there, and then, at the same time, add this further service to its responsibilities, there is no question but that it would be an additional burden and a real problem.

Senator PRYOR. Mr. Secretary, I thank you. I have a few moments left, but I know you have to leave in a few minutes. So, I am going to yield back the balance of my time to my colleagues.

The CHAIRMAN. That is very generous of you, Senator Pryor. Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman. Thank you, Senator Pryor. Thank the Secretary for being here today.

I would like to return to the question, if I could, and perhaps explore a bit further the question that was raised with Secretary Shalala about the percentage of people paying more.

I listened to your answers to Senator Grassley and I am interested if information that I have received is in the ballpark, at least in terms of what you know now, or, if you are not prepared to provide additional information until HHS has done their analysis, I would understand that as well.

But my understanding, from the staff work that has been done, is that, in terms of total cost—that is premium as well as out-of-pocket expenses—that approximately 15 percent, would pay more under the Clinton health care plan; that the 40 percent paying more relates only to premiums and does not take account of the reduced out-of-pocket expenses those people would have. Is that approximately correct, or are you prepared to answer that?

Secretary BENTSEN. I would say on the 40 percent—and I do not want to give a definitive answer on the 15 percent because HHS is working on those numbers now—you are quite right in that it did not take account of the out-of-pocket costs. That is now being computed and we will be back to this committee with those numbers.

Senator CONRAD. Is it fair to say that that 40 percent number will be substantially lower——

Secretary BENTSEN. That is correct.

Senator CONRAD.—when the out-of-pocket expenses are taken into account?

Secretary BENTSEN. That is correct; it will.

Senator CONRAD. All right.

Mr. Chairman, please stop me if others have asked this. I am sorry, with the vote that has occurred I have missed what some others have asked.

I noticed in the paper this morning on page A3 of the Washington Post, a story that was headlined "Who's Left Holding the Bag if Health Subsidies Fall Short?" I do not know if anyone else has discussed this question.

The CHAIRMAN. I do not believe so.

Senator CONRAD. The question that was asked over on the House side was, if you cap the health subsidies, what happens if that cap is reached; who, in the terms of the headline here, is left holding the bag? Do the hospitals wind up eating the amount of money because of a capped subsidy; do people who were not able to afford it wind up holding the bag? That is a question that I think needs to be addressed.

Secretary BENTSEN. Well, let me state that we have set aside enough, we think, to fund those subsidies. In fact, we think we have a cushion. The plan proposed the discount funding pool at $349 billion over the 1995–2000 period. That is $161 billion in new money. The balance is reallocated from Medicaid and other savings, and that reflects the actuaries' estimates of what will be needed.

Now, the statutory language makes it clear that eligible individuals and firms will never pay more than the discounted rate for which they qualify. And, if the alliances run short, small businesses and low-income people will not pay any more, unless the law is changed.

I think one of the things that has to be taken into account is that when you talk about the subsidy money, only $1 out of $5—only $1 out of $5—is subsidy money. So, the alliances are going to continue to receive premium payments. They will have that normal flow of funds from employers and from individuals. And, I must say, it will be obvious ahead of time if they are beginning to run into trouble.

Reports are to be coming in from the alliances on a periodic basis, enabling the President and the Congress to act expeditiously to take care of the very concern that you have, Senator, if that becomes necessary.

Now, the steps that can be taken by the regional alliances are several. They can raise the premiums to the 7.9% level or they can have the premiums re-bid, they can reduce the provider payment rates or, in turn, they can adjust their cash flow—subsidies account for only $1 out of $5—they can slow down payments to providers; they can step up premium payment compliance efforts. We have done a bit of that sort of thing in our Medicare budget, you well know.

Senator CONRAD. So, these are all options that would be available. And what you are saying, as I hear your answer, is we would be able to see that, in fact, we are getting into trouble with respect to the cap and that all of these actions would be open to the Health Care Alliance and the others who are responsible for the fiscal management of this system to manage that situation.

Secretary BENTSEN. That is correct.

Senator CONRAD. Very well. I appreciate it. Thank you, Mr. Chairman.

Secretary BENTSEN. I am glad you asked, because that is one of the big questions I asked; what if we get into trouble, what if we are wrong?

Senator CONRAD. Yes.

The CHAIRMAN. Will you have a cap in order to hit up against it?

Secretary BENTSEN. That is correct.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman. Mr. Secretary, I have a lot of trouble with a new entitlement that is proposed under this program, namely, that the Federal Government will pay 80 percent of health care premiums of all retirees between the ages of 55 and, I believe, through 64, before they go on Medicare. This has the possibilities of being a very, very expensive program. I am not sure I understand why the administration has embarked on it.

It is pointed out that, yes, it is going to be great for General Motors, and, indeed, I suspect General Motors must be very enthusiastic about the program. Likewise, U.S. Steel and so forth where those companies currently provide the health care benefits in toto or in part to all their early retirees.

But to suggest that the Federal taxpayers could step in and do this, I understand there is a policy matter but also it gets into a finance matter where you become deeply involved.

First of all, I asked the administration if there is a cap on this, if this is means tested, and they said, yes, it is; anybody beneath $90,000 gets it. That is some means test. In other words, in a family, as I understand——

Secretary BENTSEN. It seems to become more a means test every year. Let me make a statement on that, Senator. I understand your concern. But, also, for 3 years we have a recoupment of the savings to the corporation, 50 percent of that savings. And, on the other side of it, you are quite right, there is the means test at $90,000 for an individual and $115,000, I believe, for a couple. That is right.

The CHAIRMAN. That is meant to exclude anybody that works at the White House. [Laughter.]

Secretary BENTSEN. I will tell you, I guess it could exclude one member of the Cabinet who took a cut in income.

Senator CHAFEE. Well, Mr. Secretary, could you explain this temporary assessment? In other words, let us say this program is passed in 1994 and goes into effect, let us just suggest, January 1st, 1995.

Secretary BENTSEN. Yes.

Senator CHAFEE. Now, as I understand, the 3-year assessment would be for 1995, 1996 and 1997, and then would end.

Secretary BENTSEN. It would be for 1998, 1999 and 2000.

Senator CHAFEE. All right. Whatever. But then it ends. And, thereafter, the taxpayers, somebody working in a jewelry factory in Providence, Rhode Island for $210 a week, his income taxes would be used to pay health care benefits for somebody in Detroit who is on retirement or took early retirement, and who is scraping along, he and his wife, on $106,000 a year. I missed the equity in the

whole thing. I do not see the recoupment to the Treasury because, as I understand what you said——

Secretary BENTSEN. There is some cost to the Treasury, sure. You get partial recoupment.

Senator CHAFEE. Partial recoupment for just 3 years. Is that correct?

Secretary BENTSEN. And then on the means testing you get part of it.

Senator CHAFEE. Well, all right. But recoupment is what, 50 percent of what? Let us just take U.S. Steel.

Secretary BENTSEN. Well, all right. The amount of the assessment will be 50 percent of the greater of the average cost of providing health benefits to early retirees during the years 1991 through 1993—they have a fixed number so they cannot play games with it—adjusted for health care inflation since 1992, and the estimated savings realized by the employer in the current year with respect to health coverage that it provides early retirees.

Of course, part of the problem, Senator, is people who retire from 55 to 64, their health care costs are normally higher. And of course they are not qualified for Medicare at that point. That is not a total answer to you, but that is part of the problem we are trying to address.

Senator CHAFEE. Well, I just wanted to voice my deep concern, because it is an entitlement program. Second, the recoupment is for only 3 years. Then it is not the first 3 years, it is just for certain calendar years, as you pointed out.

Secretary BENTSEN. Yes.

Senator CHAFEE. And then it is all up to the Federal Treasury. Some people look on the government as an entity up there. It is the taxpayers that are paying this. I just do not understand have great difficulty with this program. I believe it will be impossible to accurately predict how many individuals will be in this program because there is this tremendous inducement for other employers and employees to take advantage of it.

Secretary BENTSEN. I have made that same point to HHS, and they have assured me they have taken that behavioral response into account in their estimates.

Senator CHAFEE. Well, I do not understand why, when we are dealing with the tremendous problems that you point out in those charts—and I agree with you that the cost of health care—suddenly we embark on a new entitlement program that no one has ever dreamed of around here that I know of.

The CHAIRMAN. The Senator is not about to lecture the former Secretary of the Navy on patriotism, but it is a well-established adage that, what is good for General Motors——[Laughter.]

Secretary BENTSEN. I thought that was under a Republican administration.

Senator CHAFEE. I will test him and see if he knew who said that. I do.

The CHAIRMAN. "Engine" Charlie Wilson.

Senator CHAFEE. You are right. Go to the head of the class.

The CHAIRMAN. And, actually, he did not say it. He had said something perfectly respectable. But that is what happens, that left-wing press we have been hearing about.

Senator CHAFEE. Thank you. Thank you, Mr. Secretary.

The CHAIRMAN. Mr. Secretary, if you have just a few more moments, Senator Rockefeller was not able to finish his questioning.

Secretary BENTSEN. Oh. By all means.

The CHAIRMAN. And that will be the conclusion of the morning.

Senator ROCKEFELLER. I thank the Chairman and thank the Secretary. There has been a lot of criticism about how numbers are arrived at. And one of the ones that is picked on is the $71 billion in revenue gains, and how is that arrived at? One would have the sense that the Clinton Administration is sort of set about to come up with that particular figure.

It is my impression—and I would wish that the Secretary would confirm this, if true, or not if it is not true—that, in fact, the models that were used to arrive at that number were the same models that were used in the Bush Administration that are commonly used in the Treasury Department. Is that correct?

Secretary BENTSEN. I am advised that is correct.

Senator ROCKEFELLER. So, we are not talking about cooking the books here, we are just talking about numbers that arrive by the same mechanism as has been done in the past.

Second, this past spring, Mr. Secretary, there were 47 Senators—this will sound partisan, but it is not because Democrats were involved, too, including all of the Republican members of this Finance Committee—who voted for something called the Nunn-Domenici Amendment, which would put a flat cap on entitlements, and, obviously, that would have reduced Medicare spending by about the same amount as the President's health care plan. I led the fight against this. We won only by four votes, I might say.

But there are some very important differences here. For example, in the Nunn-Domenici proposal there was no sort of mechanism of how this was to be done, it was just done. We voted yes, that amount would be cut out of Medicare, Medicaid, et cetera. In the President's plan there are very specific ways recorded in which this is to be done. It is carefully laid out.

Now, I have worries myself as to the amount, but certainly not as to the attention and care that was given to the way that the reductions were made as opposed to that same Nunn-Domenici bill which 47 Senators, including all Republicans in this committee, voted for.

Second, another difference, I feel, is that there are safeguards provided for in the President's bill and not for in the Nunn-Domenici bill. For example, if the savings were achieved through just an cross the board cut and no collateral or corollary adjustments were made within the private sector, there would be an enormous cost shift of Medicare, particularly onto the private sector.

This will not be the case in the Clinton proposal, because in the Clinton proposal there are not only savings made in the public sector, but there are savings made in the private sector, through budget discipline in the private sector. I would only ask if the Secretary concurs with what I have said.

Secretary BENTSEN. I am not prepared to debate the Nunn-Domenici Amendment because, frankly, I did not study it. I will say this, in the President's plan we reallocate the Medicare and Medicaid savings to improving health coverage.

Senator ROCKEFELLER. As well to improve as the Medicare program.

Secretary BENTSEN. Absolutely.

Senator ROCKEFELLER. Yes.

A final point. In both the Chafee-Dole plan and the Breaux-Durenberger plan, could you inform me, if you can find out, how many people would pay more for health care than they currently do because of the tax cap provisions in those two bills, and what would be the magnitude of the tax increase for the average American?

And could you also comment on how easy or difficult it would be for the Treasury Department to administer something called a tax cap if the exact level of the tax cap varies by region, as I understand it does in those two bills? For example, in the Chafee-Dole tax cap, it is set at the average cost of the lowest priced one-third of health plans in an area.

The Breaux-Durenberger tax cap is set at the cost of the lowest priced health plan in the area, period. It is my impression this would be very difficult to administer. If the Secretary does not care to comment at this hearing, I would like to have that.

Senator DURENBERGER. If my colleague would yield.

Secretary BENTSEN. I will be happy to see what information we can get you on your question, but I do not have the details for that kind of an answer at this time.

Senator ROCKEFELLER. All right.

Senator DURENBERGER. Would my colleague yield? I would just join you in that request. I mean, that is twice, now, this morning from that side of the aisle that there are suggestions that somehow there is something wrong with tax caps because of the IRS or something. And I would really be pleased, from our standpoint, to have the Secretary respond in whatever you feel appropriate with regard to all of these approaches.

Secretary BENTSEN. Let me see what I can get you.

Senator ROCKEFELLER. Thank you, Mr. Secretary. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Secretary, this has been hugely helpful, not just in terms of the specifics we have dealt with, but the openness with which you have come before the committee, your willingness to provide information and to follow-up as you have done.

We will have one more hearing tomorrow with Mr. Panetta, and that will conclude this cycle in the committee. It is time we began studying the legislation. We will be looking to you for information, and you have made very clear we can do just that. Secretary Samuels, Dr. Weiss, I see behind you. We will be in continuous consultation with them.

I will be introducing a bill on the taxation of handgun ammunition today, and I will send it to you for any comments you might have. Again, I express the committee's great thanks.

Senator ROCKEFELLER. Mr. Chairman.

The CHAIRMAN. Yes, sir.

Senator ROCKEFELLER. Just a quick anecdote that will please the Secretary, I believe.

The CHAIRMAN. We have order here, please.

Senator ROCKEFELLER. In a conversation I had with the First Lady, there have been a lot of discussions about a lot of work done in the administration, conflicts within HHS as to the same question and the numbers that came back, and then they went outside firms to try and make sure the numbers were correct.

But, I can report to my esteemed Chairman that the First Lady indicated that Secretary Bentsen, after having gone over these numbers as only Secretary Bentsen can do in the Treasury, came to her and reported that, the numbers are good. The First Lady, I think, was more relieved by that sentence-than any other that she heard.

The CHAIRMAN. And so is this committee. And, on that note, we will adjourn.

Secretary BENTSEN. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, sir.

[Whereupon, at 12:07 p.m., the hearing was concluded.]

# PRESIDENT'S HEALTH CARE REFORM LEGISLATION

THURSDAY, NOVEMBER 4, 1993

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

The hearing was convened, pursuant to notice, at 10:06 a.m., Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Present: Senators Baucus, Daschle, Breaux, Conrad, Packwood, Danforth, Chafee, Durenberger, Grassley, and Wallop.

[The press release announcing the hearing follows:]

[Press Release No. H-44, October 27, 1993]

FINANCE COMMITTEE ANNOUNCES HEARING ON PRESIDENT'S HEALTH PLAN; OMB DIRECTOR PANETTA 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 next week regarding the Administration's health care reform legislation. Office of Management and Budget Director Leon Panetta will testify.

The hearing will begin at *10:00 a.m. on Thursday, November 4, 1993,* in room SD-215 of the Dirksen Senate Office Building.

"Today we received the President's health care reform bill," Senator Moynihan said. "In the coming days we will hear from Administration witnesses, including Secretary Shalala, Secretary Bentsen and Director Panetta, about various aspects of the legislation. We especially look forward to hearing Director Panetta discuss the economic assumptions underlying the proposal and his view of the budgetary impact of the plan."

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

Senator MOYNIHAN. A very good morning to our distinguished witnesses and our guests. As I remarked yesterday, Senator Packwood and I are pretty much of the view that we have had a series of general hearings on the subject of health care, and pretty specific ones on the President's proposal.

This will be, for the moment, the concluding session. We will now sit down for a period of looking at specific legislative proposals. We have one before us by Senator Breaux and Senator Durenberger. That bill is before the committee. Senator Wellstone's bill is here, and the President's bill will be here presently.

For this morning, we are going to hear from our most distinguished former colleague, Mr. Panetta, who is Director of OMB, and the no less distinguished and hugely admired Deputy, Dr. Alice Rivlin, who was for so many years the head of our Congres-

sional Budget Office. Her career in government is an example to us all.

I am looking forward to Mr. Panetta's remarks, and do not know that I have anything to add at this moment.

Senator PACKWOOD. Nor do I, Mr. Chairman.

The CHAIRMAN. Senator Packwood. Senator Breaux.

Senator BREAUX. I have no statement, Mr. Chairman.

The CHAIRMAN. Senator Daschle.

Senator DASCHLE. No comments.

The CHAIRMAN. Sir, you have silenced the Finance Committee. We look forward to your testimony.

## STATEMENT OF HON. LEON E. PANETTA, DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC

Mr. PANETTA. Thank you, Mr. Chairman, and members of the committee. It is an honor for Ms. Rivlin and me to have the opportunity to testify before you. With your permission, I would like our testimony to be made part of the record and I would like the opportunity to summarize it, if I could.

The CHAIRMAN. Exactly. But be in no hurry. We have the crime bill on the Senate floor, which means we are not likely to be rushing off to do anything. [Laughter.]

Mr. PANETTA. I think I understand what you are saying.

What I would like to do is, because this issue involves both its economic impact as well as the specific numbers that relate to the Federal cost, as well as how we deal with those costs, I have asked Alice to address the portion dealing with the economic impact, and then I will go into the specific cost elements of it.

Alice worked specifically on the Health Task Force and, because of her own background, I think she could speak eloquently to the issue of its economic impact. And that is the way we would like to divide the testimony, if it meets with your permission.

The CHAIRMAN. Fine. More than.

Mr. PANETTA. Again, obviously, the key here is to try to develop a health reform plan that tries to preserve the best in the current system while trying to control costs and trying to provide universal access.

I do not have to tell anyone in this room the concern we would have, from the budget perspective, that it is absolutely essential that we deal with health care costs and the ability to try to control those costs as we try to provide benefits.

From the perspective of the budget, unless we deal with this issue part and parcel with our effort to try to reduce the deficit, if we fail to address this issue, we will not deal, ultimately, with the deficit question and we will also not deal, obviously, with the human side of this, which is providing decent care to American people. So, on that, I would like to ask Alice to address the economic imperative of why this is important to enact.

The CHAIRMAN. Dr. Rivlin.

Dr. RIVLIN. Thank you.

The CHAIRMAN. And I would note that we have something I do not think I have ever encountered. We have testimony of Leon E. Panetta and Alice M. Rivlin. Joint testimony. Very welcome.

## STATEMENT OF DR. ALICE M. RIVLIN, DEPUTY DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC

Dr. RIVLIN. Thank you, Mr. Chairman. I am very pleased to be here. I do not think anyone needs to remind this committee that our health financing system is in crisis. That crisis creates a lot of problems. There are social problems, there are fairness problems, but, above all, this is an economic problem.

If we are to have the high-growth, productive, high-wage, competitive economy that we all want, we need to do a lot of things. We need to invest, we need to get the deficit down, and we need to stop the increase in what might be thought of as the health care tax.

We spend a higher proportion of our total national product than necessary on health care and these costs are rising at frightening rates. I think if there is one statistic that now sticks in everyone's mind, it is the 14 percent of GDP that we are spending on health care.

Could we afford to have that percentage go to 19, 20, or 21 percent, as it would if nothing is done? Of course we could, but we should not. We need those resources for more productive uses.

Second, our system, besides costing too much, does not provide health security. That, again, is a human problem, but it is also an economic problem. It leads people to stay in jobs that are not the most productive jobs for them. It leads people to stay on welfare for fear of losing Medicaid. We need a system that provides health security.

The Clinton plan has two objectives. One is to provide health security through a comprehensive benefit package that cannot be lost if you lose your job or you move around the country; the second is to control cost growth.

Now, we have had a lot of analysis of why costs are rising, and there are a variety of reasons. But almost everyone has agreed that we have a market for health care and for insurance that is not working. The market mechanisms in our current system do not work to control unnecessary costs and they foster inefficient use of resources.

Fee-for-service medicine, combined with third-party payment, leads to excessive use of health resources—too many tests, too many procedures—and these excessive uses are reflected in premiums.

And, as costs of premiums rise, there are more incentives for insurers in the current system to "cherry pick," that is, to offer better rates for younger and healthier populations. This contributes to the problem of health insecurity by excluding people with pre-existing conditions. These costs, in turn, add to the deficit problem. The fastest-growing items in the Federal budget are the costs of Medicare and Medicaid.

That analysis is all too familiar. The problem is, how do we fix it? One could move to a highly regulatory system, or one could change the market incentives so the market works better.

The Clinton plan relies primarily on restructuring market incentives so that providers have more incentive to use resources, efficiently and consumers have incentives to choose the lowest cost

plan that meets their need, and they have the information on which to base a wise choice.

The plan, first, mandates that employers provide a standard benefit package to employees that is subsidized by the government to make it affordable. Corporations will pay 80 percent of the average premium rate in their area, but employees will get an array of plans that provide at least the standard benefit package at a variety of costs.

The experience of the last few years is that employees in that situation tend to shift toward the lowest cost plan. Providers will be encouraged to join groups that reduce unnecessary costs because they must compete for members.

Health alliances, which will be set up by the States, will bargain with the health plans. This alliance, or consumer cooperative, will mobilize the bargaining power that large businesses have had in the market for some time on behalf of individuals in smaller and medium-sized businesses. We know this can work. We know that large business, using its market power, can get a better deal for its employees.

And, finally, the plan will reform the insurance market. A comprehensive benefit package will be available to everyone through a standard plan. It will enforce community rating. It will eliminate the possibility of excluding people for pre-existing conditions.

We believe that these reforms will dramatically reduce the growth in health care costs. The plan relies primarily on these market changes for controlling cost. But what if it does not work? We have, as a stand-by, premium targets that will be enforced to control the rate of growth of premiums, if necessary.

We believe this system will reduce this health care tax and that it will provide security that people need if they are to move into the most productive jobs and off welfare. That is the basic economic case for the plan that we have put forward.

Back to Leon.

Mr. PANETTA. Mr. Chairman, what I would like to do is summarize very quickly, first of all, the concern that I mentioned earlier about why we need health care reform in order to deal with the deficit, and then go into the specific cost elements of this plan and how we pay for it.

If you will look at the chart to my left, this basically——

The CHAIRMAN. I do not want to be in any way——

Mr. PANETTA. It is a lousy chart for——

The CHAIRMAN. It reminds me of a lovely late summer evening, with the rim of the sun settling down over the western mountains, and a star or two. [Laughter.]

Mr. PANETTA. This was a mood chart. [Laughter.]

Dr. RIVLIN. Mr. Chairman, it appears in your package as well.

Mr. PANETTA. I don't want to tell you how much we pay for these damn things. [Laughter.]

If you look at the charts in your testimony, where we were with regard to the deficit is the upper line that goes up very close to $500 billion annual deficits by the end of the decade. With the implementation of the economic plan, you can see where the mid-session review deficit projection is.

We are now looking at a downward trend on annual deficits that will bring us down, by 1998, to about $180 billion annual deficits. We were anticipating close to $400 billion annual deficits for 1998, so we are in a position where we are going to be cutting the annual deficit by more than half on our present path. So, in 1998 we are at about $180 billion.

The problem is that it begins to flatten out. If we do nothing on health care, it begins to flatten out for the remainder between 1998 and the year 2000. It gradually begins to go up, actually, by the year 2000. It goes up to about $184 billion annual deficits. And, if you go beyond the year 2000, it begins to increase dramatically with the cost of health care.

If we implement health care reform by the end of this decade, we will keep a downward path on the deficit so that we will go from $180 billion down to less than $150 billion by the end of the decade in terms of the annual deficit. And that downward trend, we think, will continue as we enter the new century.

So, it clearly is important to the path we have set on the deficit to implement health care reform and try to provide the cost controls that have to be part and parcel of health care reform if we are serious about dealing with the deficit in the long-term.

The $500 billion deficit reduction plan was important to get us at least on the path, but, to stay on the path, you really have to do health care reform. That is an important message, and I think everybody needs to understand that, particularly those who want to approach a balanced budget in the early part of the next century.

With regard to the specific costs associated with this plan, again, I have to preface this by saying that 74 percent of the costs here are largely going to come from the same place they come from now, which is the private sector, both in businesses and households paying insurance premiums.

So, we understand that, obviously, not on this chart is the fact that there are premiums that are going to be paid for health care. That constitutes about 74 percent of the way that the plan will be paid for through the alliances.

The Federal portion of the plan is what I am specifically addressing here because that is what the Federal outlays will be. The specific costs are on the right side of that chart. They total about $332 billion.

The costs here are between 1995 and the year 2000, and the savings and revenues to pay for those total about $390 billion, which leaves us the deficit reduction we are hoping for over that period of about $58 billion.

The CHAIRMAN. I am going to have to say, sir, I hope your thoughts are clearer than that chart. It looks like one of those— [Laughter.]

Mr. PANETTA. Again, I am going to refer you to the specific testimony as I go through each piece, Mr. Chairman.

The CHAIRMAN. It sure is quick relief from headaches and other forms from the evening news. Is that the cap coming off? [Laughter.]

I am sure you obviously share our views on that.

Mr. PANETTA. Obviously, I do. I would rather just talk numbers. But they tell me that it is nice to present these damn things. [Laughter.]

At the bottom of that chart is the first cost, which is basically public health care services. The cost of providing the public health care programs that are necessary for additional outreach to try to reach those who are underserved in our population, to continue the important health research that is necessary, we are looking at about $18 billion that would largely be devoted to new public health care programs.

A portion of that would go for the WIC nutrition program, which is an important health care-related program, to try to fully fund that program at $3.1 billion. Then we would also improve community and migrant health centers.

A portion of that $31 billion would also go for start-up costs to get the alliances going. You need to provide the initial money to the States in order to organize the alliances. We estimate that cost at about $9.6 billion for the first few years. It will level off at about $1 billion per year in terms of the administrative side of it. Those are the public health and administrative costs that we expect with the program, $31 billion.

The second portion of costs, there, would be the long-term care program, totalling about $65 billion. That is a program that would phase in between the year 1996 and the year 2002. There are three elements to that component of long-term care.

One is the new home and community-based service program for the disabled; the second would be liberalized spend-down rules for Medicaid eligible institutionalized; and the third is tax incentives for the purchase of long-term care insurance.

That estimate comes to us from HHS, the actuaries there, with assistance from the Brookings Institute. Long-term care then, in that period of time, as I said, costs about $65 billion.

The Medicare drug benefit is the next major cost on the program. That is a program that would go into effect in 1996. That totals $66 billion. That estimate comes to us, again, from the actuaries at HCFA, working with our people as well.

The basic plan introduces a prescription drug benefit with a cost that is very similar to that that would be recommended in the standard benefit package for all Americans under 65. The key here is to try to move that drug benefit to those over 65.

It is a $250 deductible, it is a 20-percent co-insurance requirement, and there is a $1,000 limit on out-of-pocket spending. That program, we estimate, would cost, as I said, about $66 billion.

The fourth element is the self-employed income tax deduction of $10 billion. The plan provides a full deduction for out-of-pocket health insurance costs. At the present time, the deduction for the self-employed. is 25 percent. This proposal would take it to 100 percent. I think this is a proposal that has enjoyed bipartisan support for some time and needs to be implemented for those who are self-employed.

The fifth cost element is the premium discounts, of subsidies, and that, obviously, is the largest cost component at the Federal level. Let me break that down, if I can, in terms of its specifics so you see exactly how we arrived at those cost figures.

The first column indicates that the total amount that we would be paying for the subsidies comes to $349 billion. It is made up of payments to businesses at about $100 billion, payments to families of about $184 billion, early retirees, $12 billion, and then the poorest of the poor, those that would have to be covered for their out-of-pocket costs, would be about $9 billion.

If you add the cushion that is part of this program to try to protect us in terms of the cost of the program, the total cost is $349 billion for the premium discounts.

If you take out of that the savings that we anticipate from both those on Medicare who work—in other words, those who qualify for Medicare at the present time but who work, and, therefore, their costs would be picked up by the employers as well as by them—that is a $28 billion savings. And then there are those on Medicaid who also would have those costs now fully picked up by the alliances. All together, we would save $188 billion.

So, you have an offset to the premium cost of $188 billion. That leaves us with a net cost of $161 billion made up of two elements: the net cost we expect to pay, which is $117 billion, and the cushion that was established of $44–$45 billion.

The purpose of the cushion, as you know, is basically to ensure that we stay within the targets that we have established for these premiums costs. It was something that we strongly recommended at OMB, as well as Treasury, to try to ensure that whatever targets we established here would be held to. And that was the point of establishing not only the cost estimates, but the cushion as well.

That summarizes all of the Federal costs that are associated with the health care reform measure. The payment for these costs would be made in six ways. And, again, I would start at the base of the left-hand column.

Medicare savings would total $123 billion over that period of time. Medicare, as all of us know, has been growing at a rate of almost 11 percent per year. Our proposed savings would slow the growth rate to about 8.4 percent per year.

The Medicare portion of this is largely made up of proposals that we have seen in reconciliation bills of one kind or another over the years. All of us who have worked in budget summits have gone through the various proposals.

Senator PACKWOOD. Can I ask a question? I do not understand. There is not a cap on Medicare, is there?

Mr. PANETTA. Not on Medicare.

Senator PACKWOOD. Not on Medicare. There is no cap at all.

Mr. PANETTA. That is correct.

Senator PACKWOOD. All right.

Mr. PANETTA. These are the savings. The savings are basically policy proposals. We have got about 25 specific policy changes in the Medicare area. They include, as many of you know, an income-related Part B premium for high-income Medicare beneficiaries, those with incomes at $100,000.

Couples with incomes of $125,000 would be required to pay about 75 percent of the premium. We also provide reductions with regard to market-backed basket payments that are made to providers. We also extend into the out years some reductions that have already been included in Medicare through reconciliation.

Senator DASCHLE. Could you just tell us what the total expenditure is going to be over that period of time to give us some idea of what 123 looks like?

Mr. PANETTA. On Medicare. We can get that for you, Tom.

The CHAIRMAN. You meant over the 5 years.

Senator DASCHLE. That is right.

Mr. PANETTA. Yes. For Medicare.

Senator DASCHLE. Right.

Mr. PANETTA. I think we can get you that number.

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

The current system projections of total Medicare spending over the 1995 to 2000 time period is $1.39 trillion in gross spending. The estimate of spending during that period net of offsetting receipts (Part B premium payments) is $1.29 trillion.

Mr. PANETTA. The second area of savings is Medicaid. That totals $65 billion, and it largely comes from two key areas.

One is the replacement of the disproportionate share payments which currently go to those hospitals that treat large numbers of those who have no insurance, those for whom you have to pick up those costs because of the lack of insurance. Disproportionate share savings, we estimate, will total about $54 billion.

In addition to that, instead of having the growth, Medicaid would basically be picking up cash recipients, and, therefore, we would have savings from the capitation in that area that would total around $22.3 billion.

So, we think the combination of both disproportionate share, as well as the savings on Medicaid recipients who are going into the alliances, gives us a total of about $65 billion that we would receive in savings from Medicaid.

The next portion of savings is obviously one that I am sure you discussed with the Secretary yesterday. It is the tobacco tax, plus the corporate assessment, totalling $89 billion. I will not go into the particulars on that because I am sure the Secretary covered that yesterday. That is the revenue portion, tobacco tax plus the 1-percent corporate assessment.

The fourth element, would be Federal savings that we anticipate from programs that we currently spend on. Obviously, those health care programs include veterans' programs where we anticipate savings of about $16 billion, the Department of Defense health care programs of about $3 billion, the Federal Employee Health Benefits programs of about $13 billion, and the Public Health Service of about $8 billion.

Those savings obviously result from the fact that, for example, the VA will receive new revenue from previously uninsured veterans who will be paying into the veterans' system by virtue of being part of the alliances.

We also anticipate that DOD will share in premium contributions. Incidentally, VA will also be getting Medicare coverage, something they do not receive at the present time. That, too, will provide additional savings, we anticipate, with regard to VA expenditures.

DOD will share in premium contributions for employed dependents of military personnel. And, obviously, the Federal employees we hope to incorporate into the alliances as well. Those are all sav-

ings that will flow from the fact that we have established this kind of universal health care system.

It does not mean that you are going to see reduced services in any way with regard to veterans' care. What you are doing, as a matter of fact, is providing additional payments now into the health care system so, in fact, they can provide adequate coverage to their beneficiaries.

The last portion of it is also a portion I am sure you discussed with the Secretary, which are the other revenue effects and savings of $68 billion. That largely comes from savings from deductions that we will save, for example, in the cafeteria-type plans. We will also get additional taxable incomes and revenues. That estimate is about $68 billion.

Debt service for the deficit——

The CHAIRMAN. May I just say, you will not get additional taxable incomes. That is a term worthy of David Stockman. You mean, you will get additional tax from income.

Mr. PANETTA. That is correct.

The CHAIRMAN. Not additional taxable income, but you are going to tax people, which we do here. We do not like it, but we do it. Do we have to call it a business assessment?

Dr. RIVLIN. No.

The CHAIRMAN. You ought to call it contribution.

Mr. PANETTA. That $68 billion is the compilation of, obviously, savings at the business level that would either flow into profits or into higher wages, and we assume that additional revenues would flow from that. That is the area that we are talking about.

The CHAIRMAN. Fine. The tax revenues will increase because there will be an increase in taxable income.

Mr. PANETTA. That is correct.

That produces about, as I said, $68 billion. The debt service savings on the deficit reduction is $4 billion. The total revenue in savings that we estimate is about $390 billion, therefore, that would offset the costs, resulting, as I said, in the $58 billion deficit reduction.

Let me talk a little bit about how these estimates were arrived at. Obviously, the estimates on outlay effects of existing programs, OMB has the capacity to do that, as does CBO and others. We have a pretty clear model to be able to judge outlay effects of existing programs, Medicare, Medicaid, other programs like that. And we feel very confident of the estimates in those areas.

The estimates on revenue effects are estimates that flow from the Treasury, as well as others that have been able to make fairly accurate estimates there, although the Chairman knows we sometimes get different estimates from that group.

The third area is probably the one that was the most difficult, which is the estimates of new subsidies or premium and out-of-pocket discounts. This is an area, frankly, where we had very few models, if any, to try to give us accurate estimates about, what does it mean when you bring 30–40 million Americans onto the health care rolls, what happens with regard to utilization and what happens with regard to the impact on businesses and employees, what happens with regard to the whole issue of what kind of discounts you provide?

So, a large portion of the year was devoted to developing the models to try to develop estimates here. I do not want to kid anybody with regard to these estimates. This is not something where we had a fine science to turn to in terms of the original proposals here.

A lot of the questions we had were questions about, how will all of this, indeed, impact? And we have, as a consequence of that, I think, developed the best models in the business right now, the best estimates in the business.

Do they need to continue to be scrubbed? Yes, they do. But we do have, I think, the best estimates. They were made by a combination of HCFA, working with the Agency for Health Care Policy and Research, working with the Departments of Treasury and Labor, the Council of Economic Advisors, and OMB trying to develop a consensus with regard to analytical methods of determining these costs. That was the process.

Estimating a complete health care system overhaul is an immensely complex tax—immensely complex, task, just by the nature of putting this kind of system into place. Reasonable people can obviously differ about the many assumptions that can be made as you try to develop these kinds of estimates.

But the thing I want to make clear is that our team is consistently trying to err on the side of conservatism as we try to approach these estimates. We have to, because we are dealing with a lot of unknowns as we try to deal with this comprehensive system.

I think a good example of that was the whole issue that came out last week on the question of 60/40 payments with regard to individuals. We are continuing to do a detailed analysis of that.

I think the Secretary of the Treasury gave you that indication yesterday, that we have been working to develop a more detailed analysis on just exactly what are the out-of-pocket costs here for individuals as we develop this kind of plan.

One of the problems with regard to the analysis that was presented last week is that it focused simply on premium payments. Well, you ought to look not just at premium payments, but at total out-of-pocket costs to the individual. I mean, premium payments are one thing, but what does it mean in terms of out-of-pocket costs when you include deductibles and co-payments?

When you look at that issue, when you look at the issue of the full out-of-pocket costs, our estimate is that you are looking at nearly 70 percent of insured Americans who would be paying the same or less for the benefits that they receive, saving, on average, we estimate, about $61 per month, including co-payments and deductibles.

So, if you include all out-of-pocket costs, including the deductibles, including the co-payments, we think it approaches more like 70 percent that will, in fact, pay the same or less. That leaves you about 30 percent that are going to pay somewhat more—we think an average of about $24 per month—including, again, the co-payments and deductibles. But they will receive benefits, obviously, that they have not received before, and many will receive better benefits.

This is based on the community rating issue. There is not a plan that has been presented to the Congress that does not involve community rating in which certain people will pay additional amounts because we are trying to make it a fairer way in terms of allowing everybody to pay their fair share.

So, what we have done here is essentially what every other plan requires, which is to make sure that the young, and not just the elderly, pay their share as we get into this plan.

Let me make this point, also. If we fail to pass this plan, 100 percent of Americans can be expected to pay higher insurance premiums. 100 percent. Because that is where health care costs are going right now.

So, again, as we go through this, we have got to continually analyze these issues and we have got to continually move forward with that kind of analysis.

The CHAIRMAN. Sir, there are 37 million people who, not being insured, do not pay any premium.

Mr. PANETTA. No. But those who are covered——

The CHAIRMAN. So do not say 100 percent.

Mr. PANETTA. No. 100 percent of those who pay insurance now are, clearly, going to pay higher premiums. That is what we are focusing on here in this issue.

Let me conclude by saying that the keys to trying to protect the savings that are involved here basically come in several areas. Number one, we, as I said, tried to develop the most conservative and realistic estimates that we could. Generally, when we had an agency present several costs, we took the higher cost estimate just to be safe in terms of the estimates that were given to us by the agencies. We felt that it was very important that we not simply take the lowest cost, or the highest estimate on savings. We wanted to be as conservative as we could.

Second, we do have limits here in terms of premium increases. We have set targets for premium growth in the alliances. That is a key to trying to control the cost growth in the program.

Third, we have tried to phase-in the benefits. I think the phasing in of this program is very important because it gives us the opportunity to test the system as it goes into effect.

What the program now provides for, is that roughly about 15 percent of the population will come into the alliances for fiscal year 1996; 25 percent will come into the alliances by 1997, and the remaining 60 percent will be phased into the new system by January 1, 1998.

I think the phase-in approach to health care is extremely important when you are developing a new health care plan and new reform system to be able to benefit from the experience of doing it on a progressive basis.

Fourth, we have built in the cushion. The reason for the cushion is that we wanted to establish estimates, we wanted to establish some caps. But, more importantly, we wanted to establish some discipline as to the costs here.

It is not that we do not want to cover beneficiaries, it is not that we don't want to provide full benefits, but we also want some discipline here if, in fact, we blow through these caps for some reason. I mean, the problem is, if you look at Medicaid, if you look at other

open-ended entitlements, we know what happens. Ultimately, we have to pay the price.

Why not establish targets that basically require that if we, for some reason, do not reach those targets, that the President and the Congress go back and look at that issue? We think that is an important discipline.

Lastly, as I have said, we have established firm caps with regard to the program in a number of areas, including a capping on the long-term care benefit plan. That is essentially a capped program to the States.

Mr. Chairman, those are the cost issues that I wanted to present to you. This is obviously one of the most important debates in the history of this country. It will take place, as it should, in the committee rooms and in the chambers of the Congress, in newspapers, and meeting halls, and over kitchen tables throughout this Nation, and that is good. That is what should happen when you are dealing with what I think is one of the most important issues facing the American people right now.

I served in the Congress for 16 years, and health care during that time became a bigger and bigger problem. We tried to confront it, but failed. I have seen all the plans. In the House last year we worked to come up with some kind of approach. We could not do it. There have been a lot of suggestions, a lot of ideas, a lot of concepts proposed.

What the President has done here is, I think, presented the kind of specific, comprehensive, responsible, and detailed, paid-for plan that you have not seen before when it comes to health care reform. It is an extensive process.

I do not say we have all the answers. We do not. We do not pretend to have divine wisdom on this issue. We do not. This is too tough and complex. We welcome alternative proposals and views. It is important to have those proposals as we try to develop answers here.

But, please, let us make one thing clear. Let us be sure that when other plans are presented, when there is a plan that is offered, that it is subject to the same kind of rigorous analysis that we have been required to meet. And we appreciate that. We should be required to meet a rigorous analysis. But let us also put these other plans to the same test. The American people deserve that kind of debate because this is an issue that will affect every one of their lives.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Panetta appears in the appendix.]

The CHAIRMAN. Well, we thank you, sir, and we thank Dr. Rivlin. We certainly want to try to respond to you in the spirit in which you have come here.

If you could put that first chart up, it has a soothing effect. [Laughter.]

It means that you were getting a little vehement there about some of these estimates. I said it looks like a late summer's evening. Just the first stars are out. That is Venus, I think. Yes.

You have brought to this the rigor that we associate with you as a colleague—and Dr. Rivlin, as a scholar—the greatly respected Director of the Congressional Budget Office.

And we will make it our business to bring to you the various plans that will come here, including Senator Breaux's and Senator Durenberger's. We will try to work this out together.

I wanted to ask just a quick question of Dr. Rivlin. Do you have any data—I do not know that you would—when you say there are people who do not leave jobs because they would not get health insurance or some other situation because they have developed some health problem, do we have any estimates about how many?

Dr. RIVLIN. Yes. There is poll evidence on that.

The CHAIRMAN. Poll evidence.

Dr. RIVLIN. About 30 percent of employees say that they are concerned about losing their health insurance.

The CHAIRMAN. Could we get that just to see it? That poll evidence would be better.

Dr. RIVLIN. We could give you that. Yes.

[The information requested follows:]

A Job Lock: The current lack of portable health insurance and the prevalence of pre-existing condition exclusions are often cited as factors leading to "job lock." One empirical study suggests that the mobility rate for married men would increase by one-third if there were no preexisting conditions exclusions, although there is some debate about this. Sources on this subject include: (1) Brigitte Madrian, "Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job Lock?," *Quarterly Journal of Economics,* February 1994. (2) Phillip F. Cooper and Alan C. Monheit, "Does Employment Related Health Insurance Inhibit Job Mobility," *Inquiry,* (forthcoming).

B. Welfare Lock: At least 1,000,000 adults and children are on welfare because it is the only way their families can obtain health care coverage. Together, they comprise at least 7 percent of the 14 million people currently on AFDC. Indeed, several empirical studies have indicated that the provision of health insurance could reduce welfare caseloads by 10 to 20 percent. However, these studies did not fully reflect increased availability of health coverage for low income families due to legislation enacted during the last decade. Therefore, the Administration conservatively estimates that there are at least one million people on welfare to get health coverage. Sources: (1) Robert Moffitt and Barbara Wolfe, "The Effect of the Medicaid Program on Welfare Participation and Labor Supply," *Review of Economics and Statistics,* November, 1992. (2) Ellwood, David and E. Kathleen Adams, "Medicaid Mysteries: Transitional Benefits, Medicaid Coverage and Welfare Exits," *Health Care Financing Review,* 1990 Supplement. (3) Keane, Michael and Robert Moffitt, "A Structural Model of Multiple Welfare Program Participation and Labor Supply." Working Paper 91–29: Brown University, Providence, Rhode Island, October 1991. (4) Aaron S. Yelowitz, "The Medicaid Notch, Labor Supply, and Welfare Participation: Evidence from Eligibility Expansion," MIT mimeo, September 1993.

The CHAIRMAN. You say there are people who stay on welfare to keep Medicaid. Do we have any data on that? I will bet you we do not.

Dr. RIVLIN. I do not know what the aggregate data is on that. I think the anecdotal data is very pervasive on the number of welfare mothers who stay on welfare because they have a sick child. This is a persistent anecdote, but I will check into what the genuine data is on this.

The CHAIRMAN. There is a saying that data is the plural of anecdote. So there may be something to it, but it would be nice to know.

Dr. RIVLIN. Right.

The CHAIRMAN. Could I just ask you, since you raised it and we are just trying to sort this out, last week this 40-percent figure was

presented to us in a chart by our distinguished Secretary of Health and Human Services and we just responded to the evidence. You are saying you bring us the number as 30 percent of the insured——

Mr. PANETTA. That is correct.

The CHAIRMAN [continuing]. Which we are working off of the number of 171 million insured, which would suggest that 51 million people would pay more than they presently do. Then there are the 37 million who pay nothing because they are uninsured. They would now pay, by definition, more, since anything they pay would be more than they pay now.

But then there is a question of whether their actual medical costs will be greater because they have out-of-pocket expenses which they just pay. When they go to see the doctor they pay their doctor instead of having insurance do it.

Is there any way we are going to be able to get some numbers on that? Because it would not surprise me if combining a portion of the 37 million and 30 percent of 171 million you came up with 40 percent of the population. I do not assert. I just wonder if we——

Dr. RIVLIN. Well, we could certainly make that calculation. The important thing to keep in mind is that the uninsureds have out-of-pocket costs, but a large part of the cost that they——

The CHAIRMAN. Are cost shifted.

Dr. RIVLIN.—impose on the system are shifted to the rest of them.

The CHAIRMAN. Right. Right. Of that, I do not think anybody would doubt. We have a large number of Senators here and they all want to ask you questions, having been thoroughly confused by your charts.

So, here is Senator Packwood with chart in hand.

Senator PACKWOOD. Leon, on your cost of premium discounts, you have got families 184, early retirees, 12, businesses, 100, cushion, 44, out-of-pocket, 9. Those discounts to businesses, families, early retirees and whatnot are entitlements, are they not?

Mr. PANETTA. The discounts, yes. They are entitlements.

Senator PACKWOOD. Yes.

Mr. PANETTA. It is a capped entitlement, but it is an entitlement.

Senator PACKWOOD. Right. I want to understand how the cap works. As I understand it, the Secretary of Health and Human Services sort of monitors the spending that is going out, and, if it appears the spending is going to exceed the cap, she alerts the President. And the President has 30 days to present to Congress a plan for addressing the need for more money. What happens if Congress does nothing; how is the cap enforced?

Mr. PANETTA. If Congress fails to enact the President's recommendations with regard to——

Senator PACKWOOD. Yes.

Mr. PANETTA. Well, the cap, obviously, is enforced in that we then have to determine how we stay within those levels of funding.

Senator PACKWOOD. What is your legal authority to do so if these are entitlements?

Mr. PANETTA. Well, again——

Senator PACKWOOD. You need more money. The money is going out at a greater rate than you thought. The President comes and says, the money is going out at a greater rate than we thought, Congress. We have got to either put up more money or we have got to put a cap on it.

Mr. PANETTA. Yes.

Senator PACKWOOD. And Congress does nothing.

Mr. PANETTA. There is plenty of precedent for this.

Senator PACKWOOD. Yes.

Mr. PANETTA. The Food Stamp Program is essentially a capped entitlement. And the fact that——

Senator PACKWOOD. That requires our acting to do something.

Mr. PANETTA. But the fact is, when you reach certain levels there, if, in fact, we have reached those levels it is up to the Congress and the President to decide whether or not they stick within those levels or whether they try to modify them. The fact is, we have never reduced benefits to food stamp recipients, and I do not think you will reduce benefits here. But you are going to have to find other ways to pay for those additional costs. And that is all right.

Senator PACKWOOD. But, therefore, it may not mean it is a cap. We may have to find other ways to pay for the additional costs.

Mr. PANETTA. That is correct.

Senator PACKWOOD. It is different than a cap.

Second question. The alliances apparently get to get low-interest loans from the Treasury if they have cash shortfalls. Do I understand that?

Mr. PANETTA. I believe that is correct.

Senator PACKWOOD. All right. And the Secretary is supposed to set a limit on these loans.

Mr. PANETTA. That is correct.

Senator PACKWOOD. You, more than anybody else in this town know about these intragovernment loans, how they are accounted for, and what happens to them.

Mr. PANETTA. Yes.

Senator PACKWOOD. But here is what I am curious about—and, Leon, this is political—if I understand it, they cannot pay back the money. They borrowed the money and they cannot pay it back. The way we are going to force them to pay it back is by reducing the subsidy payments to the alliance and by increasing the State's share of Medicaid. This is the way we get our money back.

Do you think that is politically likely? They are short, they have not got the money, and we are going to reduce the Medicaid payments in order to get our money back.

The CHAIRMAN. We do that all the time.

Senator PACKWOOD. Oh, sure.

The CHAIRMAN. We have never done that, sir.

Mr. PANETTA. I think it is correct to say that if we do not have the will to stick by some of these positions that are there to control cost, then we will never control health care costs.

The fact is, you have probably led the charge, along with the Chairman, in terms of trying to find additional savings in Medicare and Medicaid. You did not have to do that, but you did.

Senator PACKWOOD. We tried. I know what it is going to be like when every Governor comes in, and they are all cash short, they will say, as they always do. And we will say, well, that is fine, but your alliance owes us $150 million and we are going to cut back your Medicaid half of that, and we are going to cut back your subsidy payments to the alliance for the other half, and that is the way we get our $150 million back.

This problem exists with every State, this is not just one or two States. I think it is unlikely that we would do that. But your answer is very honest, that this cap, at the moment, is not self-enforcing. When we reach it, we then have to enforce it or come up with more money.

Mr. PANETTA. Exactly.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Well, just to make the friendliest of points, are you sure you are not putting too many choke points in the system where, in fact, a political decision will be put to the Congress and it will almost invariably say, well, fine, in the present emergency we will have another emergency measure, we will forgive the debt. It is not easy to forgive debt.

Mr. PANETTA. Mr. Chairman, as a member of the House for 16 years, I share the concern that you have just raised because I understand the politics of what all of us will face in that context. On the other hand, you have a couple of choices here.

One, is you can create an open-ended entitlement in which, ultimately, we wind up paying a huge price and have very little control unless we have the guts to go back and try to deal with the issue after we have let the cow out of the barn. I mean, just look at what is happening with entitlements now, and that tells the story if we do not try to provide some discipline.

A second approach to it is basically not to provide any kind of discipline and just basically provide no caps, allow competition to take its course, in which event you will not provide full coverage for Americans and they will come back here and complain why they do not get coverage under that kind of health care system.

Either way you look at it, we are going to face political constraints of one kind or another. I think the question is whether we have the will and the courage to try to deal with those kinds of pressures. If we do not, believe me, I do not have any easy answers.

The CHAIRMAN. Exactly so. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman.

Leon, I could not agree more with your last statement. I do not know what the alternatives are. I would really like to explore what alternatives exist and be convinced that we can contain costs as effectively as a cap will. We have had good entitlement cap debates every year. We will have another capped entitlement debate sometime this year, I guarantee it. And I think these debates are very healthy.

But, I do not know what the alternative is. Obviously, we are going to be facing some controls on entitlements in the future, regardless. I do not know what we do if we do not take this approach.

Could you describe in a little more detail, the process you used in calculating the figures you ultimately came up with? You said

you used a conservative estimates in projecting costs. Could you describe in more detail what that process was?

Mr. PANETTA. Well, specifically with regard to the subsidies, we went through a very interesting process in which we basically determined what the target costs would be to provide the subsidies, the chart that I showed you.

We then sat down with the actuary at HCFA and it was clear that it would be very important to provide a cushion in addition to those estimates if, in fact, we were going to stay within certain boundaries.

Now, I can tell you, from a political point of view, it is easier for us to go with the smaller number. We do not have to put a cushion on this number because, clearly, the cushion adds to the cost of the subsidy.

So, from a political point of view it would have been easier for us just simply to take the specific targeted number that it had come up with and provide no cushion. But we thought that would be dangerous, and the actuary agreed with us. So, we added the $45 billion cushion, and that gives you an example of why we accepted a more conservative kind of approach to dealing with these cost estimates.

Senator DASCHLE. Let me just jump back to a previous question. You had indicated what the savings in Medicare would be over the 5 years, and I wanted to put it in proper context. What is the overall expenditure figure?

Dr. RIVLIN. The overall expenditure figure over this 6-year period that we are talking about would be, believe it or not, $1.2 trillion in total——

Senator DASCHLE. $1.2 trillion.

Dr. RIVLIN. Right. In total Medicare spending. So, the $123 billion is approximately a 10-percent reduction in the total cost of Medicare over that period.

Senator DASCHLE. Thank you for that.

Let me ask you about this 60/40 debate we continue to talk about here. Is that a 1-year or 5-year estimate? What are we talking about when we say 60/40, or, now, 70/30?

Dr. RIVLIN. Well, the 60/40 was originally the estimate—if we had this program fully phased in in 1994—of the percentage of people who now have insurance through their employers that would pay less versus the percentage who would pay more.

Senator DASCHLE. So, you are saying the first year is estimated to be 70/30. And in the out years does the number go up or down?

Dr. RIVLIN. The 70/30 is an estimate of the whole period. When we re-estimated to include the out of pocket costs, the 60 percent went to 68 percent in 1994. Then, as you move to the year 2000, there would be more people who would not be paying as much—about 72 percent. So, it is an average of those. Over the period as a whole, approximately 70 percent of the people who now have insurance would be paying less.

Senator DASCHLE. Paying less.

Dr. RIVLIN. Right.

Senator DASCHLE. So, if we did nothing, is it your contention that the entire insured population—percentage would be 100?

Mr. PANETTA. I do not think there is any question. I mean, if we essentially do nothing, what we have seen for the last 10 years in health care is going to continue for the next 10 years, which is, those costs are going to go up and premiums are going to go up.

Senator DASCHLE. And have you been able to do any analysis comparing your figures to other health reform proposals?

Mr. PANETTA. No. We are in the process of beginning that as we look at other proposals, but I think it is fair to say, as I mentioned, that every major health care reform bill provides for community-based premiums when you are looking at trying to balance out with the elderly and the high-risk patients are now paying, versus the young and the healthy. We are trying to balance that out almost under every plan so under every plan those additional costs would take place for that group of people.

Senator DASCHLE. Well, thank you, Leon. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Daschle.

Senator Chafee, you have thought long on this.

Senator CHAFEE. Thank you, Mr. Chairman.

Mr. Panetta, just a quick question on fact here. On page 14, you say—and you have said this before so it is not just here—" No firm will pay more than 7.9 percent of payroll." And, as I understand it, this applies to any size firm. You are not limiting it to firms of 75 or less. That is where the other figure kicks in.

Mr. PANETTA. That is correct.

Senator CHAFEE. So, no firm will pay more than 7.9 percent of payroll for health care costs. Are any firms paying more than that now? I am not asking you to know every firm, but, for instance, General Motors, would they be paying probably more than 7.9 percent of payroll?

Dr. RIVLIN. Yes. General Motors has an exceedingly generous plan.

Senator CHAFEE. So, as I understand it, if General Motors is paying more than 7.9 percent, that difference between whatever they are paying now—let us say that it is 9 percent just for discussion's sake—the difference would be, what, made up by the Federal Government?

Dr. RIVLIN. No.

Mr. PANETTA. General Motors is a bad example, because I think General Motors could basically drop out of this plan because of the number of employees. They have 5,000 employees or more.

Dr. RIVLIN. Yes. And, if they choose to have a more generous plan than the standard benefit package, then they have a right to do that. But the g ernment would not pick up the difference.

Senator CHAFEE. So, I am not sure I totally understand that. But, never mind. I want to move on to another point.

Mr. Panetta, in your testimony here you said something that we all agree with, which is, estimating costs of health care is "an immensely complicated task." That is something on which everybody in this panel will agree with you.

Yet, it seems to me as you embark on the goal which we all have, which is to cover everybody, i.e., universal coverage, that for some peculiar reason you also embark on increasing benefits for those

who are already insured without requiring any change in behavior on those individuals.

Who am I talking about? You give the prescription drug benefit to all Medicare beneficiaries and you also provide coverage by the Federal Government for 80 percent of all the premiums of early retirees, those who have chosen to retire early. The Federal Government steps in and pays for those.

Even though General Motors might be paying it now, you step in and pick that up. This is very, very expensive when you add those together. And there are others, but I just use those as a point. The prescription drug is $66 billion, the retirees is $12 billion. So, there is nearly $80 billion.

In a time when you are embarking on a very, very risky enterprise in which you do not know exactly how it is going to work out, I have trouble understanding why, when doing this, knowing what we seek is universal coverage, at the same time you increase very dramatically the benefits for a group that are already covered. Could you explain to me the philosophy there?

Mr. PANETTA. I think the answer is very simple. Right now, if you are on Medicare, you are paying tremendous costs with regard to prescription drugs. I mean, in my own family, my mother-in-law gets a very heavy bill on drugs. She needs a lot of them and has to pay a hell of a lot. It is a tremendous burden on her. And I think it is something we need to think about if we are going to provide comprehensive health care reform for people in this country.

Certainly, the elderly need to be treated on the same basis as those who get the basic benefit plan. If they are going to get coverage for prescription drugs—and I think they should—I think the elderly need to get the same kind of benefit. I think it was an issue of fairness here, that if we are going to provide that kind of benefit, we ought to provide it for those on Medicare as well.

Senator CHAFEE. But you do not require any change of behavior, as I understand it, on the Medicare population. In other words, they can remain under Medicare fee-for-service. They are not required to go into an alliance. Am I correct?

Mr. PANETTA. Well, I think they have the choice.

Senator CHAFEE. No. But that is a choice that currently exists now, as you know.

Mr. PANETTA. Right. Right.

Senator CHAFEE. But you do not require that. Under the existing system of Medicare, if a Medicare beneficiary chooses to go into an HMO plan, that beneficiary will receive the drug benefit.

Mr. PANETTA. Right. That is correct.

Senator CHAFEE. But you have eliminated that requirement. Under your proposal, the Medicare beneficiary can remain, as he or she is currently, with the added benefit of the prescription drug being provided. In other words you are not requiring any change of behavior.

Mr. PANETTA. Well, I mean, I think you have to look at the total plan here. And I think when you look at the total plan and what is provided here for preventive care, when you look at the total plan as far as basic benefits, when you look at the plan with regard to, again, limiting the amount of premium increases and requiring that the plans that are offered in the alliances include HMO's, fee-

for-service, and PPO's, that you, in fact, are going to affect behavior of individuals in that process and move them towards, hopefully, more preventive care as a price for getting that kind of coverage. I think you are, in fact, going to have an impact on the health care mentality of the average citizen by virtue of implementing this kind of broad system with its disciplines.

Senator CHAFEE. Well, I see my time is up. You did not get a chance to address this gratuitous——

The CHAIRMAN. Why do you not take whatever time you need, sir?

Senator CHAFEE. Well, somebody else is waiting. But, just briefly, could you explain the rationale on the retirees, which is $12 billion?

Mr. PANETTA. The rationale for that is——

Senator CHAFEE. I mean, why should we step in and pick up something that General Motors is currently paying?

Mr. PANETTA. No. I understand the concern on that issue. I think the answer to that is these companies are going to be picking up some huge costs. Frankly, this was done. I think the commitment with regard to the retirees was done at a time when nobody anticipated the kind of cost escalation that we have seen in health care. This is going to be a tremendous burden in terms of the system, and I think our feeling was that we need to try to provide some relief for those systems. And the way to do it is to bring those retirees into the alliances.

Senator CHAFEE. Well, Mr. Chairman, I just have a little trouble understanding why some jewelry worker making $200 a week in Providence, Rhode Island should have his or her taxes go to relieve General Motors of a burden that General Motors undertook, and confirmed this year in this contract negotiation. Thank you.

The CHAIRMAN. I do not want to introduce a note of partisan disparity, but I am tired of the way General Motors keeps being knocked around in this committee. [Laughter.]

I mean, I know a left-wing press distorted "Engine" Charlie's statement into that famous adage, but we may just have to have a hearing to give them a chance to defend themselves. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, it is only 2 days in a row. It may go away by next week. I would like to start with a couple of observations.

First, with regard to bona fides. I mean, I just think it is terrific that we are here in a bipartisan way and with as elaborate, if you will, an effort to try to deal with these problems.

I share the concern particularly expressed by Bob Packwood and John so far relative to how you go about it. We all know about Fasby 106, we all know about the over-commitments, and so forth. I think everyone here is pledged to deal with it.

Second, let me just thank you both, and Nancy Ann Min, in particular, for the work last week on tougher risk contracting. If we are going to do anything right it is going to have to be Medicare changes. And, I may say, Mr. Chairman, there is a real commitment here at OMB to move us in that direction, and at HCFA as well.

The CHAIRMAN. Yes. That was very clear, and we thank you.

Senator DURENBERGER. The third observation is, I just came from am OTA meeting where we are having a little bit of debate over estimating and the Office of Technology Assessment, as you may know, has been charged to try to come up with a way in which we can do estimating differently.

The great problem for me, coming from Minnesota, or you, coming from your part of California, is we do not have a way to estimate behavior change. You can see it in Monterey, I can see it in Minneapolis, you can see it in the Bay area, as I did last weekend, but how in the world do you capture that, predict it in advance, put dollars next to it, and then come in here confidently and say that our market-based program is going to work? That is a difficult thing to do.

So, the issue with which we grapple over here is not the issue of universal coverage or cost containment, or any of those things. I mean, we are of one mind on those sorts of things. The problem here, is in the challenge about the other plans, as I see it. What the administration has done is taken some of the other plans.

I mean, managed competition was not invented in the White House, it came from a lot of people who sit on this committee, on the House side, and other places, and you have incorporated that.

You have incorporated small group insurance reform, which is a key to all of them. Small group insurance reform was the previous Chairman's, now Secretary of the Treasury, and mine, and a lot of other people on this committee.

And, through that, you are getting adjusted community rating, you are eliminating experience rating which will bring down premium costs for a lot of people. You are getting the concept of a basic benefit which had not been around before.

You are getting portability, guaranteed issue, and a whole lot of the things that everybody's been complaining about out there. They cannot take their plan from job to job.

So, you have incorporated that from plans that have been here on the Hill. You have incorporated the work of the Senate Republican Task Force in your bill. But what you have added to it is the comment that I heard Dr. Rivlin make as I came in, and that is, what if it does not work? What if it does not work?

In my judgment, whether it is budgets or government-run health alliances at the State level, $9.6 billion worth of contributions to it, whether it is accountable health plan, premium caps, the complications of Bob Packwood's question, I can tell you, you cannot say we believe in markets and then put this, what if it does not work thing in place, because that is going to guarantee you that it is not going to work.

It is guaranteed not to work because people out there are so smart, they will figure out a way to get around every one of these things, and you know they will anticipate all of this. They will anticipate, what if the premium caps, what if the health alliance does this, what if, all the way through it? And you have also added universal coverage by a combination of the 80-percent employer pay premium and savings.

Speaking for only one person on this side of the aisle, the difficulty I have with your other chart is not in the color scheme, or the cushions and the layers, and so forth, it is basically on, how

do you get the savings on one side over to the expenditures on the other side? How do you capture the benefit of whatever you are doing in a system by way of market reform or change in a particular market and move it somewhere else in the system?

I asked the Secretary this yesterday, and I hope, between you, that somehow or other you can help satisfy the curiosity about that particular question because it is very difficult to imagine how you get Medicare savings unless you reduce Medicare expenditures' growth by 10 percent, or 11 percent, or whatever it is.

You do that in Duluth, Minnesota, where it is now $259 per person per year, and you do it in L.A., where it is $535, or on Long Island, where it is $600 something, you take all the invention, the innovation and the creativity out of Duluth. I mean, they are getting down to the bare bones now.

John asked you questions about the difference and how do you get to the premium discount, who pays that difference, where does it come from and how do you capture it?

And the last part of my question is, I want to refortify what others have said about Medicare reform. My sense is that we are all thinking that the elderly are going to fight us if we do Medicare reform. I do not believe that.

I mean, I believe that if we can give them the same comprehensive benefit package you propose to give everybody else in the country and let them buy it through an accountable health plan, all you have got to do is figure out, with Nancy Ann Min's help, and somebody at HCFA, what kind of check are we going to send to the health plan. Can you sort of generally respond to that?

Mr. PANETTA. That is what Deputy Directors are for, to turn to them.

Dr. RIVLIN. First, on the question of whether having a premium target means that we will not get the savings from the competitive elements that we would like to introduce into the system, I do not see any reason to think that would be true.

We really believe that places like Minnesota and California have demonstrated that, when you combine—particularly HMO systems—with large buyers who can bargain with those systems, that you get very considerable savings in cost.

Now, as you point out——

The CHAIRMAN. Dr. Rivlin, can I just interject? This is a continuing line of inquiry from Senator Durenberger. To what degree do we have a proposal here which will, in effect, penalize just those systems that have done what we would hope other systems would do? In Duluth, they are down to $247. Is that what you said?

Senator DURENBERGER. $259.

The CHAIRMAN. $259, which is half Miami. This is a concern which we have here, which is normal to us. We are a representative body.

Dr. RIVLIN. Well, that goes to the Medicare question. But I do not see any reason to think we are penalizing places that have done well. Part of the reason they have done well is that their reimbursement rates are lower and that they are using some of the competitive processes that would be introduced for everybody into these Medicare changes.

Senator DURENBERGER. But, Dr. Rivlin—and I do not want to get into a debate—the Chairman knows, and you may not know, that, for 1994, Duluth is going to have its reimbursement not increased by the 15 percent that Long Island or the 5 percent that L.A. will have, it is going to have it cut. It is at $259.

Dr. RIVLIN. Well, that is fine.

Senator DURENBERGER. So, you are not correct when you say——

The CHAIRMAN. Not in Duluth.

Senator DURENBERGER. They are being penalized by the payor for holding those prices down and for doing it for less, for showing that the fee-for-service system does not work. But you continue to increase the payments to the fee-for-service system and penalize these people who are trying to do it well. That is just reality.

Dr. RIVLIN. Well, an alternative, as you point out, would be to put the whole Medicare system into the alliances. That is certainly a possibility that ought to be considered. It was our judgment that you cannot do everything at once, and that leaving Medicare as it is, a system which old people are reasonably satisfied with, was a way of not trying to do everything at once.

The CHAIRMAN. Fair enough. We will have another round.

Might I just take a moment to say that we have talked about entitlements with great disdain. The Medicare system has a trust fund surplus of about $125 billion. If we had not squandered it and begun using it as general revenue, that money would be, in some sense, available. Medicare pays for itself, just as Social Security pays for itself. This is not a matter of dispute between us at all.

Now, Senator Danforth, you are next.

Senator DANFORTH. Thank you, Mr. Chairman.

Mr. Panetta, one of the things that the administration has estimated is that tax revenues will be increased by $23 billion because individuals and businesses will be spending less for health care.

And, as I understand it, the theory is that, well, if they are spending less for health care they will be able to spend more for other things. The economic activity will increase, and they will pay more taxes.

Have these estimates factored in the decline in revenues to health care providers?

Mr. PANETTA. The estimates come from Treasury, and I think that they do, in fact, include that estimate as part of it.

Senator DANFORTH. So, I mean, if a doctor makes less money that is less taxes.

Mr. PANETTA. No. That is correct. They have looked at the impact across the board.

Senator DANFORTH. I just really have one question other than that little one. That is, that on your chart here called "Financing Health Care Reform," where it says, "Deficit reduction, $58 billion." When the President made his State of the Union speech and talked about dealing with the problem of the deficit, he said so strongly that we are not going to control the deficit unless we control the growing cost of health care. And in his book, "Vision of Change for America," the information, as I understand it, was that the reform of health care was going to reduce the deficit between 1994 and the year 2000 by $300 billion. It would seem to me that there has been a change of policy, then, between the time we were dealing with

the budget, and when we received the health care legislation, because, instead of $300 billion being applied to the deficit, we are applying, or are apt to apply only $58 billion to the deficit, and the rest is going to be spent on increased health care benefits.

Mr. PANETTA. I think, with regard to, specifically, the "Vision of Change for America," I am not sure in what context that referred to the savings here. But, clearly, we have achieved savings in health care in the budget reduction plan, the economic plan, in which we achieved close to almost $60 billion in savings in this area and applied it to deficit reduction.

But, one of the debates we had early on as we were developing the economic plan was the whole issue of whether or not we ought to use any health care savings for purposes of deficit reduction, should we not use those for purposes of health care reform. I mean, you can understand the nature of that debate.

It was our view that, as a step toward getting the economic plan and getting deficit reduction in place, that we had to use at least some of those health care savings for purposes of reducing the deficit.

And, in the context of putting together a large health care reform plan, that additional savings from Medicare, Medicaid and other Federal programs ought to be applied to offset the costs of implementing that kind of program.

I even think, from the point of view of the substance of trying to achieve additional savings in Medicare and Medicaid, that the battle in the Congress has often been, you mean you are going to cut Medicare and Medicaid just to put it deficit reduction? And we have gone through large battles just on that issue alone.

It seems to me to make much more sense to take whatever savings you are going to get from Medicare, Medicaid, or other Federal programs and apply them to a health care reform bill that is going to serve all Americans, and, in particular, the elderly.

Senator DANFORTH. All right. I mean, that really is, I think, the most fundamental of all issues. What is to be done with whatever savings there are, how real are the savings. We know that adding new drug programs, long-term care programs, and relieving businesses of early retirement health care programs have real budget consequences. And we are hoping for theory working out with respect to the health care savings. The timing of new benefit programs, relative to the savings, is going to be a major subject of debate.

Mr. PANETTA. Absolutely.

Senator DANFORTH. I mean, my own preference would be to use the savings for deficit reduction and not to create new programs. But, politically, you have to have a little bit of sugar with the medicine.

Mr. PANETTA. Senator Danforth, I think that it is a legitimate area for debate, and it should be debated as to what programs should be in or out of comprehensive health care reform.

The only thing I would urge is that, whatever we do provide, we show that we can pay for it because, ultimately, I think we have got to convince the American people that, by providing whatever additional benefits are provided, providing whatever reforms are

provided, we will ultimately reduce that line that I talked about in terms of where the deficit is headed.

Senator DANFORTH. Thank you.

The CHAIRMAN. Thank you, sir.

But, surely, you are going to have to revisit the question of whether the Treasury can make a loan which the Congress can forgive. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

I think, Mr. Panetta, your last statement is correct. That is, ultimately the American public is going to have to be convinced to pay for it.

I am wondering when we are going to see a more complete explanation of the assumptions behind a lot of the savings and costs that are incorporated in this plan. That is, the degree to which utilization increases or decreases in certain areas, the degree to which competition will result in savings. What I am really getting at is, how did you arrive at all of these specific conclusions?

How did you arrive at the dollars that you attribute to either increases or decreases; what are the assumptions behind all of that? The more we have all this out in the open, the more each group, each person is able to look at them and examine them, the more likely it is that we will achieve that objective.

Americans will feel more comfortable and confident that this really will work, and, the more likely it is that we can improve the plan. Maybe you can go over some of the assumptions right now.

Mr. PANETTA. Sure.

Senator BAUCUS. But I think in just a few minutes we are not going to be able to scratch the surface of the assumptions that OMB used, that Treasury used, and other departments used in trying to put this together.

Mr. PANETTA. Senator Baucus, I will try to respond as briefly as I can. In the chart that lays out the costs here, just to walk through each of these areas, on the cost side of the ledger there, the public health and administrative cost increases of $31 billion, we feel very confident about that because we basically are deciding what additional funds we are going to spend on the programs that involve outreach, such as community health centers, or migrant health care centers. That is a number we can specifically break down for you.

Long-term care, we have some very good estimates on the cost of implementing long-term care programs because of the present Medicare program and the present Medicaid program. So, the actuaries and the HCFA estimates are pretty good with regard to that, and I can specifically break that down for you. So, I am confident of that number.

The Medicare drug benefit number, again, we have pretty good experience based on what you provide in deductibles plus what you provide in coverage to come up with the $66 billion number. The self-employed tax deduction is just a straight 100-percent tax deduction on what is currently paid by the self-employed, so we are confident of that number.

The premium discount number, I have to share with you, is the one area that does involve the development of new estimates and new models, and we can go into specifics on that.

Just by the nature of now determining that we are going to provide additional discounts, we are going to provide subsidies to groups of businesses and individuals, we know, generally, what those businesses are because we have some scope of the nature of the small businesses that will need that kind of help. We have some idea, obviously, on individual families. Those below a certain percentage of the poverty rate, we generally know what families are going to need help.

But, I have to share with you that that is probably the one area where I think we have to continue to improve our estimates, and that is a big number.

On the savings side of it, Medicare savings numbers, we have been doing that for years and we have got pretty tight numbers on the savings that flow from certain policies. If you decide to——

Senator BAUCUS. We have done that here over the years.

Mr. PANETTA. Sure. We have premium tested.

Senator BAUCUS. That is right.

Mr. PANETTA. If we are going to premium test or income test a premium, you know what the income is going to be.

Senator BAUCUS. Right.

Mr. PANETTA. If you are going to reduce market basket, you know what the income is going to be.

Senator BAUCUS. Right.

Mr. PANETTA. Medicaid savings and disproportionate share, it is the same thing. If you are going to cut disproportionate share by a certain amount, that is a pretty solid savings number. You know what taxes you raise with tobacco tax and the corporate assessment.

The Federal programmatic savings. This is an area that I think we need to look at more closely in terms of the savings that will flow from it.

Senator BAUCUS. Well, when are you going to tell us more precisely how you arrived at those figures?

Mr. PANETTA. We have a chart that gives you the specific breakdown, and we can go through each area.

Senator BAUCUS. The question is how did you get them, not what they are.

Dr. RIVLIN. As far as the assumptions go, we are preparing a document that gives, in excruciating detail, the documentation behind these——

Senator BAUCUS. The assumptions.

Dr. RIVLIN [continuing]. Estimates and the assumptions. It is not quite ready, but we would be delighted to share it with you and with your staff. We think it is going to become sort of the centerpiece of a good debate among health economists.

Senator BAUCUS. Well, I expect that it will, and it should.

Dr. RIVLIN. I also think that when you see it, you will recognize that we have made quite conservative assumptions on almost all of these things.

Senator BAUCUS. And when will we see this document?

Dr. RIVLIN. Fairly soon. I don't know. Next week, maybe.

Senator BAUCUS. Rough guess.

Dr. RIVLIN. These people have been working so hard on these estimates, that getting them to turn to and produce this documentation document has been difficult.

Senator BAUCUS. Well, I just urge you to be more complete, comprehensive and explicit than not.

Dr. RIVLIN. Oh, I think we can be.

Senator BAUCUS. This is crucial. We need some time to digest all of this. I strongly urge the administration just to lay it all out.

Dr. RIVLIN. We intend to.

Mr. PANETTA. We will.

Senator BAUCUS. How you got the numbers; assumptions used. The public wants meaningful health care reform, and I think they will look at those assumptions and those figures without rushing to criticize, but to try to figure out how to make all this work. I urge you to be very full and complete in disclosure.

Mr. PANETTA. Absolutely. We will present all of our assumptions to this committee and make them available so you will know what goes behind every number up here.

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

The CHAIRMAN. And tell those four people to take the weekend off, get some sleep, because if it takes an extra 2 days, that will be all right. It will be painful enough in any circumstances. Senator Wallop.

Senator WALLOP. Thank you, Mr. Chairman. Just following a little bit on the line of Senator Baucus. I think that one of the things that upsets the public the most is your pronouncement that we achieve the $100 billion in savings in the President's economic package. There may be savings to the government, but it represents the cost to providers and consumers. Is that not correct? It is not real savings, it is just cost shifting, what you blame the public for on other things.

Mr. PANETTA. My view on that, Senator, is that everybody ought to participate in deficit reduction, including doctors and hospitals.

Senator WALLOP. As though they have not yet.

Mr. PANETTA. As though we have not sufficiently dealt with that problem.

Senator WALLOP. Yes. But is it not unfair to call it a savings?

Mr. PANETTA. No, not at all.

Senator WALLOP. Well, a savings implies that somehow or another you have reduced the cost of medicine, which is hogwash.

Mr. PANETTA. Savings implies that there are ways to save money in health care areas that are as worthy of saving as in agricultural subsidy programs.

Senator WALLOP. I am not enthusiastic about those, either, Mr. Panetta.

The CHAIRMAN. You have got the wrong man. [Laughter.]

That is Malcolm Wallop. He does not believe in too much government.

Senator WALLOP. Along with the language that government uses, which is always some source of cynical amusement, do you really believe there is any such thing as a capped entitlement?

Mr. PANETTA. Sure. Food stamps is a capped entitlement. We have got other entitlements. Title 20 is a capped entitlement.

Senator WALLOP. And you are asking the American people to believe that, once you gather them all under the Federal umbrella, mandate their participation, if you run out of money that that entitlement is still capped?

Mr. PANETTA. Well, I think if you supported the Nunn-Domenici cap on entitlements you have supported the same kind of approach.

Senator WALLOP. You are honestly telling me that when we run out of money we just run out of medicine until the next year starts?

Mr. PANETTA. I am saying, if we are going to discipline ourselves in terms of providing benefits and holding onto the costs, that we have got to implement a discipline that says to the President and the Congress, if you establish targets and for some reason you do not meet those targets, go back and find out what the answer is.

Senator WALLOP. Yes. Well, that is where the cap falls apart. That is when the public knows that you have mandated either a new tax upon them or withdraw some other benefit for them. Is that not correct?

Mr. PANETTA. Well, I think Social Security is clearly a program that has been able to fund itself and has done a very good job.

Senator WALLOP. With ever increasing taxes. There comes a time when the worker bee can no longer support the drones.

Mr. PANETTA. Well, when we did the Social Security Commission it was done on the same basis, that we had to address the problem of a program that needed help, and the Congress and the President joined together in doing that. There is nothing wrong with that process. Nothing wrong with it at all.

Senator WALLOP. Well, some of us would suggest that there is, when you put in place where it does not now exist a certain highway that goes directly to a tax increase under every set of circumstances that you can describe. That is different than Social Security.

Mr. PANETTA. Well, I would tell you this, that, under the present program, the tax that you are applying to people is the tax on our children who are picking up the bill and the deficit. And you have got to change that.

Senator WALLOP. Under the present program.

Mr. PANETTA. Under the present system that we are operating with right now.

Senator WALLOP. System of what, government or——

Mr. PANETTA. Health care expenditures, where they are headed; other expenditures and where they are headed. The fact is, somebody picks up the bill. You cannot just——

Senator WALLOP. And you think all Americans want to have this little card and be told who they can go to and that they are willing to pay, no matter what it costs, forever?

Mr. PANETTA. The purpose of the card is to give individuals what they do not have today, which is health care security. If you do not think everybody ought to get health care security, then we have a fundamental disagreement. If you think that people ought to have health care security, then this is a plan that——

Senator WALLOP. I think that they ought to have health care security. I think there are ways of getting there. I think the way that has been established, which is the government's arms around ev-

erybody and every State, and mandating to the States, who is going to pay the cost of putting these alliances together?

Mr. PANETTA. It is the same approach that currently occurs where you are paying premiums for health care. Everyone pays a premium for health care now. Everyone should pay a premium for health care coverage.

Senator WALLOP. And the States, what happens to the State in that, just new cost for them of doing government?

Mr. PANETTA. The States are way ahead of both of us right now. There are many States that are trying to implement this plan.

Senator WALLOP. Well, I think that is one of the reasons why some of us are expressing skepticism at the scope of the solution. I think that you can get universal coverage without having the Federal Government being involved in everybody's health care at every level.

Mr. PANETTA. If you can develop, Senator, an approach that develops universal coverage with health care security that is different from this one, we would like to see it.

Senator WALLOP. Well, I would suggest that the House Republican package covers universally, at considerably less cost and considerably less cost in freedom.

Mr. PANETTA. Look. There is, I think, a consensus with regard to some of the things that I believe Senator Durenberger mentioned, where there is a consensus with regard to some of the changes that can be made on insurance reforms and community ratings, and some of the things around the edges. But there is a fundamental decision that has to be made here.

The fundamental decision is whether or not we are going to cover all of those Americans who are not covered now, and whether we are going to provide security so that those health benefits cannot be taken away. That is the fundamental decision. The plan that you have presented still allows people—many millions of Americans—to fall through the gap. And that is the problem we have with it.

Senator WALLOP. Some of us suggest differently. My time is up.

The CHAIRMAN. Well, we will have a second round. We will get back to you. Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman. First, a request for something in writing. You noted that your proposal contains 25 provisions that would reduce Medicare spending by $123 billion. Could you provide the committee with a table showing the line item savings that those provisions would realize?

Mr. PANETTA. Yes. Yes, we would be happy to, Senator.

Senator GRASSLEY. All right.

[The information requested follows:]

The attached chart entitled "Itemization of Health Security Act (HSA) Medicare Savings Provisions" includes a list of the 25 provisions of the HSA that would reduce Medicare spending between 1995 and 2000. Note that at the time of the testimony, the proposed Medicare cuts were estimated to a total $123 billion. The final estimates used in the FY 1995 budget total $118 billion.

ITEMIZATION OF HSA MEDICARE SAVINGS PROVISIONS

[In billions of dollars]

| | 1995–2000 |
|---|---|
| Income Related Part B Premium ($100K, $125K) | 3.85 |
| Extend HI Tax to All State and Local Government Employees | 7.57 |
| PART A: | |
| Reduction in Update for Inpatient Hospital Services: −2% | 17.76 |
| Reduce Payments Capital-Related Costs—Inpat. Hosp. | 6.20 |
| Revisions in Payment Adjustments for DSH | 17.25 |
| Moratorium on Designation of Additional LTC hospitals | 0.53 |
| Extension of Freeze on Updates to Svc Costs of SNFs | 0.92 |
| Transfer from Medicare Trust Funds for Grad. Med. Educ. | −0.28 |
| Transfer from HI Trust Funds for Academic Health Centers | 18.45 |
| HI Interactions | −1.78 |
| PART B: | |
| Set Cumulative Expenditure Goals for Physician Services | 5.48 |
| Use Real GDP to Adj. for Vol. & Intensity | 5.78 |
| Reduce in CF for Physician Fee Schedule | 2.85 |
| Limit Physician Payments to High-Cost Hospital Staffs | 2.45 |
| Med Incentive for Physicians to Provide Primary Care | −0.08 |
| Eliminate Formula Driven Overpayments in Hospital OPDs | 9.60 |
| Imposition of Coinsurance on Laboratory Services | 7.58 |
| Competitively Bid Part B Services | 0.98 |
| Competitively Bid for Medicare Labs | 1.55 |
| General Part B Premium: Stand Alone Provision | 4.70 |
| Interaction | −7.39 |
| Income Related Part B Premium ($100K, $125K) Interaction | −0.28 |
| Mandatory Assignment for All Part B Services | −1.13 |
| PARTS A & B: | |
| Medicare Secondary Payer: Extension of Data Match | 0.47 |
| Medicare Secondary Payer: Change Firm Size Threshold | 2.56 |
| Medicare Secondary Payer: Extend Period ESRD Benefit | 0.13 |
| Pay Limits for HMO's & CMPs with Risk Sharing Contracts | 1.29 |
| Extension of Home Health Freeze (Reduction in Cost Limits) | 2.70 |
| Coinsurance for Home Health Visits | 8.02 |
| Expand Centers of Excellence: | |
| Part A | 0.38 |
| Part B | 0.23 |
| TOTAL MEDICARE SAVINGS | $118.31 |

Senator GRASSLEY. I want to say up front that the first question I am going to ask you is something that I asked Secretary Bentsen about yesterday. I am not sure that the administration has really had a chance to think about this; maybe in the meantime somebody has notified you and you might be able to shed some light on it.

It has to do with the reliability of the small business discount or subsidies promised in the bill. The most that the smallest businesses with the lowest average annual wages would have to pay is supposed to be 3.5 percent of payroll.

Then later on in the bill there is a section numbered 6125, and it is entitled, "Employer Collection Shortfall Add-On." This section seems to provide that, if an alliance does not collect from employers the amount that it expects to collect, it can seek additional amounts from all employers. And it looks like the alliances can collect these additional premiums without regard to promised discounts or subsidy.

So, as I read this, it does not look as though small business will really know how much they are going to have to pay for this program, so the first point is to comment on that.

The second point is, does this possibility not make the amount of the discount or the subsidy to small businesses very uncertain? Then, three, and lastly, what might be the circumstances that could lead an alliance to seek additional resources from employers?

Dr. RIVLIN. I think it would be good if we came back in writing on that, because I do not know all of the details of the bill. But we would be happy to do that.

The CHAIRMAN. Fair enough.

[The information requested follows:]

The purpose of the Employer Collection Shortfall Add-On is to cover premium bad debt in the new financing system. For example, if a firm fails to pay premiums into the regional alliance and subsequently goes bankrupt, those unpaid premiums would be covered through the add-on. The employer Collection Shortfall Add-On is a responsibility of firms not subsidized by the Federal government.

We expect this add-on liability to be quite small. The Health Security Act includes stiff penalties for non-payment, and those low income households who would be unlikely to pay for their share of the premiums are largely subsidized by the Federal government.

Senator GRASSLEY. Thank you, Mr. Chairman. Well, yes. As long as I have still got some time, let me make a comment that I would have made in my opening remarks.

Mr. PANETTA. Senator, if I could just make one comment.

Senator GRASSLEY. Yes. Sure.

Mr. PANETTA. And we will provide the specific answer to you. I think the answer to your question is that a small business will have a hell of a lot more certainty under this system as to what they are going to be paying than what they presently are experiencing in terms of health care coverage, those businesses that provide health care coverage to their employees.

At the present time, they are experiencing, as you well know, dramatic increases in terms of the premium costs for their employees, to the point that it is eating up much of their payroll costs.

So, I think, clearly, what we are trying to establish here in the system is to make very clear to those businesses just exactly what they will be required to pay and try to make sure that they do not exceed certain limits.

So, yes, there may be, within those limits, some increases that may be required, but we have made very clear they are not going to pay above a certain amount.

Senator GRASSLEY. Under your plan there might be more certainty, but, let me tell you, the options at that point for the small business person is that you have got to pay the tax. Now, if a small business finds itself in a position of uncertainty and he gets a bill from his insurance that it is going to go up a massive amount, he has got alternative insurance he can look at, he can look at some sort of a catastrophic approach, he can look at self-insurance.

And your plan is very, very rigid. Very, very rigid. I think it is really too rigid for the geographical vastness of our country, the heterogeneity of our people, and the different socioeconomic situations that we have in America, because it is so diverse, that you squeeze everybody into one alliance where there is no option. So, yes, he may have some more certainty, but that certainty can be paying a heck of a lot more money without looking elsewhere of how to get around it.

Mr. PANETTA. Well, the biggest problem you have right now—and it is a problem that we are trying to deal with as you try to deal with health care costs generally—is that, yes, that small business could probably decide to try to find another plan or try to find an HMO, but the fact is, that most of those businesses decide they are not going to get any kind of health care.

So, ultimately, what happens is their employees are not covered, that business is not covered, and somebody then picks up the bill at some point when they need help. That is the kind of concern that we need to address. As I said, I do not say we have all the answers here. But, if you share that concern, that is an issue that I think we need to work towards.

Dr. RIVLIN. Can I jump in on that? I think the thing about being in an alliance is that it will give a small firm a lot more choices than they really have now. It is not to give them fewer choices, it is to give them more. The day that you and I spent in rural Iowa with the First Lady brought home to me the point you just made, that is, that the country is very diverse.

But farmers, particularly, have very few choices now because they are in a high-risk business. What most of them do is, their wife works in town to get some insurance coverage. But, for farmers, for small businesses, to be in a whole alliance will give them more options at a more affordable cost than they have now.

Senator GRASSLEY. Yes. I do not have any problem with the fact that we have to have universal coverage and that you have to have a mandate that everybody has to have insurance. I do not have any problems with the concept of an alliance.

I only have problems with the concept of forcing a country that is so diverse into one mold, the alliance. I think that the alliance ought to be available as an economic fact of life. I think most people are going to buy through the alliance. But why squeeze everybody into that one mold?

Mr. PANETTA. What I really would like you to do is, let us continue to discuss the issue of the alliances.

Senator GRASSLEY. All right.

Mr. PANETTA. I think you will find that there will be differences between the different States as they set up the alliances and the plans that are part of them. I do not think they will be as rigid. And I have heard that criticism and that concern, but I think there is a lot of flexibility here that we can work with.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Fair enough.

Can I now say, Mr. Panetta, on almost a point of personal privilege, that yesterday, with the Secretary of the Treasury here, I raised the question of the medical costs of handgun wounds and noted the fact that, since 1918, the Federal Government has taxed ammunition and since 1938 has licensed manufacture.

Licensing is very casual. For $10 a year you can just write in and get your license to manufacture ammunition. You can make as much ammunition as you want and you do not report. The Bureau of Alcohol, Tobacco and Firearms has never been interested in what happens. I am. If you want to talk about dangerous occupations, it is being a police officer in an American city.

Here is a new round. I spoke yesterday about the new Black Talon. It is manufactured by Winchester. There it is, sir. That is what is fired. This is after it is fired. Six beautiful, sharp points that cut through the flesh and are designed to do so. Just touch this damn thing. Here.

In the magazine, "Handguns for Sport and Defense," it is called the "ripping bullet." It describes, "The Talon expands razor-sharp, reinforced jacket petals. These cut tissue in the wake of the penetrating core."

Winchester, which is owned by Olin, makes them in 9 millimeter, 10 millimeter medium-velocity, .45 and .40 caliber. That means these are available in those spray guns in drive-by shootings, the 9 millimeter. That is what the police are up against in our cities. Just one of these will take you apart.

I suggested that we did not need them, and a representative of the National Rifle Association thought it was laughable. Mr. LaPierre said, "It is laughable that someone would not want a round like that fired at a police officer." And I would just like to say that I have some letters here which we had received. This is from Dr. John Gallagher, who is the Director of Emergency Medicine at the Albert Einstein College of Medicine, Bronx, New York. He says, "I would like to inform you of a serious threat to victims of violent crime: the Black Talon bullet. This new hollow-point bullet opens on impact to produce six extremely sharp teeth, arranged evenly in a circle around it. In 20 years of working in a municipal hospital trauma center in the Bronx I have never seen a more lethal projectile.

This bullet, which is manufactured by Winchester, is advertised to create more tissue damage and to produce "optimum penetration." Unfortunately, this is exactly what it will do. Because of this, I believe this bullet should not be available to the general public." Dr. Gallagher, from the emergency room at the Albert Einstein College of Medicine, the Bronx. The National Rifle Association thinks this is laughable. Laughable that police should be hit with such rounds?

I have a letter from the Children's Memorial Hospital in Chicago pleading to stop this. Stanford University Hospital Trauma Center, Drs. Stone, Martinez, Neff, and Kathy Montgomery, secretary, and Dr. Katherine Kaufer Christoffel from Children's Memorial. The American College of Emergency Physicians, State Chapter of California, Dr. Dennis, says, stop.

The Medical College of Wisconsin, Dr. Stephen Hargarten, says it is outrageous that people should have to face such rounds. And the National Rifle Association says this is laughable. Well, you are not supposed to say such things about the National Rifle Association, but I think that is obstinate.

We have a right to tax this. We have taxed such ammunition. And I think this round should be taxed out of existence. Gunshot wounds cost, we estimate, about $4 billion a year. If you ever get this round, the Black Talon, the ripping bullet into those 9 millimeter clips that are all over our cities, they are a horror. I do not think it is laughable one damn bit.

I wanted to say that. I do not think you think it is laughable either, sir. That is a round which has the sole purpose of maximizing

the possibility of killing another human being. No hunting, no sport, but just to kill cops. Now, we did outlaw, in 1986—and everybody in this body voted for the bill—watch your fingers. Thanks very much, but watch your fingers. Show that to Alice.

Senator WALLOP. Mr. Chairman, it is a case, I believe—and I agree with you that it represents an enormous danger in general sale—but it was a round that was developed for the police.

The CHAIRMAN. That cop killer. Yes. And the police finally said, when they developed body armor, said, my God, this could penetrate body armor. So, they came to us and asked us to ban the round, and we did.

Senator WALLOP. No. But I am talking about, this round was developed for the police.

The CHAIRMAN. Then, by God, I am sorry to hear that. I am sure they would want to reconsider. That is all. I just wanted to say that.

Mr. PANETTA. Mr. Chairman, if I could, I think, as everyone has pointed out, there clearly is a relationship between the increasing violence in this country and medical care costs. Something like this makes the point, and I think it is something we need to look at with you.

The CHAIRMAN. Thank you, sir. I would like to place these letters in the record. My thanks to the doctors involved, and also the article.

[The letters appear in the appendix.]

The CHAIRMAN. Now, Senator Daschle, sir.

Senator DASCHLE. Mr. Chairman, I applaud you for your statement. I think that your continued determination to follow through with this is not only appropriate, but praiseworthy. It is not only the police, as tragic as that is, but it is children, as one of your letters indicates. In the Washington Post just last week, I saw children, who, at 12 and 13 years old plan their funerals these days.

The CHAIRMAN. Yes.

Senator DASCHLE. They decide which prom dress they are going to wear and what kind of music they will have. And others in my part of the country are talking about becoming President of the United States.

Let me, again, applaud you for your answers on the efficacy of caps. We have had some remarkable debates about the need for caps. And it seems that there is support for caps on programs affecting "them." Yet there does not appear to be as much support for caps on programs affecting "us." I think we must conclude that, disciplinary action in a budgetary way is essential to put our money where our mouth is, literally. And I think that is what those charts indicate.

I would be interested in one last question having to do with the importance of early universal coverage in effecting cost containment. To what extent is there a relationship between universal coverage—not universal access, but universal coverage—and our ability to contain costs?

Mr. PANETTA. I am going to let Alice take a whack at this too, because she has been intimately involved in that whole issue from that perspective. But it is pretty clear when you look at the need

to control health care costs. I think the Congressional Budget Office agrees with us.

As a matter of fact, I think Bob Reischauer spoke specifically to this issue when he testified before one of the budget committees where he said, if you are really interested in controlling health care costs you have to do several important things.

One of those is universal coverage. Second, you have got to provide some kind of standard benefit plan. Third, you have got to deal with premium increases. And he listed a whole series of things that are included in this bill.

The reality is that, unless you are providing that kind of coverage, what you are doing is you are creating the kind of gaps then that ultimately wind up driving up costs.

So, if you say in one area where you have some competition and maybe some effort to try to hold down costs—probably Medicare and Medicaid, I will tell you, is probably one of the best examples. We enact Medicare and Medicaid savings almost every few years and try to reduce the cost there. As we are doing that, costs elsewhere are escalating. They are dramatically escalating.

So even though we have got a handle on, perhaps, one part of this ledger we do not have a handle on the rest. So, you have got to have universal coverage in order to give us a handle in terms of trying to control health care costs generally. Otherwise, you are going to create the gaps the are ultimately going to cost us a hell of a lot of money.

Dr. RIVLIN. Well, I think that is absolutely right. Another piece of this is the cost of caring for people who do not have coverage. That is a very large cost because we do not turn people away who are very sick if they come to a hospital. They may come too late and it may be more expensive than it would have been if they had had coverage and had preventive care, but we do take care of them and the whole system pays. And we cannot control those costs unless we have universal coverage.

Senator DASCHLE. Is that as true for specific benefits as it is for the population as a whole? That is, are we in a better position to contain costs if we include things like drug prices and long-term care; can one make that same argument for benefits?

Dr. RIVLIN. Yes, I think so.

Mr. PANETTA. I think to the extent that you provide a set of benefits, and then to the extent that you control costs in those benefits, what you basically then do is you have got some leverage over where costs overall are then heading.

If you do not provide those benefits, what is going to happen? I will tell you what is going to happen, you are going to suddenly wind up seeing tremendous premium increases in order to provide those benefits. And that is what we are seeing right now.

With regard to basic benefits that ought to be provided—and I happen to believe drug coverage is one of those, and I happen to believe long-term care is one of those—to the extent that you provide those in a basic benefit package, then you basically are preventing the kind of escalation you are going to see with regard to premium costs elsewhere.

Senator DASCHLE. Thank you both. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Daschle.

Now, once again, Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. First, Mr. Chairman, I want to commend you for your proposed tax on handgun ammunition, and I will support you to every extent possible. I think you are absolutely right. As you know, I have introduced legislation to ban all handguns in the United States. I think the slaughter that is taking place throughout our society is terrible.

They are turning up in schools in incredible numbers. Imagine the school budgets that are crying for additional money having to put up $4,000 screening metal detectors manned by people having to be paid extra, filtering the children through those in order to find handguns in the schools in our cities. It is just terrible. So, your measure, I think, will be a big step forward. As you say, it is bullets that kill people. So, I want to do everything I can to be helpful to you.

The CHAIRMAN. Senator, can I just say to anyone who might be watching, that is coming from a Marine who was on Iwo Jima.

Senator CHAFEE. No, no. Wait. I was not on Iwo Jima.

The CHAIRMAN. Guadalcanal.

Senator CHAFEE. Guadalcanal.

The CHAIRMAN. At the Canal, as the Marines say. That is not a man who has never heard a gun go off.

Senator CHAFEE. Well, thank you, Mr. Chairman.

Mr. Panetta, I am not sure I understand the way your tax cap works. In other words, currently all health benefits are deductible by the employer and are non-taxable to the employee, a tax-free fringe benefit.

Under your proposal, as I understand it, that remains the same except for those benefits that are beyond the basic benefit package. Let us just say for illustration that dental care was not in your basic benefit package but is currently being provided by—I am beating General Motors up, I guess. Let us take Ford.

So, if, currently, Ford is providing a dental benefit that is not in your basic benefit package, Ford would continue to be able to deduct that, the total package, and the employee would continue to be able to receive that benefit tax-free, except at the end of 10 years, again, making the assumption that dental care was not in your basic benefit package. At the end of 10 years, then the cost of the dental care would then become, what, non-deductible by the employer?

Mr. PANETTA. Yes, I believe that is correct.

Senator CHAFEE. And would it become taxable to the employee at the end of 10 years?

Mr. PANETTA. That is correct.

Senator CHAFEE. I see. So, in summary, the only thing you deal with at all, as far as deductibility and taxability to the employee, is something beyond the basic benefit package.

Mr. PANETTA. That is correct. That is correct.

Senator CHAFEE. Now, in our plan, the Republican Senators' Task Force Plan, we choose what we arrive at—and you can argue at how you arrive at it—a reasonable cost of a benefit package. Then anything above that reasonable cost—and, as I say, you can use it the average of all the plans, or however you want to arrive

at it—becomes non-deductible to the employer and taxable to the employee.

Now, that is to have a downward pressure on what you might call a gold-plated plan. We see considerable merit in using that to reduce health care costs. Could you give me your reaction to that, please?

Mr. PANETTA. I think this is one area that, frankly, we need to explore your formula and what we have provided because I think we are after the same thing in this instance. And I think the question becomes, what is that level of cost then, and we provide the basic benefit package and basically establish that as our core program.

Senator CHAFEE. And, again, I am always talking the basic benefit package in our plan.

Mr. PANETTA. Right.

Senator CHAFEE. Under your plan, you could have a very, very—I want to use the term luxurious way of providing the basic benefit package. In other words, if somebody comes up with a proposal that doctors will make house calls. That is under the Aetna plan. So, it is $500 a month, whereas, all of the other plans in the neighborhood are $300. But it is a nice plan. Always delivering the basic benefits services, but it is how you deliver them.

Under your plan that would be all right. It would be deductible by the employer, non-taxable to the employee. We have problems with that. We do not think that is enough downward pressure on expenses in the delivery of health care. That is our philosophy.

Mr. PANETTA. Yes. No, I understand what you are saying. I think the reason that we have approached it in that fashion is basically to say, we are going to provide a basic benefit plan, but, indeed, if there are companies that are out there—insurance companies or others—that want to provide more attractive benefits and people are willing to pay for those benefits, they ought to have the right to do that. I mean, it was basically the choice issue that I think influenced the approach that we have taken on this.

Senator CHAFEE. Alice?

Dr. RIVLIN. That is right. Clearly, your plan would provide more downward pressure and more incentive for employees to choose lower cost plans, but the trade-off is that some people who now have coverage under the plans that they have worked out in collective bargaining arrangements would then find that their taxes are going up.

Senator CHAFEE. Or they could choose a lower cost plan.

Dr. RIVLIN. They could. But if they want to keep the benefits they have now they would be taxed more.

Senator CHAFEE. Well, I do not think it is fair to say, keep the benefits. It is to keep the delivery of the benefits, because we all agree that you are only talking a uniform benefit package. And, under your proposal, at the end of 10 years that is all that is deductible, the delivery of the uniform benefit package. I am correct on that, am I not?

Mr. PANETTA. That is correct.

Dr. RIVLIN. Yes.

Senator CHAFEE. Yes, I am not talking benefits.

Mr. PANETTA. I understand that. But how do you develop what are the reasonable costs unless you defer to a benefit plan of some kind? I mean, you have to.

Senator CHAFEE. Under our plan we take the average of the lowest one-half of the plans submitted. Let us say there are 12 plans submitted. One-half of that is six. We take the average of the lowest costing four plans. That becomes your reasonable cost. Anything above that, if somebody chooses plan seven that is more expensive, they pay a tax on the difference and the employer cannot deduct the difference.

Mr. PANETTA. Yes.

Senator CHAFEE. As I say, there is nothing magic about how to arrive at a formula, but I think there should be some reasonable cost level set forth.

Mr. PANETTA. I do not disagree with what you are saying. I think the question here is more the formula that you use to get to the same point we both want to get to.

Senator CHAFEE. Yes. I do not want to beat this to death.

The CHAIRMAN. No, no, no. Go ahead.

Senator CHAFEE. But you do not have any formula.

Mr. PANETTA. No. Our formula is——

Senator CHAFEE. As long as you are only delivering the basic package——

Mr. PANETTA. That is correct.

Senator CHAFEE. You can deliver it in the most luxurious fashion, always with the basic benefit package. And that is totally deductible by the employer and non-taxable to the employee.

Mr. PANETTA. But do not forget, that basic benefit plan, to some extent, is the equivalent of your reasonable cost basis because that basically establishes essentially what the benefits are that are going to be provided and what everybody ought to be choosing in that process.

Senator CHAFEE. Well, I understand that. But, as you know, there is going to be a difference in cost and quality.

Mr. PANETTA. Sure. Sure. If they want to get a better plan, if they want to get more benefits.

Senator CHAFEE. No, no, no. I do not want to talk different benefits. Always talking the same benefit package, there are different ways of delivering it so there will be differences in cost. How does a person make a choice? Differences in cost, differences in quality. If it is an HMO, clearly it is going to cost less than a fee-for-service proposal. All right. Well, thank you.

The CHAIRMAN. Well, I think to be continued, do you not?

Senator CHAFEE. Well, it will be continued.

Mr. PANETTA. To be continued.

Senator CHAFEE. This is a long-running show. We are going to see a lot of Mr. Panetta over the years. We have gotten to know Ms. Rivlin very well over the years, and we are going to get to know, probably, Mr. Panetta very well over the years.

Mr. PANETTA. Whether I like it or not. [Laughter.]

The CHAIRMAN. I would make the point that, under the President's proposal, after the year 2002, any benefit plan that is not part of the basic benefit system is taxable income.

Mr. PANETTA. Yes. That is correct.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

I am going to continue it just briefly because, for a lot of us, Democrats and Republicans, this is a pretty critical issue. We all represent some of these large plans, like the union plans, and so forth, and we are sensitive to them, too.

In addition to what John said about averaging out the low three, the other proposals are to take the average of the low three plans, another proposal would be to just take the low plan, and another one would be to take a dollar amount—that is what Senator Dole and I have been talking about for 10 years—and try to find some way that that reflects health status and some other things by community.

My question is, in dealing with the politics of people who are going to get taxed if the cap literally went into effect, have you explored the possibility of trade-off for other non-taxable benefits in any way with these people?

In other words, to avoid the argument that a $600 plan and a $350 plan community is going to represent $250 a month in additional taxable income, the key point here is to get people to buy only what they actually need. They do not need a $600 plan, they only need, on my assumption, a $350 plan. And we are subsidizing something that works against bringing the costs down and serving the people's needs.

One alternative would be to offer people in those kinds of situations some other benefit, an enrichment in pensions, or long-term care, or some other alternative that might be non-taxable. Has that been explored, do you know, in the negotiations with some of these people?

Mr. PANETTA. I have to tell you, in the discussions that we had in the development of the plan we really did not look at other areas that would serve as attractions for trying to go lower. We basically focused on the health care issue and issues associated with health care. So, the answer to your question is, we have not explored that.

Senator DURENBERGER. But maybe it is helpful in the ongoing debate to do that.

Let me also then talk about the small business discounts, and so forth. It would be helpful, I think, to all of us to understand, within the proposal, which is 75 employees or fewer, and then there is this scaling up of $25,000 to $40,000, different small businesses are differently situated.

Some of them just are quite a number of people at, say, $20,000 a year; others might be firms in which principals, two, or three, or four principals are at $100,000 a year. And then there is a lot of the basic clerical people. But, because you have a few people in a small firm at a high income, you are pulling everybody up to the $40,000 threshold, or $25,000 threshold.

The CHAIRMAN. Like a law firm.

Senator DURENBERGER. Yes. And investment firms, and maybe some insurance firms, if there are going to be any left, whatever the case may be. But it is a fairly typical situation in many of our small towns all over America because now they have health plans which are suited in some way to the income and in some way to

the community, in effect, you would be pulling up, I think, the cost to everybody in the system unnecessarily.

So, if we just had a little bit more background on how you arrived at the particular formula and how it applies to different small businesses, that would be helpful.

Mr. PANETTA. Let me provide that for you because there was a lot of analysis on this question and a lot of those same questions were raised as we were discussing this very issue because our concern was, what then happens with the law firm, what then happens with that kind of situation where you have got those kinds of salaries.

Senator DURENBERGER. Right.

Mr. PANETTA. I think this is an area, frankly, we need to look at a lot more closely.

[The information requested follows:]

There are two types of employer subsidies in the Health Security Act (HSA). The first is the small business subsidy which applies to firms with fewer than 75 employees, and the second is the general subsidy for all firms in the regional alliance.

The small firm subsidy schedule is shown below. Each firm's liability for health insurance payments for its workers are capped at a percentage of total payroll. The applicable percentage of payroll cap is a function of the number of workers in the firm and the average pay of the workers in the firm. The smaller the firm and the lower the average wage of the workers in the firm, the lower the firm's liability for premium payments.

HSA SMALL FIRM SUBSIDY PERCENTAGE OF PAYROLL CAPS

| Firm size | Average pay of workers in the firm | | | | | |
|---|---|---|---|---|---|---|
| | <$12,000 | 12,000-15,000 | 15,000-18,000 | 18,000-21,000 | 21,000-24,000 | 24,000+ |
| <25 | 3.5% | 4.4% | 5.3% | 6.2% | 7.1% | 7.9% |
| 25 to 50 | 4.4 | 5.3 | 6.2 | 7.1 | 7.9 | 7.9 |
| 50 to 75 | 5.3 | 6.2 | 7.1 | 7.9 | 7.9 | 7.9 |

For example, a firm of 20 workers with average pay equal to $16,000 would be required to pay the lesser of (1) 5.3% of payroll and (2) the cost of the employer premium shares for each of his/her workers. On the other hand, a small high wage firm (such as a small law firm) would face the same liabilities (7.9% of payroll or the cost of the employer premium shares for each worker, whichever is lower) as a larger firm in the regional alliance.

The schedule was constructed in three steps for different sizes of small firms in an attempt to reduce the payment "cliffs" inherent in moving from one firm size to the next. You can see that at each successive small firm size category, the payroll caps increase by the same amount as they would if the average pay in the firm were increased by one step.

The Senator cites an example from the President's Report to the American People describing the Health Security Act. The example is of a full-time messenger, making $13,000 per year who is married to a non-worker, and they have a child. The family premium is $4,360 per year, making the family 20% share $872. Since the family is low income, however, they qualify for a subsidy, making their share only $384 per year. The husband's employer is also required to make an insurance contribution on behalf of this family. The employer is not liable for 80% of $4,360 ($3488), however, as the Senator suggested. The firm is liable for the adjusted per worker premium of $2,479 for a worker in a two parent family. The reason that the adjusted per worker premium is less than 80% of the actuarial value of the premium is that it takes into account the number of families with more than one adult worker.

In order to eliminate the administrative burden of having employers of dual worker households coordinate payments with each other, the HSA divides the 80% share of the actuarial premium by the number of family households plus the number of "extra" workers in family households. In this way, each employer pays the adjusted per worker premium, regardless of the labor force participation status of the em-

ployee's spouse. Over all employers (and non-working households) in the aggregate, the correct amount of money is collected in this manner.

These adjusted per worker premiums are then subject to the percent of payroll caps applicable to a given firm. In the example of the messenger service cited by the Senator, the firm would likely be eligible for a small firm cap, reducing the employer obligation significantly. If the firm were not below 75 workers, but was in the regional alliance, it would still be eligible for the 7.9% of payroll cap. If, for example, average wages in the firm were $14,000, and there were 100 workers in the firm (all of whom were parents), the employer's obligation would be $1106 per worker instead of $2479. If the firm had fewer than 75 workers, the employers obligation would be even lower.

As constructed, the HSA subsidy schedules perform two functions. They protect low income families from some or all of the family share of health insurance premiums. In addition, the subsidy structure provides protection for low wage employers in the regional alliance so that the cost of providing health insurance for an additional low-income worker is not excessive. Although we believe that each employer should contribute to the provision of health insurance for his/her workers, we felt that it was important that employers providing jobs to low income individuals have their obligations limited to a greater extent than others. Finally, for the months when there is no working adult in the family, the HSA protects families without non-wage sources of income from further liability.

Senator DURENBERGER. All right.

Following this along again, and remembering that there are some people who would just as soon get the lawyer out of the system on it.

Mr. PANETTA. I understand.

Senator DURENBERGER. I think we are all committed to the value of the employer being involved. If we can see what your thinking has been and your proposals have been for integrating, after we eliminate Medicaid and begin to put a direct subsidy under low-income access to these health plans, how is the direct subsidy to the premium for low-income people integrated with the employer subsidy which, at some point, should be encouraged to come on top of this?

Is there a simple way, without complicating it too much, so that we can see how those two subsidies will work with each other and sort of maximize, if you will, the use of the direct subsidy, if that is most efficient, but that we actually can see how we are going to be encouraging small businesses, particularly those that have to hire low-income people, people that have to hire a lot of part-time employees?

You have an example in here, for example, of a messenger, on page 122 of the President's message. You used a Minnesota example where a single wage earner takes home $13,000 a year, or $250 a week as a messenger.

And you say, this person could get a plan costing $4,360, of which the employer would pay $3,488. I am trying to figure out who that runs a messenger service could even afford the $3,488 for a $13,000 person. If you follow me, I would guess that you have got some way to balance the direct subsidy with the employer contribution that would be helpful to us to understand.

Mr. PANETTA. Yes. Again, what I would like to do is have our people sit down with you, and we can provide it for the record as well, to go through the balance there because you have identified a very tricky element because these things do have to work together. You are going to get the maximum.

Senator DURENBERGER. Do you also have the estimate on the tobacco tax and what the impact is on consumption and how that relates to projected revenues?

Mr. PANETTA. Yes. Treasury has that and we can provide that as well.

Senator DURENBERGER. Great. Thank you very much.

[The information requested follows:]

The revenue from the tobacco tax was estimated by the Treasury Department ($67.4 billion between 1995 and 2000). The Treasury Department can best respond to further questions about assumptions underlying their estimates.

The CHAIRMAN. I think a learning process is going on here. I am very encouraged. Senator Chafee.

Senator CHAFEE. Well, Mr. Chairman, I guess this concludes our part of it.

But I do want to just say to Dr. Rivlin and Mr. Panetta that, speaking as one Republican Senator and as Chairman of the Republican Health Care Task Force, that we are deeply, deeply concerned about the potential cost of this program and that just, with no reflection upon the sincere efforts and the skill that you have done, with your modeling and the attempts to project what this thing is going to cost, our belief is that no one can do it, and you, yourself, have acknowledged how difficult it is. And we very strongly believe we should move into this cautiously.

We ought to keep in mind, it seems to me, our objective to, first, cover those who are not covered, and then, if the savings are there, we will have a chance—we, meaning the U.S. Government—to tell whether these savings accrue to the extent they think they are. I mean, we all put great hope in things like malpractice reform, and antitrust reform, and insurance market reform, and all of these things. But who knows?

Who am I to tell either of you, we have had such bitter experiences with this whole field of Medicare and Medicaid? So, therefore, it is the Republican Senators' view that I am associated with to proceed slowly before we move upward in our coverage of those who are currently not covered, and certainly go very, very slowly on providing additional benefits for those who are currently covered.

Mr. PANETTA. Senator, first of all, let me express my respect for your leadership and your sincerity on this issue. I think you have provided great leadership on this issue and you obviously were trying to work towards the same goals.

You have identified, obviously, a concern, and the administration shares the same concern, which is, how do we try to make sure that we not only are controlling the costs but we are doing it in the most efficient and effective way possible? That was part of the logic for the phase-in, as well as these other protections, cushions, caps, and what have you. We are more than prepared to work with you as we try to develop that kind of approach.

The only concern I would raise with you is that the slower you do it, the less savings you develop and you begin to find yourself tumbling as you provide expanded benefits, and those costs start to escalate and you have not done the kind of universal coverage that you need in order to try to bring in some of the savings. That is the problem area that we have got to work together on.

Senator CHAFEE. Yes. I do not want to belabor this too much, but it seems to me, before you embark on increasing benefits you, first, provide coverage for those who are not covered.

Mr. PANETTA. That is right.

Senator CHAFEE. And it is true, as you yourself said earlier, the way you are going to get the savings is through universal coverage so there will not be the terrible cost shifting that is taking place now. Well, in any event, we are going to have plenty of time, anyway. I look forward to working with both of you in the days ahead.

The CHAIRMAN. Yes. Can I just say that I think Senator Chafee was invoking that first law of medicine which was formulated by Hippocrates, but, for some reason it is always cited in Latin, primum non nocere. Mr. Panetta, you have some Latin roots. What means primum non nocere? "First, do no harm." Thank you, Senator Chafee.

I am going to take the last 12 seconds to read the concluding passage of the article on the Black Talon round which we just obtained. This is from "Handguns for Support and Defense." Listen to this language.

"Overall, the Black Talon SXT ammo is a genuine improvement over conventional JHP ammo in wound ballistics. Winchester has refined and developed a reliable way to add tissue cutting to the bullet action in addition to tissue crushing and stretching. The Black Talon SXT may just be the new law of the land."

Well, I am damned if it should be the new law of the land. You have the May issue of the American School Board, and the cover says, "Blown Away—The Expectation of Safety in School is Dying of Gunshot Wounds."

And the Olin Corp. is making profits out of that round. There is just some things that are enough. I think everybody is crying out, enough. If we can bring a little money to help health care, so much the better. I think your brief probably did not extend to discussing taxes this morning.

But it has been a very helpful morning to all of us. You see this committee searching for the same solutions you are involved with. We appreciate it very much, to our former colleague and our friend. And, Dr. Rivlin, a special pleasure to see you back in the Finance Committee. And with that we stand adjourned.

[Whereupon, at 12:20 p.m., the hearing was concluded.]

# APPENDIX

## ADDITIONAL MATERIAL SUBMITTED

### PREPARED STATEMENT OF LLOYD BENTSEN

Chairman Moynihan, Senator Packwood. It is a pleasure to have the opportunity to discuss the President's comprehensive health reform plan with you today.

As you know, this is an issue which holds great interest for me, and one on which we worked closely with one another over the years when I was chairman of this committee.

Reform of the health care system is one of the President's highest priorities and an integral part of his economic strategy.

From the beginning, this administration has been dedicated to raising the standard of living in this country for us and for our children. Over the long term the only way to ensure higher standards of living is to have faster real wage growth.

Faster real wage growth requires investment in plant and equipment. But when this administration took office, the country's debt and deficits were growing faster than the economy. This was driving up interest rates and creating a climate that was hostile to business planning and investment.

The first thing we had to do was get our deficit headed down. Our budget plan and its $500 billion in deficit reduction has provided the basis for economic growth and rising wages. As soon as the critical elements of the plan emerged last winter, interest rates began to fall and they have been falling ever since. They're the lowest they've been in 20 years. The interest sensitive sectors of our economy are responding, and we are well on our way to a healthy and steady, investment-led recovery.

Deficit reduction by itself, however, will not ensure higher standards of living. For too long now, rising health care costs have been a drag on wages and profits. So now we turn to health care reform. Let me assure you, from an economic standpoint, failing to act is not an option.

when employers pay their workers more, but health care costs rise also, workers' paychecks don't go up as they should. The average worker today would be earning at least $1,000 more a year if health insurance costs had not risen faster than wages for the last 15 years.

Some projections show that if nothing is done, every bit and more of projected wage increases in the coming decade could be consumed by health care costs. Talk about going backwards!

As a nation, we spend 14 percent of GDP on health care. No other developed country spends near that. Japan spends 7 percent and Germany 9 percent. If nothing is done, health care will consume more than 19 percent of GDP by the year 2000.

Maybe spending all this money would be worth it, if we saw good results. But other countries have longer life expectancy and lower rates of infant mortality. They spend less and they cover everyone. We're spending more money and not providing all Americans the security they need.

The Health Security plan addresses the fundamental problems with the current system. The current system costs too much, and the real tragedy is that too many people have inadequate coverage or lack coverage altogether. We are the only major industrialized nation without universal coverage. Nearly 15 percent of our population—more than 37 million Americans—have no health coverage. About a third of those are children. Another 22 million Americans are underinsured.

This lack of universal coverage is not a problem just for the uninsured. Every time someone without insurance shows up at the emergency room and is treated, every one of us who has insurance foots the bill. Every time a business leaves its employees without insurance, those with insurance pay the price. Estimates show that many corporate insurance premiums are 10 percent higher than they need be

in order to pay for uncompensated care. Removing that burden will end the cost-shifting to businesses and individual policyholders.

Universal coverage is critical to getting costs under control. I remember when Lawton Chiles was chairman of the Budget Committee in the Senate. He was convinced that it was necessary to control health care costs before extending coverage to everyone. Lawton left the Senate and became governor of Florida. Within less than a year he was telling this committee that he had changed his mind. Having universal coverage ends the cost-shifting that hurts our businesses and individuals who have to pay higher premiums for the treatment of those who have no coverage.

The Health Security plan takes on the coverage issue. It will provide security to Americans and shift resources to more productive uses. As a result, some businesses will see their costs fall, and others will be able to offer insurance for the first time. Slower cost growth will allow workers to enjoy faster growth in real wages.

Universal coverage will ensure that workers no longer have to fear losing their health insurance coverage if they change jobs or want to start their own businesses.

To avoid major disruptions, the new system will be financed primarily like the current system. The key to making this plan effective is to build on the system of insuring individuals through their employers. Most businesses, small and large, already cover their workers. Nine of every 10 Americans with private health insurance get it through work. Just as they do today, employer and individual health insurance premiums will pay for the bulk of health coverage.

Employers will be required to pay 80 percent of the average premium. However, the plan limits the percentage of payroll that would be devoted to health care premiums to 7.9 percent for large firms. Small low-wage firms and individuals of modest means would be provided discounts.

The President's plan not only has important benefits for individuals, over the long run it can lower what business must spend on health insurance. By the end of the decade, preliminary estimates indicate total business spending on the services covered by the health security plan will fall by $10 billion. That savings could be used to hire more workers, to increase wages and benefits, to invest in plants, in equipment, in training or education or research. It also could go for increased dividends or lower prices. Every one of these possibilities can stimulate the economy and increase jobs.

And, through the bargaining power of health alliances, it can also level out the playing field for small businesses when it comes to premium rates.

Before I deal with some of the specific revenue issues, there are three general points I want to make.

First, our plan is the only comprehensive proposal that spells out exactly what will be provided and how it will be financed. This is the only fiscally responsible thing to do. During the development of the plan, the administration consulted with the nation's best actuaries and health care experts. I feel confident we have approached the estimating process in a very responsible way.

Second, we have protected both the private sector and the public sector from cost overruns by insisting on accountability.

And third, this plan will be phased in, which allows sufficient time to make adjustments should we find that modifications are needed.

Our plan clearly spells out the costs to the federal government and how we are going to pay for them, including discounts to eligible businesses and individuals, long term care and the new Medicare drug benefit. Funding for these, and for program improvements will come largely from slowing the growth in Medicare and Medicaid, a 75-cent increase in the tax on a pack of cigarettes, an assessment on large companies that choose to establish corporate alliances, and increased revenues as compensation shifts from non-taxable health care benefits to taxable wages.

Now, as to some specific revenue items in the bill. Our proposal contains a number of issues that have been of particular interest to this committee over the years.

As you know, the plan includes a proposal to increase the tax on tobacco products. Specifically, the excise tax on cigarettes would be increased by 75 cents per pack—raising the federal tax from the current level of 24 cents to just under a dollar a pack. The administration also proposes to increase the federal excise tax rates on all other tobacco products.

As Senators Bradley and Chafee and others on the committee have been saying for years, increases in tobacco taxes will promote better health—not just among adults, but very importantly among our children. I am particularly concerned about the use of tobacco products by adolescents.

Although we know it will promote better health, I want to elaborate briefly on this point. This is an entirely appropriate way to finance health care for several reasons.

First, tobacco consumption is the leading preventable cause of death and disease in the United States. As members of this committee know, it accounts for about half a million deaths a year and billions of dollars in health care costs.

Second, since the President's health care plan does not generally allow differential health insurance premiums for smokers and non-smokers, the fact of the matter is non-smokers will bear some of the increased health costs of smokers.

Studies by the Department of Health and Human Services, as well as the Canadian experience, demonstrate that raising tobacco taxes can successfully discourage the use of tobacco products by the young. This is particularly true for the proposed increase in taxes on smokeless tobacco. Studies have shown that nearly 20 percent of male high school students use this type of tobacco, and it presently is taxed at a disproportionately low rate in comparison to cigarettes.

The health security plan also contains a 1 percent payroll assessment on large employers who opt to form their own health alliances. That will contribute, among other things, to underwriting important work in health research from which every American benefits.

Another major revenue source in the package is the tax receipts that will result. This accounts for about $23 billion. Let me explain. Increased competition, greater cost-consciousness on the part of both consumers and providers, and other cost containment measures will lower health insurance costs. Standard revenue estimating rules assume that as tax-preferred employer health care costs go down, more worker compensation will come in the form of taxable wages. That will generate more income and payroll taxes, despite the increased number of workers covered.

There are other tax provisions in the President's health plan that will accomplish many of the goals of this committee.

For example, the individual income tax health insurance deductions for self-employed taxpayers will be increased to 100 percent of the costs of the comprehensive benefit package. Members of both parties on this committee have been trying to get that done for years. It's time we got it done. We propose that a self-employed taxpayer could claim the full deduction once the state of residence establishes a regional alliance. The 25 percent health insurance deduction for self-employed workers will continue until the 100 percent deduction is applicable.

In addition, I know that many of you here are very interested in making certain our rural residents, and those who live in the inner cities, have adequate access to quality health care. This plan does that with incentives that encourage doctors and nurses to locate in underserved areas.

We are proposing two tax incentives to encourage adequate medical care in all areas of the country. A physician who works full-time in an area designated as being short of health professionals can receive a tax credit of up to $1,000 per month for up to 60 months. Other health care providers working in these areas can receive a tax credit of up to $500 per month. In addition, physicians who work in these areas will be able to expense an additional $10,000 for medical equipment each year.

There are other ways the tax system will be used to achieve other objectives of the health plan. For example, it will expand and improve long-term care options, stressing home and community-based services and the improvement of the tax rules governing private long-term care insurance.

The plan proposes to modify the current tax treatment of long-term care expenses and insurance. Long-term care expenses incurred by certain incapacitated individuals will be treated as deductible medical expenses, and taxpayers will be able to exclude up to $150 a day from taxable income for benefits paid under qualified long-term care policies. In addition, employers could deduct the premiums paid for these policies, and employees will also be able to exclude the value of this employer-provided coverage from taxable income.

Senators Pryor, Dole, Packwood and I tried to get that done in the last Congress. I am pleased to say that this bill includes that change.

One last point that many on this committee have been discussing for some time. This legislation will base the Medicare Part B premiums on income. Many members have supported this proposal. High-income taxpayers who enroll in part B will see their premiums increased from about 25 percent of program costs to about 75 percent of program costs. The additional premiums will be paid by single taxpayers with income above $90,000, and married couples with income above $115,000. We anticipate this will affect about 2.5 percent of beneficiaries.

## CONCLUSION

The administration has offered a bold and comprehensive plan to give Americans health security and take charge of health care costs. Next year alone, before we can

fully phase in our plan, our health care bill will exceed $1 trillion. That's one dollar in every seven in our economy.

The plan we have drafted accomplishes everything many of us tried to do in the last session, and much more. You may recall that last year we worked together to fashion several proposals that, taken together, would have made important but incremental progress in extending health coverage to low income families. I helped develop four of those bills because at the time it was as far as I thought we could go in achieving some reform of the health care system.

Things have changed. It has, in fact, been a sea change. Americans recognize that our health care system needs a comprehensive overhaul. You can see that reflected in every poll in every newspaper you pick up. Americans are concerned about what's become of our system of health care, and they have a right to be.

It is clear to me that we are going to do something this term. You need only look at the legislative landscape to figure that out. There are no fewer than half a dozen plans out on the table. There is quite a bit of similarity among them.

For example, all but one call for some form of competition. Every plan wants to get rid of exclusions for pre-existing conditions. Every plan offers a choice of health plans and providers. Each proposes reforms in our malpractice system. And each propose increasing the deduction for self-employed Americans.

We have a significant amount of common ground here. But only the president's plan is truly universal and comprehensive. It provides universal coverage, builds on our existing system of obtaining insurance, contains a Medicare drug benefit, a long term care benefit, cigarette taxes, a requirement that employers help pay for health insurance, and it has a budget to ensure it is fiscally responsible.

I've been waiting a long time for a president willing to take the lead on this issue. The health care problem will cripple our economy if we don't act. I'm proud to be part of an administration willing to seize this opportunity.

President Clinton is committed to universal coverage and comprehensive benefits, with lifetime coverage, and coverage and cost protections for every American. He is committed to choice in health care.

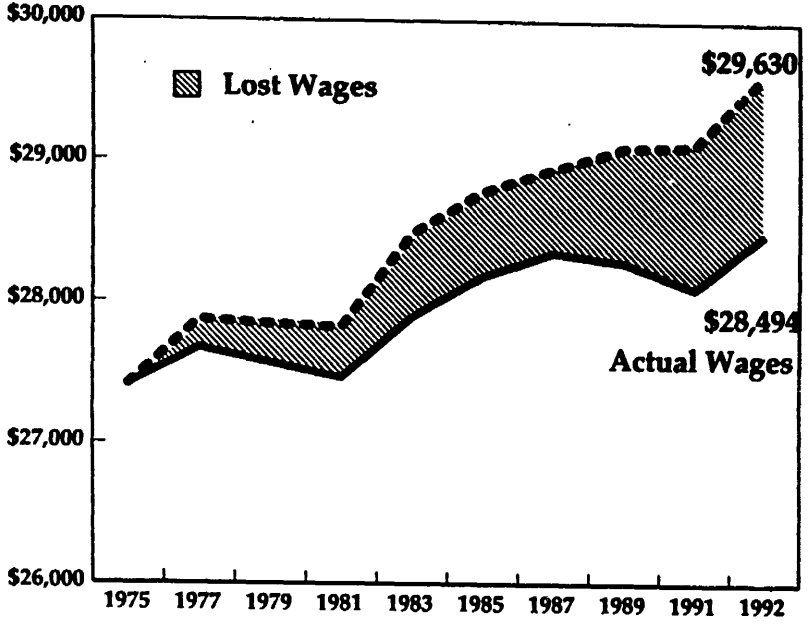
Furthermore, President Clinton is intent on seeing that the quality of health care improves. He wants to reduce the paperwork burden for individuals and employers. He wants to make everyone responsible for health care. And, he is intent on financing the Health Security plan in a responsible manner. This plan does all of that with minimal government intrusion.

The President wants a bipartisan solution to this problem. It is an American issue, not a partisan one. The President looks forward to working with the members of this committee, and others in Congress, to enact a comprehensive and lasting reform of our health care system.

Thank you.

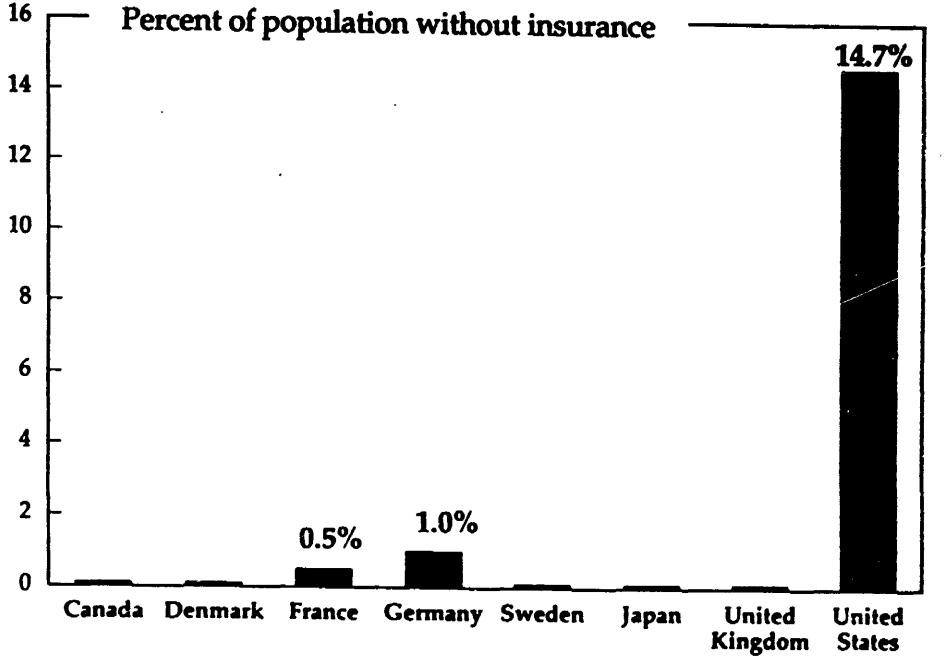
# Workers are Losing Wages to Rising Health Costs

If health care had been reformed in 1975, American workers would have over $1,000 in extra wages every year




Source: Commerce Department, Office of Management and Budget

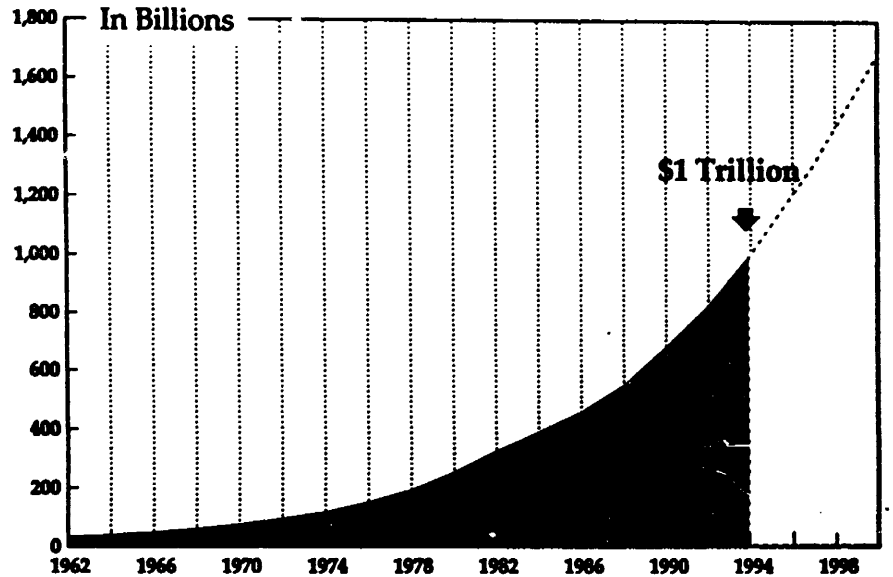
# More Americans Lack Health Security




Source: Organization of Economic Cooperation and Development

# National Health Spending

***The U.S. will have a $1 trillion health care bill next year***




Source:CBO Forecasts

# REVENUE PROPOSALS IN HEALTH SECURITY ACT

| Proposal 1/ | Effective Date | Fiscal years 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 1994–00 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | ($ millions) | | | | |
| 1 Increase in tax on tobacco products | 10/1/94 | 0 | 12,289 | 11,107 | 10,886 | 10,613 | 10,348 | 10,074 | 65,277 |
| 2 Assessment on corporate alliance employers | 1/1/96 | 0 | 0 | 3,750 | 4,940 | 5,080 | 5,120 | 5,210 | 24,090 |
| 3 Health insurance | | | | | | | | | |
| a Increase in deduction for health insurance costs of self-employed individuals | 1/1/94 | -100 | -500 | -600 | -900 | -1,700 | -2,900 | -3,100 | -9,800 |
| b Limitations on exclusion of employer-provided health coverage in cafeteria plans | 1/1/97 /2 | 0 | 0 | 0 | 5,000 | 7,700 | 8,300 | 8,900 | 29,900 |
| 4 Long-term care | | | | | | | | | |
| a Qualified long-term care services treated as medical care | 1/1/96 | 0 | 0 | -66 | -172 | -179 | -186 | -194 | -799 |
| b Treatment of long-term care insurance | 1/1/96 | 0 | 0 | -87 | -249 | -341 | -437 | -532 | -1,846 |
| c Tax treatment of accelerated death benefits | 1/1/94 | -1 | -3 | -3 | -4 | -5 | -6 | -7 | -29 |
| d Credit for cost of personal assistance service required by employed individuals | 1/1/96 | 0 | 0 | -23 | -118 | -125 | -134 | -143 | -543 |
| 5 Tax incentives for health service providers in shortage areas | | | | | | | | | |
| a Tax credit for health professionals | 1/1/95 | 0 | 0 | -2 | -5 | -8 | -11 | -15 | -41 |
| b Expensing for medical equipment | 1/1/95 | 0 | -10 | -17 | -10 | -6 | -4 | -2 | -49 |
| 6 Compliance | | | | | | | | | |
| a Modification to self-employment tax treatment of certain S corporation shareholders and partners | 1/1/96 | 0 | 0 | 158 | 487 | 509 | 528 | 544 | 2,224 |
| b Modification to penalty for failure to report payments made to independent contractors | 30 days after d/o/e | 0 | 53 | 74 | 76 | 80 | 84 | 88 | 455 |
| 7 Post-retirement medical and life insurance reserves and retiree health accounts maintained by pension plans | 1/1/95 | 0 | 21 | 35 | 43 | 51 | 59 | 67 | 276 |
| 8 Tax treatment of health care organizations | 1/1/97 | 0 | 0 | 0 | 96 | 169 | 186 | 205 | 656 |
| TOTAL (REVENUE PROPOSALS): | | -101 | 11,830 | 14,324 | 20,050 | 21,818 | 20,945 | 21,095 | 109,962 |
| Effects of employer mandate, cost containment, and subsidies on income and payroll taxes | 10/1/95 | 0 | 0 | -100 | 700 | 3,800 | 8,000 | 10,800 | 23,000 |

Department of the Treasury
Office of Tax Analysis

November 2, 1993

Notes: 1/ Estimates are not broken out between on-budget and off-budget effects.
2/ Limitations on the exclusion for supplemental health coverage (including employer-paid copays and deductibles) will be effective in 2003.

# Financing Health Care Reform

## Sources of Funds (billions of dollars)

02-Nov-93

| Fiscal Years | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 1995-00 |
|---|---|---|---|---|---|---|---|
| **Medicare Savings** | 2.5 | 10.0 | 15.2 | 23.0 | 32.4 | 40.3 | 123.4 |
| Part A | 0.0 | 4.1 | 7.4 | 12.3 | 16.3 | 20.2 | 60.3 |
| Part B | 1.6 | 2.2 | 3.7 | 7.1 | 9.6 | 10.5 | 34.7 |
| Parts A and B | 0.9 | 1.9 | 1.6 | 1.2 | 4.1 | 7.1 | 16.9 |
| HI Tax Extended to all State & Local Government Employees | 0.0 | 1.5 | 1.5 | 1.5 | 1.4 | 1.4 | 7.3 |
| Income Related SMI Premium with outlay and premium effects | 0.0 | 0.4 | 0.9 | 0.9 | 1.0 | 1.1 | 4.2 |
| **Medicaid Savings** | 0.0 | 1.0 | 3.9 | 10.4 | 22.2 | 27.8 | 65.3 |
| Savings from Capitation of Cash-Eligible Beneficiaries | 0.0 | 0.3 | 1.2 | 3.9 | 6.7 | 10.2 | 22.3 |
| Reduced Disproportionate Share Hospital Payments | 0.0 | 1.4 | 4.7 | 13.0 | 18.8 | 18.6 | 54.5 |
| less Offset for Reserve | 0.0 | -0.2 | -0.4 | -1.0 | -1.0 | -1.0 | -3.6 |
| Less Wrap-around Benefits (net of offset) | 0.0 | -0.1 | -0.6 | -1.5 | -1.9 | -1.9 | -6.0 |
| Payment Lag, Administrative Savings, and Other Changes | 0.0 | -0.4 | -1.0 | -4.0 | 1.5 | 1.9 | -2.0 |
| **Tobacco Tax/ Corporate Assessment** | 12.3 | 14.9 | 15.8 | 15.7 | 15.5 | 15.3 | 89.4 |
| Tobacco Tax | 12.3 | 11.1 | 10.9 | 10.8 | 10.3 | 10.1 | 65.3 |
| Corporate Assessment | 0.0 | 3.8 | 4.9 | 5.1 | 5.1 | 5.2 | 24.1 |
| **Other Federal Savings** | 0.0 | 1.0 | 2.8 | 10.1 | 12.2 | 13.5 | 39.5 |
| Veterans Affairs (b) | 0.0 | 0.6 | 1.7 | 4.3 | 4.5 | 4.7 | 15.8 |
| Defense Department Health (a) | 0.0 | 0.1 | 0.2 | 0.7 | 0.8 | 0.8 | 2.6 |
| Federal Employees Health Benefits | 0.0 | 0.0 | 0.0 | 3.3 | 4.5 | 5.4 | 12.2 |
| Public Health Service Savings | 0.0 | 0.3 | 0.9 | 1.8 | 2.4 | 2.6 | 8.0 |
| **Other Revenue Effects** | 0.1 | 0.1 | 0.4 | 14.5 | 21.9 | 25.4 | 62.1 |
| Effects of Mandate, Cost Containment, and Subsidies | 0.0 | -0.1 | 0.7 | 3.6 | 8.0 | 10.8 | 23.0 |
| Exclusion of Health Insurance from Cafeteria Plans | 0.0 | 0.0 | 5.0 | 7.7 | 8.3 | 8.9 | 29.9 |
| Incentives for Health Providers in Shortage Areas | -0.0 | -0.0 | -0.0 | -0.0 | -0.0 | -0.0 | -0.1 |
| Anti-Abuse Rule -- Certain S Corp. Shareholders | 0.0 | 0.2 | 0.5 | 0.5 | 0.5 | 0.5 | 2.2 |
| Reporting Penalties -- Non-corp. Ind. Contractors | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.5 |
| Modify Tax Treatment of Certain Health Care Orgs. | 0.0 | 0.0 | 0.1 | 0.2 | 0.2 | 0.2 | 0.7 |
| Modify Tax Treatment Retirement Funding Accounts | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.1 | 0.3 |
| Assessment on Employers for Retiree Subsidies | 0.0 | 0.0 | 0.0 | 2.4 | 4.4 | 4.7 | 11.4 |
| Recapture Retiree Subsidies High-Income Recipients | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.2 |
| **Debt Service** | 0.3 | 0.6 | 0.6 | 0.3 | 0.6 | 2.1 | 4.5 |
| **TOTAL** | 15.1 | 27.6 | 44.7 | 73.9 | 104.5 | 124.3 | 390.1 |

(a) Under the proposed legislation, the Secretary of Defense is to decide when the military system will be coordinated with national health reform. This table shows the estimated budgetary effects on the Department of Defense if the military system were to be fully coordinated with national health reform by FY 1998.

(b) New receipts to reimburse veterans expenses

LB-480

# Financing Health Care Reform

02-Nov-93

## Uses of Funds (billions of dollars)

| Fiscal Years | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 1995-00 |
|---|---|---|---|---|---|---|---|
| Public Health/Administration | 3.6 | 5.3 | 5.9 | 5.6 | 5.3 | 5.4 | 31.1 |
| WIC Enhancement | 0.0 | 0.5 | 0.6 | 0.6 | 0.7 | 0.7 | 3.1 |
| New Public Health Initiatives | 0.4 | 1.5 | 2.6 | 3.3 | 3.7 | 3.8 | 15.3 |
| Net New Spending on Acad. Health Ctrs. and Medical Educ. | 0.0 | 2.2 | 1.4 | −0.1 | −0.1 | −0.2 | 3.2 |
| Total Spending | 5.9 | 6.3 | 6.7 | 8.0 | 9.5 | 9.6 | 46.0 |
| Less Current Medicare Funding | −5.9 | −3.6 | −3.6 | −3.6 | −4.0 | −3.9 | −24.6 |
| Less Premium Offset | 0.0 | −0.5 | −1.7 | −4.5 | −5.6 | −5.9 | −18.2 |
| New Federal Administrative and Start-Up Costs | 3.2 | 1.2 | 1.3 | 1.8 | 1.1 | 1.1 | 9.6 |
| Long-Term Care | 0.0 | 5.7 | 9.3 | 12.7 | 18.5 | 20.6 | 64.7 |
| Net Home Based Care for the Disabled | 0.0 | 4.5 | 7.8 | 11.0 | 14.7 | 18.7 | 56.7 |
| Total Spending | 0.0 | 6.9 | 11.2 | 14.7 | 18.7 | 23.0 | 74.5 |
| Medicaid Offset | 0.0 | −2.4 | −3.4 | −3.7 | −4.0 | −4.3 | −17.8 |
| Liberalized Medicaid Eligibility | 0.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 5.0 |
| Tax Incentives for Long-term Care | 0.0 | 0.2 | 0.5 | 0.7 | 0.8 | 0.9 | 3.0 |
| Medicare Drug Benefit | 0.0 | 6.6 | 13.5 | 14.2 | 15.2 | 16.2 | 65.8 |
| Benefits, Administration, and Pharmacists Costs | 0.0 | 8.2 | 16.3 | 17.5 | 18.7 | 20.0 | 80.8 |
| Less Rebate | 0.0 | −1.6 | −2.8 | −3.3 | −3.5 | −3.8 | −15.0 |
| 100% Tax Deduction for Self-Employed Health Insurance | 0.5 | 0.6 | 0.9 | 1.7 | 2.9 | 3.1 | 9.7 |
| Premium Discounts (Subsidies) | 0.0 | 7.3 | 18.4 | 47.8 | 44.4 | 43.2 | 161.1 |
| Premium Discounts (Subsidies) -- Net of Cushion | 0.0 | 5.7 | 13.9 | 35.8 | 31.7 | 30.1 | 117.0 |
| Capped Entitlement for Premium Discounts | 0.0 | 10.3 | 28.3 | 75.6 | 78.9 | 81.0 | 274.1 |
| Total Discounts (Subsidies) | 0.0 | 12.8 | 35.7 | 96.3 | 100.6 | 103.6 | 349.0 |
| Employers (net of cushion) | 0.0 | 3.9 | 10.9 | 27.9 | 28.3 | 28.6 | 99.6 |
| Non-retired Households (net of cushion) | 0.0 | 6.0 | 16.7 | 43.7 | 45.5 | 47.3 | 159.3 |
| Retirees -- low income subsidies (net of cushion) | 0.0 | 0.9 | 2.6 | 6.9 | 7.2 | 7.4 | 25.0 |
| Retirees -- added subsidies (net of cushion) | 0.0 | 0.0 | 0.0 | 3.0 | 4.2 | 4.4 | 11.6 |
| Out-of-Pocket | 0.0 | 0.3 | 1.0 | 2.6 | 2.7 | 2.8 | 9.4 |
| Total "Cushion" | 0.0 | 1.6 | 4.5 | 12.2 | 12.7 | 13.1 | 44.0 |

# Financing Health Care Reform

## Uses of Funds (billions of dollars)

02-Nov-93

| Fiscal Years | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 1995-00 |
|---|---|---|---|---|---|---|---|
| Less Offsets | 0.0 | -5.5 | -17.3 | -46.5 | -56.2 | -60.4 | -187.9 |
| States' Required Maintenance of Effort | 0.0 | -2.5 | -7.4 | -20.7 | -21.7 | -22.6 | -74.9 |
| Discontinued Medicaid Coverage | 0.0 | -2.0 | -6.9 | -19.8 | -26.5 | -29.8 | -85.0 |
| Basic Benefits | 0.0 | -1.9 | -6.5 | -18.5 | -24.7 | -27.9 | -79.5 |
| Net Wrap-around Benefits | 0.0 | -0.1 | -0.4 | -1.3 | -1.8 | -1.9 | -5.5 |
| Medicare Offset for Employed Beneficiaries | 0.0 | -1.0 | -3.0 | -8.0 | -8.0 | -8.0 | -28.0 |
| Total Spending | 4.1 | 25.5 | 48.1 | 82.0 | 84.3 | 88.4 | 332.4 |
| Deficit Reduction | 11.0 | 2.1 | -3.4 | -8.1 | 20.2 | 36.8 | 57.7 |
| TOTAL | 15.1 | 27.6 | 44.7 | 73.9 | 104.5 | 124.3 | 390.1 |

## PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

[November 3, 1993]

Mr. Chairman, I am looking forward to Secretary Bentsen's testimony today.

My impression is that the Administration's financing estimates have been met with a lot of skepticism. There seem to be several reasons for this.

First, the proposed Medicare reductions of $124 billion do not seem politically feasible, especially coming as they do on the heels of the $56 billion reduction we imposed on the program in this years' Reconciliation bill.

Secondly, the estimates for reductions in health care spending for the private sector seem too optimistic. They appear to assume a lower level of health care spending increases than many of the other democracies have been able to achieve.

Thirdly, the anticipated increase in federal tax revenues as a consequence of health care reform may also be too optimistic.

And finally, our experience with estimating federal revenues and federal spending is not encouraging.

The Administration has wisely tried to provide some cushion for the possibility that the estimates might be wrong. As I understand it, they have built in $45 billion in spending to take account of unanticipated effects. That's about fifteen percent of the anticipated total federal cost of the program.

Now, Mr. Chairman, the original estimates for the first five years of Medicare Part A spending, for instance, made in 1965, underestimated what was actually spent in those first five years by about 65 percent.

Of course, that was almost thirty years ago. Maybe our more recent estimates have been better.

Unfortunately, it doesn't look like it. Gail Wilensky points out in a recent article that the original estimate for abolishing the three-day hospital stay required prior to nursing home admittance was $150 million for 1989. According to Dr. Wilensky, the current best estimate for the cost of that change was $1.4 billion.

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## PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

[November 4, 1993]

Mr. Chairman, there is a lot of skepticism about the Administration's financing estimates. Some of that skepticism has already been expressed by members of this Committee.

One of the reasons for this is that *we* chronically make big estimating errors in developing major legislation.

The Administration has wisely tried to provide some cushion for the possibility that its estimates might be wrong. They have added about 15 percent on the spending side to take account of unanticipated effects.

Now, Mr. Chairman, the original estimates for the first five years of Medicare Part A spending, made in 1965, *underestimated* what was actually spent in those first five years by about *65* percent.

I don't think our estimating methods have become much more reliable, Mr. Chairman. And I base that on the data, and on my interest in this since 1984, fighting with the Congressional Budget Office on their estimates.

At a press conference focused on health care reform and the economy on October 6 at the White House, a reporter asked Laura Tyson, the Chairman of the Council of Economic Advisors:

"Have you got a range that you can give us, a range on the inflation, upper or lower, as you've done generally for the employment numbers?"

She responded:

> "Well, I'm sure we could. But my sense is that . . . you should use numbers when you believe the numbers can be defended with precision. But we're in a situation here where we don't have the modeling capabilities—not just us, incidently, nobody has the modeling capability to really get a precise estimate of those effects."

The obvious point here is that, according to history, we have the potential to be seriously wrong in estimating the various effects of whatever health reform plan we adopt. If we are, that reform is liable to go seriously off the tracks.

We in the Congress, together with the Administration, are going to have to use great caution in estimating the effects of these plans. We are going to have to build in a lot of slack. At the moment, it is not clear to me that a fifteen percent cushion is going to be enough.

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## PREPARED STATEMENT OF ORRIN G. HATCH

[November 3, 1993]

Mr. Chairman, thank you, and thank you Madame Secretary for having the graciousness and the courage to appear before us today.

I must admit that I did not have the opportunity to read all of "War and Peace" last night, but as far as epic bills go, this one is certain to set a precedent. And I admire you and I admire the President and Mrs. Clinton for your dedication in bringing this bill forward.

Dr. Shalala, I agree with much of what is contained in your opening statement.

—Our system is weighted down in too much paperwork and we need to fix that.
—Citizens don't have the choices they should in health care.
—There are too many without access to coverage, although I do not agree the figure is as high as 37 million citizens.
—I don't agree with you, though, that skyrocketing costs are the sole reason for placing health care out of reach of many Americans. I'm convinced that each time we ratchet back on reimbursements here at the Federal level, without accompanying changes to foster efficiencies in the system, we cause providers to stop covering our vulnerable beneficiaries.

That is one of my big concerns with your plan. Your $124 billion in proposed savings for Medicare would translate, I understand, to about $80 billion from hospitals. Of that, Utah hospitals would have to absorb $200 million. We only have 1.6 million people in Utah to start with, and they just can't absorb that high an amount.

—I'm not sure I agree with you either that "employers, governments at all levels, and individuals continue to exercise less responsibility for our national health care system and their personal health care."

There is no doubt that we need to do much, much more to encourage individuals to take responsibility for their health care. But I don't think you can expect to inject government more into the system and make it function right. Government is one reason our health care delivery system has problems today; an example is the costly Medicaid mandates that our distinguished Chairman and Senator Durenberger sought to correct with their managed care legislation last year.

I agree completely that we must seek to fix what is wrong with our health care system, and preserve what is right. That is precisely the task before us.

You mentioned in your statement that you had visited several states recently . . . Maine, Oregon, Montana, Michigan, Vermont and Kentucky.

I invite you to come to Utah at your earliest opportunity, because I think you'd be pleasantly surprised by our innovation in health care, by what we are doing that is right.

But some of our health care officials could explain to you why too much government involvement in health care is not a good thing.

Last Thursday, for example, two of our pre-eminent hospitals just received word that the Justice Department dropped an antitrust investigation that had spanned years and cost millions. This is money that could have been going to health care, not to lawyers' fees.

I know you don't handle antitrust, and frankly, that is one reason why I considered giving HHS the lead for health care in the bill I am drafting.

But I say this to illustrate a broader point. The President's plan doesn't "build on the existing structure of health insurance," it totally revamps that system. And I think we have to be perfectly clear about that.

I don't recall ever seeing our government restructure 1/7th of the economy before, but I'm not optimistic about the prospects.

I know the Secretary has a time commitment, Mr. Chairman, and so I will end my remarks there. I look forward to continuing our dialogue.

## PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

[November 4, 1993]

Mr. Chairman, I would like to join with my colleagues in welcoming the Director of Office of Management and Budget to our committee. Mr. Panetta, you are uniquely qualified to discuss with us the fiscal details of the Administration's health care reform proposal.

As the former chairman of the House Budget Committee, you are well aware of the importance Congress places on having credible data to support major initiatives such as the health care reform proposal. As the current Director of OMB, you can facilitate providing us with that information. Your well-known expertise in budg-

etary issues gives you the advantage of anticipating the questions we will be posing. In fact, given your many years of experience with the intricacies of governmental budgeting, I hope that you will volunteer answers to the important questions that we neglect to ask!

All of us are looking forward to discussing with you the "nuts and bolts" of the Administration's proposal, so I will conclude by once again welcoming you to our committee.

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PREPARED STATEMENT OF LEON E. PANETTA AND ALICE M. RIVLIN

Mr. Chairman, it is a pleasure to be here today to discuss the Clinton Administration's health care reform plan. No one needs to remind this committee that our health care system is in crisis. While the quality of health care in the United States is the best in the world for those who can afford it, the total cost of care is unnecessarily high and rising at frighteningly rapid rates. Moreover, millions of Americans are without adequate health care coverage and millions more live in fear that they will lose their health insurance.

The challenge before the congress is to develop a plan that preserves what is best in the current system while controlling costs and providing universal access to high quality health care. The plan presented to you by the President and the First Lady does that. It controls costs and guarantees health security: For the first time, every American will have health insurance coverage with a comprehensive package of benefits that can never be taken away.

We would like to focus first this morning on the vital part the Administration's health reform plan plays in our overall strategy to improve the future vitality of the American economy. Then we would like to turn to the impact of the plan on the Federal budget—what new costs would be incurred and how we propose to pay for them.

HEALTH REFORM IS AN ECONOMIC IMPERATIVE

If we are to have the productive, high wage economy that we all want, we must reform the health care system. Indeed, health reform may be the single most important change that is needed to make the economic future brighter for our children and grandchildren.

The current health financing system threatens America's economic future in three ways: (1) health costs are unnecessarily high and rising too rapidly—draining resources from more productive uses to support an inefficiently organized health care system; (2) the rising costs of government health programs add to the Federal deficit and reduce national saving; and (3) health care insecurity locks people into existing jobs or onto welfare rather than allowing them to move into more productive employment.

The United States spends more of its Gross Domestic Product (GDP) on health care than any other country in the world. The numbers bear repeating: Today, 14% percent of our GDP goes for health care, and by the end of the decade, we could be spending an almost unthinkable 19% of GDP on health care. No other country spends more than 10% of its output on health care. During the last decade, our real per capita health care costs grew at a rate of 4.4% per year, while our real per capita GDP grew at only 1.6% a year. By any measure, we are spending too much of our income on health care.

Inflation in health care costs is robbing government budgets of scarce resources needed for critical investment in our future—education, job training, infrastructure, and technology development. The Federal government devotes 19% of its budget to health care right now. If current projected trends continue, that percentage will rise to 25% by fiscal year 1998. This means that almost 50% of Federal spending growth between 1993 and 1998 will be for health care. Make no mistake about it: getting Federal health spending under control is essential to long-run deficit reduction.

Despite all this spending, 37 million Americans are uninsured, and increasing numbers of Americans are vulnerable to losing their insurance upon developing a serious illness or medical problem. Pre-existing condition restrictions lead to "job lock": it is estimated that 30% of workers restrict their search for better jobs for fear of losing their health insurance coverage.

WHAT TO DO—REFORM THE MARKET

Economists have written volumes on why health costs are rising, and there are debates about how much each of the relevant factors has contributed to the cost spi-

ral. There is no argument, however, that we need to change the incentives in the marketplace today.

There is broad consensus that the health insurance market, especially the small group insurance market, performs poorly. The absence of universal coverage and community rating makes it more profitable to select healthy enrollees than to organize the delivery of cost-effective health care. The result is:

- Very expensive insurance for the covered—we pay more per capita for health care than any other nation, and by quite a margin;
- All Americans feel vulnerable; many of us are one serious illness away from being uninsured;
- No insurance at all for 37 million Americans, most of whom are working or in families with workers; and
- Higher health service prices for the insured, as we pay hidden taxes to cover the costs of caring for the uninsured and the underinsured.

The market for health services is also performing poorly. The incentives for providers in traditional fee-for-service medicine and for patients with comprehensive indemnity coverage simply guarantee that unnecessary care will be delivered in virtually every setting.

Insured patients have no incentive to learn about how little medical value per dollar is delivered by the services they receive, because they usually do not bear the costs themselves. Fee-for-service providers have every incentive to provide additional services no matter how low the value, because they are reimbursed for every added procedure they perform, regardless of their value.

This inefficiency spreads throughout the health care system. Managed care providers, in most markets where fee-for-service still dominates, have strong incentives to match their prices to those prevailing in fee-for-service plans. The higher volume and greater intensity of services resulting from these pricing decisions drives up insurance premiums even further.

Faced with markets performing poorly because the incentives are so wrong, reformers have two basic choices:

- One option would be for the government to take over the functions of the health insurance industry. It could set the prices for providers, and draw up rules for allocating care. We rejected this alternative.
- Another option—the one embodied in the Clinton plan—is to restructure the incentives within our existing system to permit market forces to work more effectively.

RESTRUCTING THE MARKET FOR HEALTH CARE

The Administration plan would preserve and strengthen the system of employer-based health insurance that Americans are used to. It would ensure universal coverage by mandating that all employers provide a comprehensive package to their employees, and make that coverage affordable through discounts for small and low-wage firms.

At the same time, the plan would change the way the health care market works in fundamental ways. First, it would give consumers a financial stake in choosing the lowest cost health plan and information on which to base that choice. While employers would pay 80% of the average cost of health plans in their area, employees will have a choice of health plans that provide at least the comprehensive benefit package at various prices. Experience in large companies has shown that employees tend to choose lower cost plans when they have the financial incentive to do so.

Second, the Administration plan would encourage health providers to join together in groups that provide care as effectively as possible and to reduce unnecessary costs in order to compete for members.

Third, the plan would build on the experience of recent years in which large companies and other large purchasers of health care have demonstrated their ability to bargain hard with health plans to get the best price. The Administration plan would require the States to set up regional health alliances to bargain on behalf of individuals and small- and medium-sized businesses. The alliances would use their collective market power to obtain for their members the favorable prices now available only to employees of large companies.

Fourth, the Administration plan would reform insurance markets by requiring community rating. Risk selection will be eliminated by:

- A comprehensive benefits package, to homogenize the product and make shopping among health plans easier for consumers;

- Community rating to remove the incentive to select healthier enrollees, with risk adjustment to compensate plans that have a disproportionate share of medical claims;
- Ending pre-existing conditions restrictions, medical underwriting, lifetime limits, and other techniques that deny many Americans coverage.

Providers and insurers will also be required to provide vital information. Meaningful and interpretable medical outcomes reporting at the plan level will be required in all alliances. This will provide Americans with the information they need to assess the relative quality of competing plans. In addition, it will provide insurers and providers with incentives to be efficient while satisfying their customers and patients.

These insurance market reforms will force insurers to organize cost-effective delivery networks which preserve choice for consumers while delivering medical value for the dollar. In this sense, our targets for the growth of insurance premiums should be viewed essentially as backstop devices to provide some breathing space while insurers, providers and consumers learn to make managed competition work.

There is reason to think that introducing these new market incentives will lower the rate of growth of health care costs. The most effective means of cost control known to economists is to let producers compete and consumers choose.

Other means of controlling costs may work in the short run, but are likely to be ineffective in the long run. Experience with price controls from other areas is sobering. The best chance of bringing health care costs under control is through market reforms such as the President has proposed.

ECONOMIC ADVANTAGES OF HEALTH SECURITY

Universal health insurance coverage will have economic advantages beyond providing a needed benefit to the uninsured. No longer will Americans be afraid to change jobs because they would risk losing their health insurance. By ending "job lock," health security will increase economic flexibility and improve productivity.

No longer will Americans be afraid to leave welfare because they would lose Medicaid benefits. A welfare mom who gets a job will not have to turn it down to protect her children from uninsured illness. The end to "welfare lock" will also promote the health of our economy.

HEALTH REFORM AND THE FEDERAL BUDGET

The President's Economic Plan, which the congress approved in August, will bring about a significant reduction in the Federal budget deficit—$500 billion over the period from FY 1994 to FY 1998. But we have not conquered the deficit. Health reform is absolutely essential to further deficit reduction. [Chart 1]

The President's health reform plan will begin to get Federal health expenditures under control. It will take time. The bulk of the savings in the President's plan occurs after the end of 1997, once the alliances are fully up and running.

In the interim some Federal expenditures will rise. After all, extending coverage to the uninsured will have some cost, as will the new drug benefits for Medicare recipients and the start-up costs of establishing the alliances. The President's plan offers a responsible means of financing the new health benefits it provides.

FINANCING HEALTH REFORM

Now I would like to turn to the specific effects of health reform on the Federal budget: what we propose to spend on the new system, and how we propose to finance it. [Chart 2]. Let me make clear that in our system of health alliances, 74% of total health insurance spending comes from the same place it comes from now: the private sector—businesses and households paying insurance premiums. The President's Health Security Act builds upon existing employer-sponsored insurance arrangements to create a new foundation of coverage for all Americans.

The Health Security Act proposes new Federal outlays in the following 5 areas:

1. *Expanded public health service activities and administrative costs of the new system*—$31 billion. Approximately $18 billion of these funds will be devoted to new public health programs such as outreach and enabling services to ensure that underserved populations have access to the new system, enhanced funding for the WIC program, and improving community and migrant health centers. This funding also supports grants to states for alliance start-up costs.

2. *Long-term Care*—$65 billion. There are three major components of our long-term care initiative: (1) a new home and community-based service program for the disabled; (2) liberalized spend-down rules for the Medicaid-eligible institutionalized;

and (3) tax incentives for the purchase of long-term care insurance. This program will be phased in from FY 1996 to FY 2002.

3. *Medicare drug benefit*—$66 billion. As you know, many elderly Americans are constantly worried about paying for necessary prescription drugs, prescriptions that can improve the quality of their lives, prevent more serious illnesses and help avoid hospitalization. Our plan introduces a prescription drug benefit with cost sharing very similar to that in the standard benefit package for all Americans under 65: $250 deductible and 20% coinsurance with a $1000 limit on out-of-pocket spending for the year. This means that seniors will no longer have to worry about foregoing necessary prescriptions in order to buy food or pay the rent.

4. *100% Tax Deduction for Self-Employed Health Insurance*—$10 billion. Historically, self-employed individuals have been penalized by being unable to deduct all of their health insurance premiums, while their counterparts in business and industry have been able to deduct the full amount. Our proposal will "level the playing field," and extend full deductibility to the self- employed. This issue has had bipartisan support for some time now; we must finally pass and implement this change. The total cost of this benefit is $10 billion over five years.

5. *Net new subsidies or discounts for employers and households*—$349 billion [Chart 3]. Net of other savings made possible by reform, the added Federal cost is $161 billion. To enable all Americans to take responsibility for their health insurance, premium discounts are available to the following types of households:

- those with family incomes less than 150% of poverty;
- those with unearned incomes less than 250% of poverty if they don't have a full time working member;
- those which include early retirees;
- those with relatively low incomes from self- employment.

To share the cost of insuring workers equitably across different firms, the following firm level guarantees are available:

- no firm will pay more than 7.9% of payroll, and most will pay less;
- firms with fewer than 75 employees with low average wages will pay less than 7.9% of payroll, in fact as little as 3.5%, depending on their exact size and average wage.

Finally, we provide out-of-pocket discounts for individuals who earn less than 150% of poverty and who do not have access to HMOs, to compensate them for the higher expected cost of fee-for-service coverage.

The point-estimate that our model-builders arrived at for their subsidies was $305 billion over the 6 years from FY 1995 to FY 2000.

In addition, we added 15% (about $44 billion) to this estimate to cover potential behavioral changes that are difficult to model directly. Simulations of those potential behavioral changes suggest that our cushion is more than adequate to cover those extra subsidy costs.

The total estimated cost of the discounts for people served by the alliances is $349 billion over 1995–2000. This figure, however, is offset by $188 billion in Federal program savings, so that the net cost of the premium discounts to the Federal Government is $161 billion, or $117 billion plus the $44 billion cushion.

The offsets to the discounts come from three sources. First, $28 billion will be saved as working Medicare beneficiaries get employer-sponsored insurance and Medicare becomes a secondary payor for them. Second, current Medicaid enrollees who are not cash recipients (AFDC plus SSI) will leave the Medicaid program entirely and get their coverage through regional alliances. This will result in $85 billion in direct Federal savings as Medicaid rolls shrink. Third, states will be required to maintain their current financial effort on the non-cash Medicaid population in the form of payments to the regional alliances for the express purpose of offsetting the Federal subsidy liability. $75 billion is the sum of these payments over FY 1995 to FY 2000. Thus, the net cost of discounts is $161 billion.

*Sources of funds*

We propose to pay for these new Federal outlays in the following 6 ways [Chart 2]

1. *Reductions in the rate of growth in the Medicare program*—$123 billion. Medicare has been growing at a rate of almost 11% per year. We have identified a set of approximately 25 policy changes that will achieve $123 billion in savings. These policy changes include "reconciliation- type" reductions that affect the payment rates to providers, as well as new proposals to control utilization. We have also included a proposal to income-relate the Part B premium for high-income Medicare beneficiaries—singles with income of $100,000+ and couples with incomes of $125,000+.

[Chart 4]. These spending reductions produce a moderate decline in the extremely rapid baseline growth of the Medicare program. Under our plan, by FY 2000 we will have reduced the rate of growth in Medicare from its current annual rate of 11% per year to around 8.4%—even while adding new coverage for prescription drugs.

2. *Medicaid savings*—$65 billion. The Medicaid savings counted here result from two sources. The Health Security Act will provide all Americans with health coverage, and therefore it will nearly eliminate uncompensated care. This will allow a replacement of Medicaid disproportionate share payments with a much smaller special reserve of funding to be directed toward hospitals that treat large numbers of low-income populations, including undocumented persons. In addition, the growth in alliance premiums paid by Medicaid on behalf of cash recipients will be constrained to grow at the same rate as private sector premiums. This is feasible because under our plan, Medicaid recipients will be receiving health care services in alliance health plans, like other Americans with private insurance. [Chart 5]

3. *Tobacco tax and corporate assessment*—$89 billion. These revenues will come from a combination of the increased tobacco tax, which the Treasury Department estimates will raise $65 billion in revenues, and a 1% of payroll assessment on the large corporations that will benefit from reduced cost-shifting, and thus lower health care costs, in the new system. Treasury estimates that this assessment will raise $24 billion.

4. *Federal Program Savings*—$40 billion. [Chart 2] As the Federal health programs—Veterans' Administration health, Department of Defense health, Federal Employees Health Benefits program, and the Public Health Service—are integrated into the reformed health system, we expect savings from lower expected premiums and new revenues. For example, the VA will receive new revenue from previously uninsured veterans and DOD will share in premium contributions for the employed dependents of military personnel. These savings estimates are not derived from reductions in services; in fact, we believe that the services provided to these beneficiaries will be improved.

5. *Other Revenue Effects*—$68 billion. Health reform will lower insurance premiums relative to our baseline projections and thereby raise taxable incomes and tax revenue. changes in the tax treatment of health insurance will also lead to increased revenue.

6. *Debt Service*—$4 billion. Finally, modest savings in debt service, about $4 billion, will be realized as the deficit is reduced.

HOW THE NUMBERS WERE DERIVED

There are three broad types of estimates underlying the summary budget data:

1. Estimates of outlay effects on existing programs;
2. Estimates of revenue effects;
3. Estimates of new subsidies, or premium and out of pocket discounts.

Standard OMB methods were used to determine the first type of estimates. OMB budget examiners worked in conjunction with HCFA and SSA actuaries, as well as agency program personnel, to "scrub" the estimates and account for the many interactive effects among programs.

The Treasury Department estimated the revenue effects and the tax-related provisions of the Medicare savings package, as they would for any Administration proposal.

A unique interagency process produced the subsidy estimates. Economists and actuaries from many different departments and agencies—including the Health Care Financing Administration, the Agency for Health Care Policy and Research, the Departments of Treasury and Labor, the council of Economic Advisers, and OMB—worked to develop a consensus on analytical methods. Experts from private think tanks and consulting firms were also involved. A team of private actuaries and health economists was brought in to evaluate and make suggestions about our estimation methods and data sources.

Estimating a complete health care system overhaul is obviously an immensely complex task. Reasonable people can differ about the many assumptions that must be made. But the thing I want to make clear is that our team consistently tried to err on the side of conservatism.

HOW ARE THE DEFICIT SAVINGS PROTECTED?

We estimate that the total new cost of the Health Security Act to the Federal government will be $331 billion, and we will have $390 billion in revenues to finance these new costs. This will leave us with approximately $58 billion in deficit reduction over the FY 1995 to FY 2000 period. We believe these numbers are solid and

that they are real—because of the process we used to produce them, and because of the safeguards we have built into the new system. Let me outline some of these safeguards.

First, we tried to be as conservative and realistic as we could in estimating the costs. For example, we asked two agencies to estimate the cost of the premiums for the comprehensive benefit package. An interagency team spent months analyzing the estimates, and we chose to use the higher estimate from HCFA. Furthermore, after the initial estimating was done, the agencies spent several weeks in an intensive "scrubbing" of all the numbers to vet the assumptions and make sure we accounted for interactive effects.

Second, we have set targets for the rate of premium growth in the alliances. If competition alone does not keep premium growth within the targets, premium caps will be triggered. If the combination of competitive forces and premium caps work as we expect they will, then future savings will grow progressively, as the rising trend in health costs is broken.

Third, we made realistic assumptions about the speed at which states would come into the new system. We looked long and hard at the most realistic phase-in of the new system, and settled on a plan that assumes that states representing 15% of the population will come into alliances during FY 1996; another 25% (for a total of 40%) will come into alliances during FY 1997; and the remaining 60% will be phased into the new system by January 1, 1998. We believe that these assumptions are realistic, and that they give the states a reasonable amount of time to get alliances established and to provide for some valuable learning experiences.

Fourth, as I discussed earlier when I was outlining new Federal outlays, we added 15% to the estimate of the subsidy costs—about $44 billion—to cover potential behavioral changes that are difficult to model.

Finally, we rejected the notion of an open-ended entitlement program. We believe that our estimates of the Federal funds that will be needed for the subsidies are conservative and reasonable, particularly in view of the 15% cushion and the mechanism allowing excess funds to be carried forward and applied to the next year's cap. It is unlikely that the caps will ever be in danger of being breached. If there were a problem, however, because of a severe downturn in the economy or a massive economic dislocation, it would mean we had a serious situation that the President and Congress would have to address. That is how it should be.

## THE BOTTOM LINE—CONCLUSION

Mr. Chairman, we have begun one of the most important debates in the history of this country. It will take place not only in the committee rooms and the chambers of the Congress but in newspapers, in meeting halls, and over kitchen tables throughout the nation.

For 16 years, as you know, I served as a member of Congress. And for 16 years, as you also well know, because we entered the Congress at the same time, the health care issue became a bigger and bigger problem. It was ignored until it became a crisis, as costs for families, businesses, and government spiraled out of control, as the number of uninsured Americans grew, and as more and more families came to fear the loss of their insurance coverage.

We saw a lot of suggestions, a lot of ideas, a lot of concepts proposed. But until this President, nobody presented the kind of specific, comprehensive, responsible, detailed, paid- for plan that you now have before your Committee.

We have gone through an exhaustive process to ensure that we are presenting the most credible, the most reliable, the most honest estimates possible of our policies and their impact.

So as the great national debate proceeds, we expect to be challenged on policy; we expect a strenuous and far-reaching discussion of how best to achieve the goal of comprehensive health care reform. The Administration does not pretend to possess divine wisdom on this issue. We welcome alternative proposals and views.

But let's make one thing clear. Let's be sure that when other plans are presented, they meet the same kind of rigorous analysis to which we have subjected this plan. Let's make sure that their numbers have been thoroughly examined and analyzed. That way, we can be sure that this is a discussion over policies and issues, not numbers and statistics.

The American people deserve that kind of debate as we address an issue that will directly affect every one of them every day of their lives.

# ALTERNATIVE DEFICITS 1993 - 2000

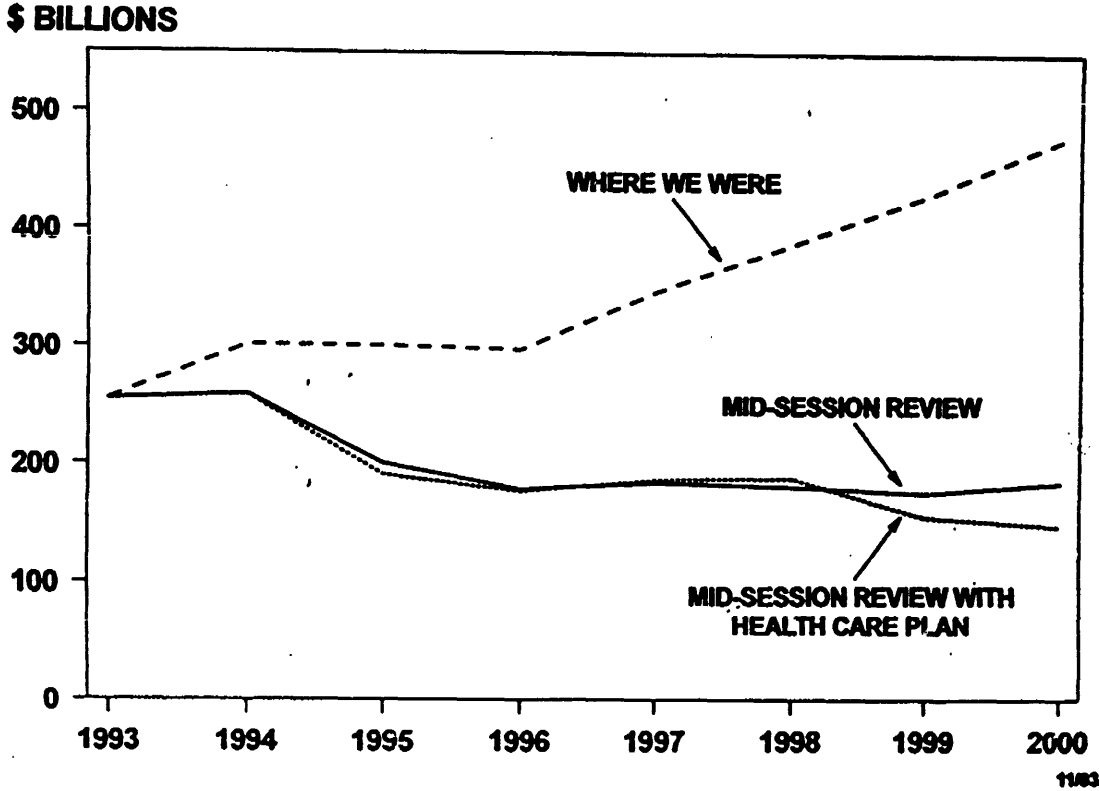



CHART 1

# FINANCING HEALTH CARE REFORM

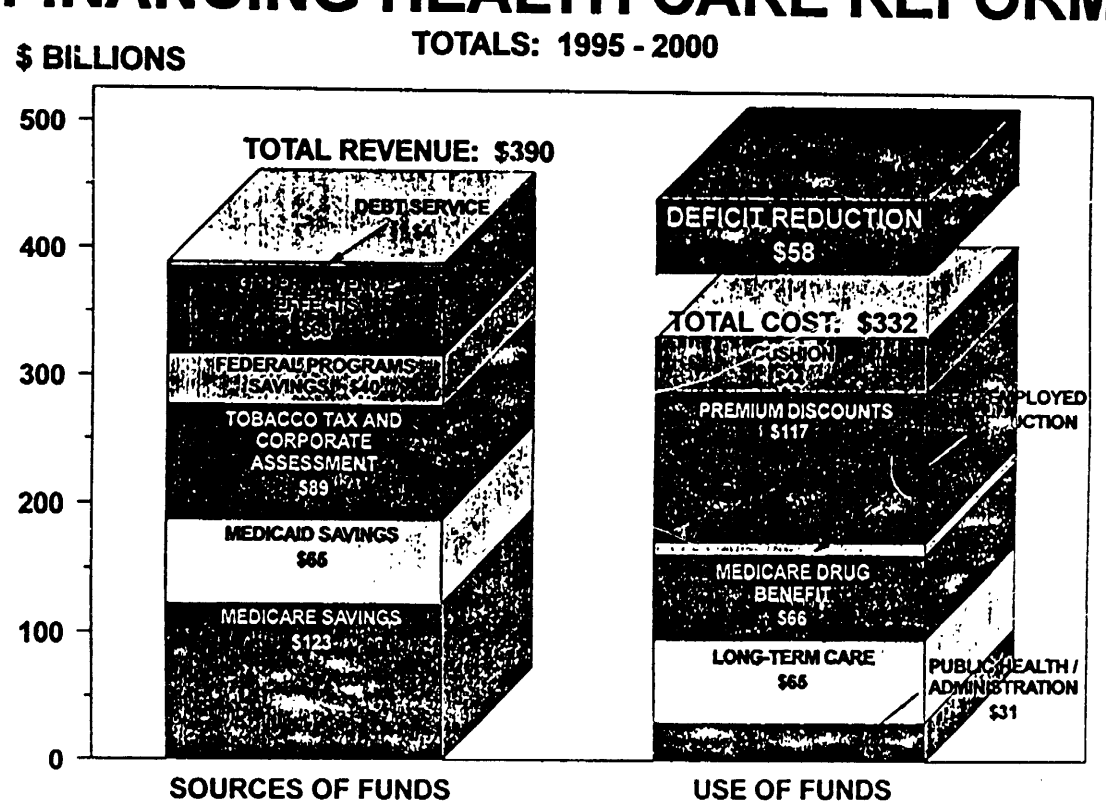





CHART 2

# COST OF PREMIUM DISCOUNTS

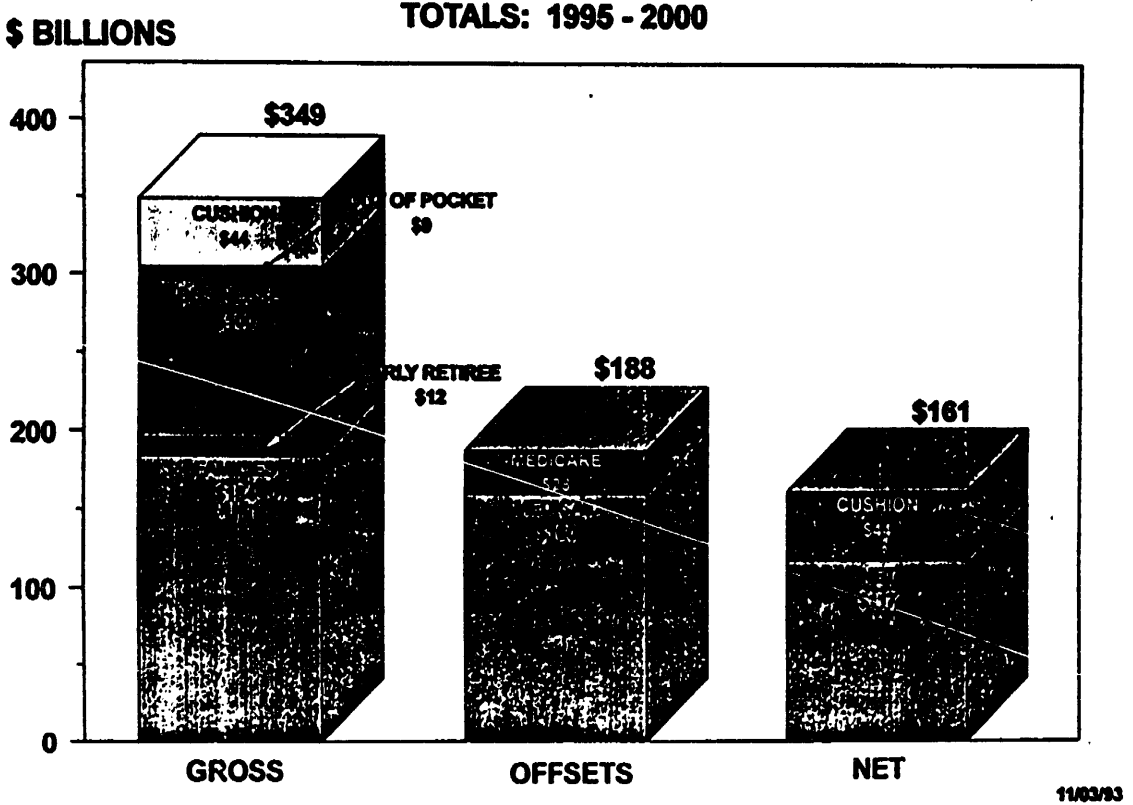



CHART 3

# MEDICARE SPENDING UNDER HEALTH CARE REFORM

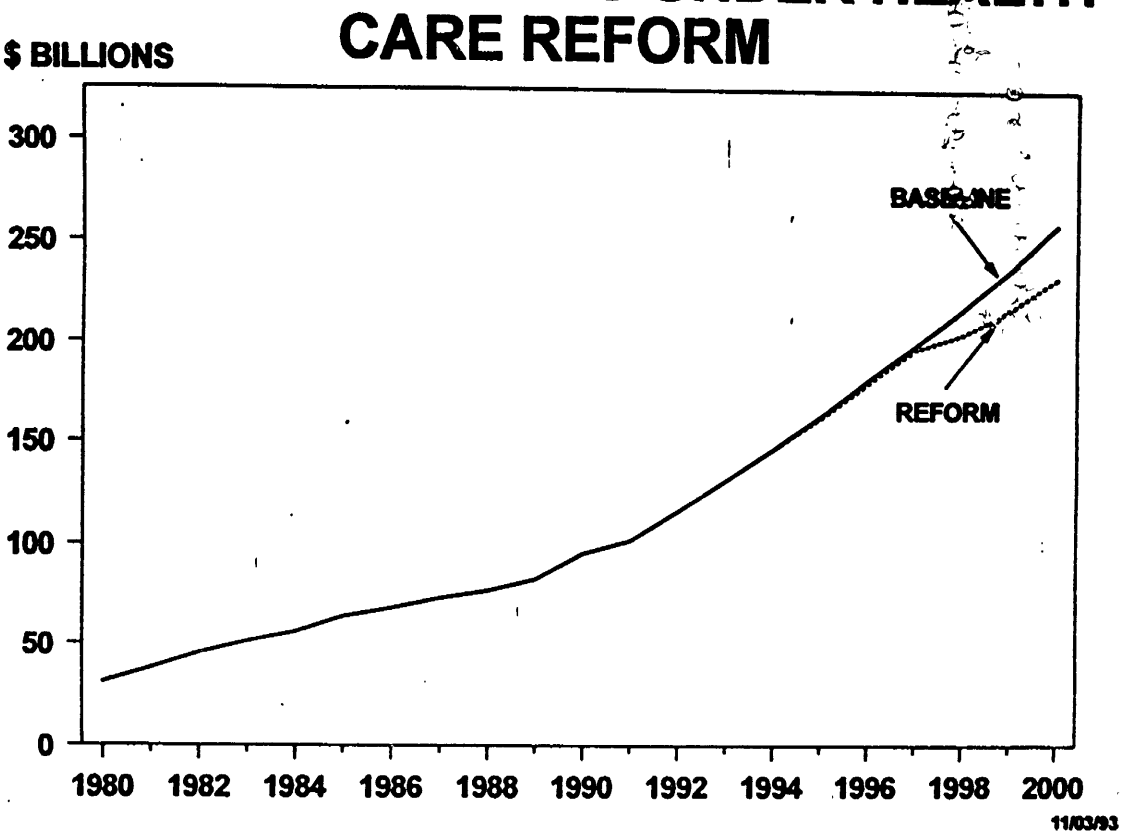



CHART 4

# FEDERAL SPENDING FOR MEDICAID

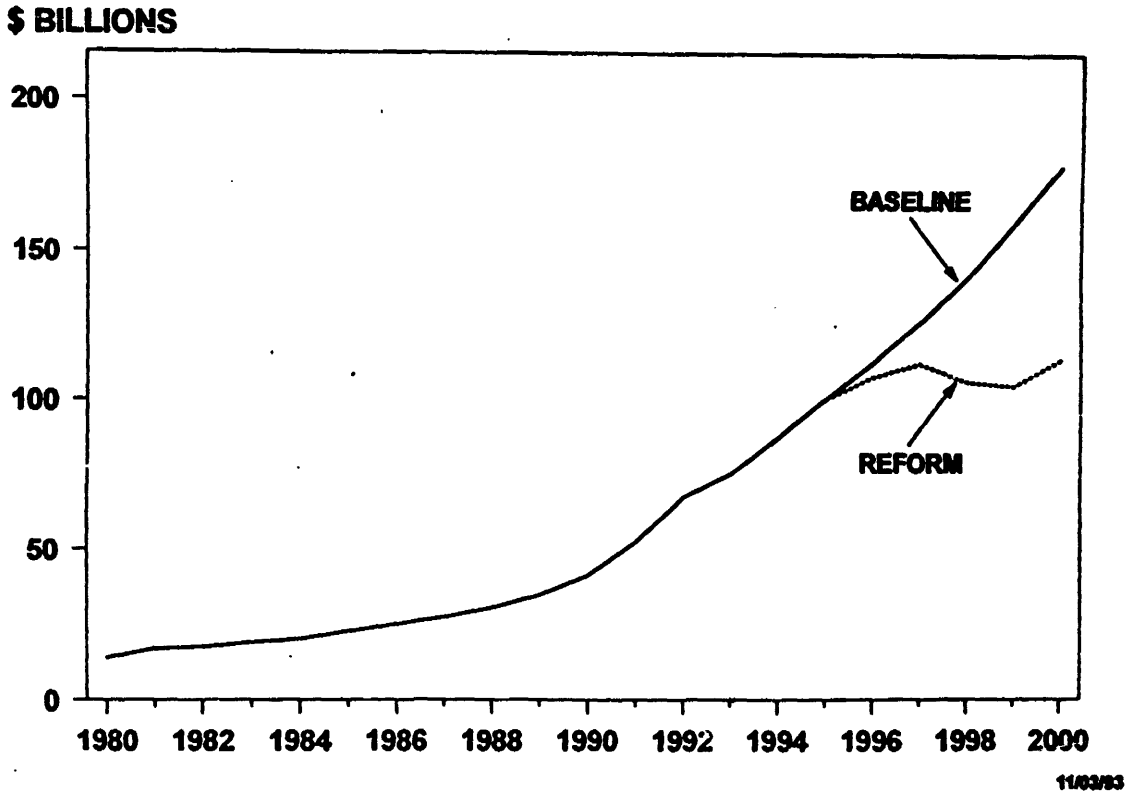



CHART 5

The New York Times

NEW YORK, THURSDAY, NOVEMBER 4, 1993

# *Moynihan Asks Big Tax Increase On Ammunition*

By ADAM CLYMER
Special to The New York Times

WASHINGTON, Nov. 3 [redacted], chairman of the Senate Finance Committee, said today that he would insist that President Clinton's health-care plan include a huge increase in Federal taxes on handgun ammunition that would make some especially destructive bullets unaffordable.

The New York Democrat has often argued that the best way to attack gun violence would be to restrict the sale of ammunition, not guns themselves. He noted today that the nation has a 200-year supply of guns but only a 4-year supply of ammunition.

"Guns don't kill people; bullets do," he told the Senate as he introduced his legislation today. "It is time the Federal Government began taxing handgun ammunition used in crime out of existence."

From most lawmakers, such a proposal might seem a quixotic challenge to the gun lobby, which immediately denounced the plan as laughable.

But coming from the chairman of the Finance Committee, one of the two Senate committees with a predominant role on the health bill, a proposal to tax ammunition immediately becomes a serious issue.

Senator Moynihan said he was sure that the committee would agree with his proposal and would add the provision to the health bill before sending it to the Senate floor. "I feel very strongly, and I can't imagine one coming out of the committee without this," he said.

The Administration has plainly been reluctant to add another enemy, gun owners, to the critics of its bill, who range from insurance companies to

*Continued on Page B20, Column 1*

*Continued From Page A1*

small business to foes of abortion. Hillary Rodham Clinton answered sympathetically in September when questioned about taxing guns, but told lawmakers that the Administration was not including such proposals.

In a Finance Committee hearing, he won an unenthusiastic promise from Treasury Secretary Lloyd Bentsen to consider the proposal. "Obviously that is a source of revenue that could be examined, and we will consider it," the Secretary said.

Mr. Moynihan's proposal would raise the current 11 percent tax on the wholesale price of handgun ammunition to 50 percent in most cases. It would not raise the tax on .22-caliber ammunition typically used for target shooting.

But it would raise the tax to 10,000 percent on the Winchester 9-millimeter hollow-tipped Black Talon cartridge, which is advertised as expanding "to expose razor-sharp reinforced jacket petals."

"These cut tissues in the wake of the penetrating core," the ad says.

The advertisement, in Handguns for Sport and Defense Magazine in November, said "Black talon" cartridge "penetrates soft tissue like a throwing star — very nasty; very effective; a real improvement in handgun ammo."

The manufacturer would not disclose the wholesale price, but Cameron Hopkins, editor of Firearms Industry Magazine in San Diego, said a box of 20 Black Talon cartridges would typically wholesale for about $16, including the 11 percent tax, and retail for about $24.

The 10,000 percent tax would push the price of a single box to almost $150,000. The tax would not apply to people in law enforcement or the military.

Mike Jordan, manager of marketing technical services for the Winchester Ammunition Division of the Olin Corporation, said, "I wish the Congress people would attack crime as zealously as they do guns and ammunition."

He said in a telephone interview from East Alton, Ill.: "The Black Talon is a premium handgun bullet like many others in it there. It's a good bullet that performs very consistently. It was designed using the criteria for the F.B.I. to insure that it meets their standards. Law enforcement likes this bullet."

That high tax rate would also apply to all .50-caliber ammunition, which are for very large handguns. "These bullets have no purpose other than to cause the greatest possible destruction of human life," Senator Moynihan said about the ammunition he wants to tax at 10,000. "We must effectively tax these hyper-bullets out of circulation."

For most ammunition, the price increase dictated by a higher tax would appear to be modest. Mr. Hopkins said the usual markup is about 30 percent. A box of 50 higher-grade .38-caliber cartridges may sell for about $16, with the tax about $1.20. The tax would increase to about $5.90 under the Moynihan proposal.

Mr. Moynihan's bill would also raise the current $10-a-year license for manufacturing ammunition to $10,000.

The proposal was immediately attacked by Wayne LaPierre, executive vice president of the National Rifle Association. He said: "I seriously doubt anyone in America believes crime is going to go down because taxes are going to go up. It shows how eggheaded this whole debate has become."

But Senator Moynihan said the issue was public health. He said that in 1989, the last year for which statistics were available, 34,776 people in the United States were shot and killed. He said it appeared that another 175,000 were wounded.

The Administration has defended its proposed 75-cent-a-pack tobacco tax as desirable both for revenue and for its public health effect in discouraging smoking. But it has plainly been reluctant to tax other, more politically powerful interests like liquor or guns.

When the issue arose on Sept. 28 at a Ways and Means Committee hearing, Representative Mel Reynolds, Democrat of Illinois, chided Hillary Rodham Clinton for explaining that only tobacco was taxed because it was the only product that was unhealthy when used as directed. He told, "If a Tech-9 semi-automatic weapon is used as directed, it will have a severe impact on our health care system." She told him the Administration respected his proposal and would work with him, but was not including it.

Senator Bill Bradley, Democrat of New Jersey, asked her two days later about a similar proposal, with a huge increase in dealers' fees and a 25 percent sales tax on handguns and automatic weapons. "Speaking personally — and that's all I can do," she said, "I'm all for that." She spoke of a friend who was outraged that a gun dealer had opened a shop across the street from a high school and told Senator Bradley: "We will look at your proposal and be happy to talk with you about it. I'm speaking personally, but I feel very strongly about that."

PREPARED STATEMENT OF DONNA E. SHALALA

Good morning Mr. Chairman and members of the committee: It is a pleasure to be here this morning to discuss the President's Health Security Plan. This is indeed a momentous occasion and the beginning of a process that I believe will lead to a better, stronger, and more secure health care system for all of the people we serve.

The President's proposal seeks to fix what is wrong with our health care system and preserve what is right. It seeks to strengthen all elements of the system so that those Americans who fall ill and those who seek to preserve and improve their health can rely on a high-quality system that is affordable, portable, and permanent.

We in the Administration have worked for many months to craft a proposal that addresses the serious deficiencies in our current system. We have consulted with hundreds of experts, including nearly all members of the Congress; we have gone directly to the people of this country to hear their complaints and their hopes.

The bottom line is that the quality of our current system is steadily eroding. You know all too well the fundamental problems:

- 37 million of our citizens have no health insurance, while another 25 million have inadequate coverage.
- Skyrocketing costs increasingly place coverage and care out of reach for many Americans.
- Our system is weighted down with too much paperwork and too many bureaucrats.
- Many citizens watch helplessly as their health care choices evaporate, leaving them with no say in where they get their care.
- Our quality of care remains uneven, giving the majority of our citizens the best care in the world, but leaving some others with a level of care no better than Third World countries, and,
- Employers, governments at all levels, and individuals continue to exercise less responsibility for our national health care system and their personal health care.

The American health care system has lost sight of those who it is designed to serve—the patients. We must change the system so that it is clearly understood and so that it serves all Americans when they need care.

And we must get a handle on the cost of health care. As Secretary of Health and Human Services, I know only too well the price we pay for uncontrolled health spending. While the overall budget of my Department has increased some 229 percent since 1980, almost all of that has been swallowed up by inflation in our health care programs. Medicare spending, for example, has risen 363 percent in the past 14 years. The Federal share of Medicaid spending has increased even more dramatically—526 percent. As a result, health care programs have been the single largest contributor to our federal deficit and have systematically squeezed out resources that could be spent on other important priorities including education, job creation, infrastructure, and economic development.

Rising health costs and uneven health care coverage have also taken their toll on American businesses. Over the last decade the annual amount spent on health care by the average American family has more than doubled from $1,742 to $4,296. And that amount will double again by the year 2000 if nothing is done. Even in the last year, as the health care sector has attempted to slow its growth, two-thirds of American companies saw their health care costs rise; only 7 percent saw their costs fall. For many companies, health care costs are the single largest expense they incur; for many others, that expense is so great that benefits have been pared back or even eliminated.

In the five weeks since the President addressed the Congress, we have spent much of our time listening. Listening to the comments and advice of lawmakers here on Capitol Hill and legislators and governors in our state capitals. Listening to those who are in the health care trenches—doctors, nurses, hospital administrators, and others. And listening to the people. Since the President's speech, I have been to Burlington, Vermont; Billings, Montana; Bangor, Maine; Detroit, Michigan; Portland, Oregon; and Louisville, Kentucky.

What we've heard has helped us to improve our plan. But let me make one thing clear, the one thing that has not changed is the core set of beliefs that have guided us from the start.

SIX PRINCIPLES

The President laid out the six principles that are at the core of our proposal and must be at the center of any health reform bill enacted by this Congress. (Chart

1) They are Security, Simplicity, Savings, Choice, Quality, and Responsibility. We've seen wide bipartisan agreement on these principles. That's good. Now it's time to begin making them a reality.

Today, I'd like to discuss some of these principles with you, starting with security.

SECURITY

It's not only the 37 million uninsured who lack health care security. They are only the most vivid evidence of this problem. Under our current system, no American has real peace of mind. Most workers who lose their jobs lose their insurance. People who change jobs often lose their insurance or have to change their coverage. Families stricken by illness face the added burden of trying to make sure their coverage won't disappear. And conscientious businesses and individuals who attempt to buy insurance are often turned away because the price is out of reach. At the same time, the lack of health care coverage in many low-wage jobs frequently traps young mothers in welfare.

To deal with this central concern, the President's plan builds on the existing structure of health insurance that has, for nearly 50 years, provided coverage to workers and their families.

(Chart 2) Under the President's plan, the largest portion of financing for health care premiums—over three-quarters—will come from employers and households through their contributions to the cost of coverage. The remaining 24 percent will come from government.

(Chart 3) We have calculated that the federal share, including our contribution to premiums, public health investment, long term care, and deficit reduction will amount to $389 billion over the period of 1994 to the year 2000.

We will produce that total in the following way:

- *$124 billion* will come from savings achieved in the Medicare program. That will bring the annual rate of growth in that vital program more in line with growth in the private sector. Fully half of these savings can be achieved simply by continuing policies adopted by this Congress in the Omnibus Budget Reconciliation Act of 1993 and by reductions in payments to disproportionate share hospitals made possible by universal coverage.
- Another *$65 billion* will be saved in the Medicaid program, by enrolling remaining Medicaid beneficiaries in private health plans with lower cost growth and then a similar reduction in the disproportionate share hospital payments.
- We will produce another *$40 billion* in savings in other federal programs, including the government employees, military and veterans' health care.
- Another *$71 billion* in federal revenue will come as a result of (1) slower growth in tax-exempt health spending that will produce higher wages and taxable profits; (2) excluding health insurance from cafeteria plans; (3) other tax changes; (4) the corporate retiree assessment; and (5) reduction in debt service.
- And, finally, we gain another *$89 billion* by increasing the federal excise tax on cigarettes and the one percent assessment on corporate alliances.

How will these federal dollars be spent? The overwhelming majority of these funds will finance premium discounts for small employers, individuals, and early retirees. Another $66 billion will pay for the new Medicare prescription drug benefit; $65 billion will go for our long term care initiatives; $10 billion will pay for tax incentives and deductions for the self-employed allowed under the plan; and $29 billion will cover our investment in public health and some fairly minor start-up costs. That leaves another $58 billion in deficit reduction. I must point out to the Committee that we have deliberately built in a cushion of $45 billion to deal with behavioral effects that cannot be modeled.

UNIVERSAL COVERAGE

A key to security is the assurance that all of our citizens are covered by an affordable health plan. We achieve such coverage by asking states to create one or more regional Health Alliances to serve as the negotiators for consumers and employers. We ask our employers to pay at least 80 percent of the average weighted premium for a plan in each region with workers picking up the remainder. The vast majority of American firms already provide such benefits; in fact, many do even better.

(Chart 4) All health plans will be required to offer a comprehensive set of benefits to provide all Americans with the kind of care that our health professionals tell us is best. A package that has a strong emphasis on prevention. A package that covers inpatient and outpatient care. A package that offers specialty and primary care. And a package that improves on our mental health and substance abuse treatment coverage and helps remove the stigma attached to these conditions.

(Chart 5) We recognize that these new requirements may pose a temporary challenge for some companies, particularly those that currently do not offer coverage. Our plan provides significant discounts for employers that will hold the cost of coverage to no more than 3.5 percent of payroll for small low-wage firms—defined as those companies with 75 or fewer workers with an average wage of $24,000 or less—and 7.9 percent of payroll for all other companies.

Individuals will be eligible for discounts as well. For those required to pay the 20 percent share of a health plan premium, discounts will be available for those with income at or below 150 percent of the federal poverty line. Such individuals also will be protected by a limit of 3.9 percent of income on individual contributions. For the nonworking population that get no assistance from an employer with premium costs, discounts are available for those with non-wage income at or below 250 percent of poverty. And, finally, for retired workers between age 55 and 65, the federal government will eventually pay the full 80 percent employer share of the premium.

To further reduce the cost of coverage, we will reform the insurance market to eliminate unseemly underwriting practices that weed out the sick and cover only the healthy. We will end the practices of cherry-picking and cream-skimming. No insurance company will be allowed to turn away a person seeking insurance because of a pre-existing medical condition affecting that individual or a member of that family. Nor will insurers be allowed to continue pricing those who are sick or disabled out of the market. We propose returning to the historic method of community rating that served our country well and offered all Americans coverage at a reasonable cost.

(Chart 6) Together, these changes will result in virtually universal coverage of our population. In contrast, if we do nothing, the number of uninsured will grow from 37 million to an estimated 55 million at the end of the decade, or nearly one in five Americans.

During the last five weeks, we have gone over of the numbers in our plan, scrubbed them and rescrubbed them so that we can explain with confidence to you and to the American people how this plan will work. There are no rosy scenarios here, no magic asterisks. These are conservative numbers that will stand the test of public scrutiny.

A key feature of the President's plan is predictability. It will be easy for all Americans to determine the cost of their coverage and the scope of that coverage.

Health plans will be required to offer four distinct classes of premiums for each policy: one covering single individuals; one covering couples; one covering single-parent families; and one covering two-parent families.

While the premiums charged by each Health Alliance will differ according to local community costs, we have determined the average national premium for each group in 1994 dollars. For the majority of Americans, this plan would result in a reduction in insurance costs. For a relatively small number of our citizens, this new system will cost a bit more. But for all Americans, it provides a peace of mind that cannot be priced by any actuary. The national averages are as follows:

- $1,932 for a single person.
- $3,865 for a couple without children.
- $3,893 for a single-parent family, and,
- $4,360 for a two-parent family with children.

For those families and individuals who must pay the maximum 20 percent of these premiums, monthly out-of-pocket costs will range from a low of $32 to a high of $73.

As I said, these amounts will vary from state to state and community to community, but these national averages give us a good idea of how reform will change our current system for the better.

For employers, the new system will be predictable as well. According to our estimates for 1994, the *average* undiscounted cost to some employers will be as little as $1,546 for individuals and as much as $2,479 for two-parent families with children. With the premium discounts we offer, however, the cost to employers will be considerably lower.

Stable, predictable health insurance expenses will be of great value to business owners—particularly small businesses—who today cannot know with any reliability what their annual costs will be. Under today's system, one illness in one family can devastate a year of financial planning by a grocer or a hardware store owner. This must change—and it will—if we're going to have an economy in which small business can flourish.

SAVINGS

In order to ensure the kind of security I have just discussed, we must control the cost of health care.

In the current year, the United States will spend approximately 14 percent of its gross domestic product on health care. That is far greater than any other industrialized nation. In fact, our closest competitor in the health care arms race is Canada, which spends only 10 percent of its GDP on health care. If we do nothing about our costs, health care will rise to 19 percent of GDP at the end of the current decade.

Through changes in the competitive market, our plan places restraints on this growth that will still allow spending to increase, but by a much more reasonable amount—one much closer to the rise in other consumer prices. To ensure that these changes achieve the necessary savings, we will create a backstop system of enforceable premium caps. That way, no company or individual will pay more for coverage than is appropriate.

(Chart 7) We extend this concept of savings to all payers of health care—public and private. By applying reasonable limits to the growth of Medicare, we can reduce the rate of that program's growth from almost 11 percent annually to 8.4 percent at the end of this decade even while adding new coverage for prescription drugs.

By applying these limitations, we will expand the Medicare program to include an important new benefit covering the cost of prescription drugs. Numerous studies indicate that, without such coverage, many of our senior citizens are forgoing prescribed medications, independently changing their dosages to make prescriptions last longer, and even trading unused portions of prescriptions among neighbors. All of this is done in the name of saving money; all of it endangers the health and lives of our senior citizens. The end results of our efforts will be a stronger Medicare program that will continue to serve all of our senior citizens.

We also plan to completely transform our Medicaid program for acute care services. Medicaid beneficiaries have suffered too long with a system that offers, in many ways, second tier medical care. Uneven coverage and reimbursement rates have left too many of our needy citizens without coverage. And even those who are in the program are often turned away by health care professionals who refuse to accept Medicaid patients.

Under our plan, we place all of these individuals in a mainstream medical system: They will be enrolled in Health Alliances, which will provide them access to accountable health plans. Each Medicaid beneficiary will get the same health security card as all other Americans. They will receive the same comprehensive benefit package, plus additional services traditionally provided through Medicaid to allow access to the health care system. Non-cash recipients also will gain access to these health plans with accompanying wrap-around benefits that will ensure that none of our neediest children will lose the services they now utilize.

SIMPLIFICATION

Another important element of a reformed health system is simplicity. We have all heard the complaints from the men and women who provide medical care. They tell us that the current system is too confusing, too intimidating, and too expensive. We are wasting time and money filling out forms, filing claims, and flailing at an unresponsive bureaucracy. Nurses and doctors often must take time away from patients to fulfill the demands of some faceless bureaucrat based 500 miles away.

Our new system (Chart 8) makes it easy for consumers to gain access, get the care and counseling they need, and go on with their daily lives. It is structured with the consumers' viewpoint in mind. And from that viewpoint, it is a clear and concise system.

(Chart 9) The Alliances will have important responsibilities but they will not be a new level of bureaucracy that gets in the way of business owners and consumers. Rather they will be a tool to cut through the bureaucracy of private insurance. The responsibilities of the Alliances are clearly specified in the legislation. Some of these are:

- Enrolling individuals in health plans and issuing Health Security cards.
- Transferring premiums from employers and individuals to health plans.
- Providing consumers with information about the quality and cost of health plans.
- Working with health care professionals to develop fee schedules for fee-for-service plans, and
- Serving as an ombudsman for employers and consumers.

The President's plan also assists health care professionals and institutions. We will do away with the more than 1,500 often conflicting claims forms now in use

and provide a single form that will be easy to understand and easy to complete. And we will encourage greater use of electronic claims and speed the process of reimbursement throughout the system.

CHOICE

One of the prices we have paid for our current patchwork system has been the loss of involvement of consumers in the choice of their health plan and their medical providers.

Our proposal guarantees every American a choice of health plans, including at least one fee-for-service plan. In many areas of the country, we expect there to be a great deal of change. We realize, however, that in some parts of our country such wide-ranging choice may not be quickly available. The President's plan calls for specific efforts to improve choice in rural areas of the country including the creation of new community health centers, a doubling of the size of the National Health Service Corps, provision of technical assistance to those who want to create new health plans, the training of additional mid-level practitioners, and designation of many rural hospitals and other health facilities as essential providers.

But we must remember that the greatest benefit we can provide to the rural parts of our country is universal coverage. Our most recent data indicate that 30 percent of our rural population is uninsured. This creates a tremendous drain on rural communities and the facilities that serve them. That will change.

The guarantee of choice goes beyond health plans. Americans are used to a system that allows them to select their health care professionals. This *will* be preserved. First, every Health Alliance will be required to offer at least one fee-for-service plan. Second, all plans will be required to offer a point-of-service option that will allow consumers to go outside the plan for services they desire. And, finally, all physicians will be allowed to join multiple health plans.

QUALITY

There is no question that any health care system must be based on high-quality medicine and must have built-in mechanisms to measure and protect that quality.

The President's plan calls for the creation of a National Quality Management Program designed to improve access, effectiveness, and appropriateness of care. Working with consumers and providers of care, we will develop national measures of quality performance; develop and improve consumer surveys; and recommend performance goals for the health plans.

In addition, the work now being done by the Agency for Health Care Policy and Research on practice parameters will continue and that information will be shared with all health plans and health care professionals as well as the general public.

RESPONSIBILITY

Finally, no system that we design can work without the participation of all involved. We offer Americans a great deal through our health care plan; in return, we ask something of everyone.

We ask employers to contribute to the cost of coverage for their employees. In return, we make sure that all companies play by the same rules and we give assistance to those who need it.

We ask employees to contribute to the cost of their coverage and to educate themselves about the choices available to them. In return, we provide lasting coverage that moves with them wherever they go.

We ask our caring health care professionals to provide high-quality care to all Americans at a reasonable cost. In return, we eliminate the incidence of bad debt and charity care, and allow health care professionals to spend their time with patients, not paperwork.

We ask our state and local governments to maintain their current efforts, particularly toward the poor and disabled. In return, we give states the maximum flexibility in designing their systems to meet their local needs.

CONCLUSION

In conclusion, Mr. Chairman, I believe we have come to an historic crossroads. One that allows us, as public servants, to leave behind us tangible evidence of our work and our caring; to fulfill one of the great unfinished items on our national agenda; and to create a sense of lasting security for all Americans on one of the most personal of issues, health care.

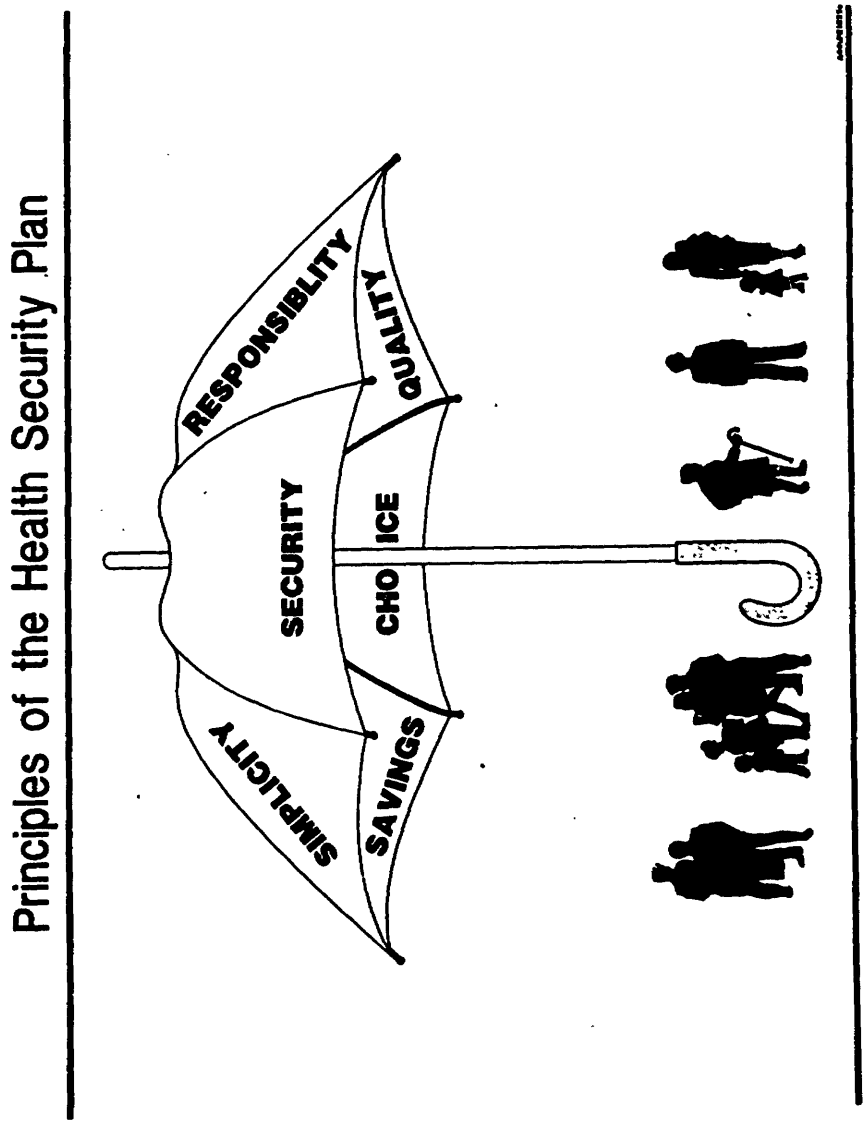
Working together, we can create a system of health care that is secure but not stagnant. One that is simple but not simplistic. One that saves resources instead

of sapping them. One that offers choice instead of chance. One that guarantees quality for all, not for some. And one that asks for responsibility while eliminating risk.

We can do this. We should do this. And together I know we will do this.

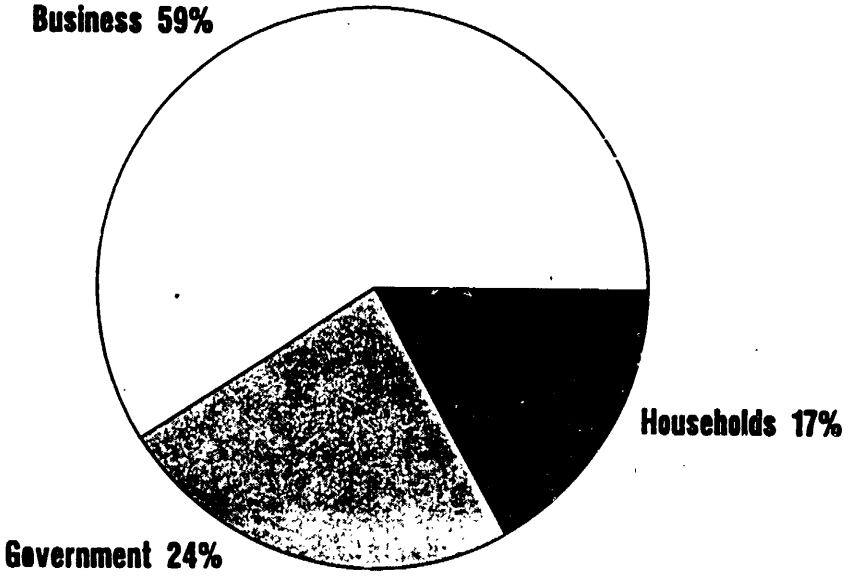
Thank you.

CHART 1



# Source of Revenue for Premiums

Percent of Public and Private Premiums Under Reform

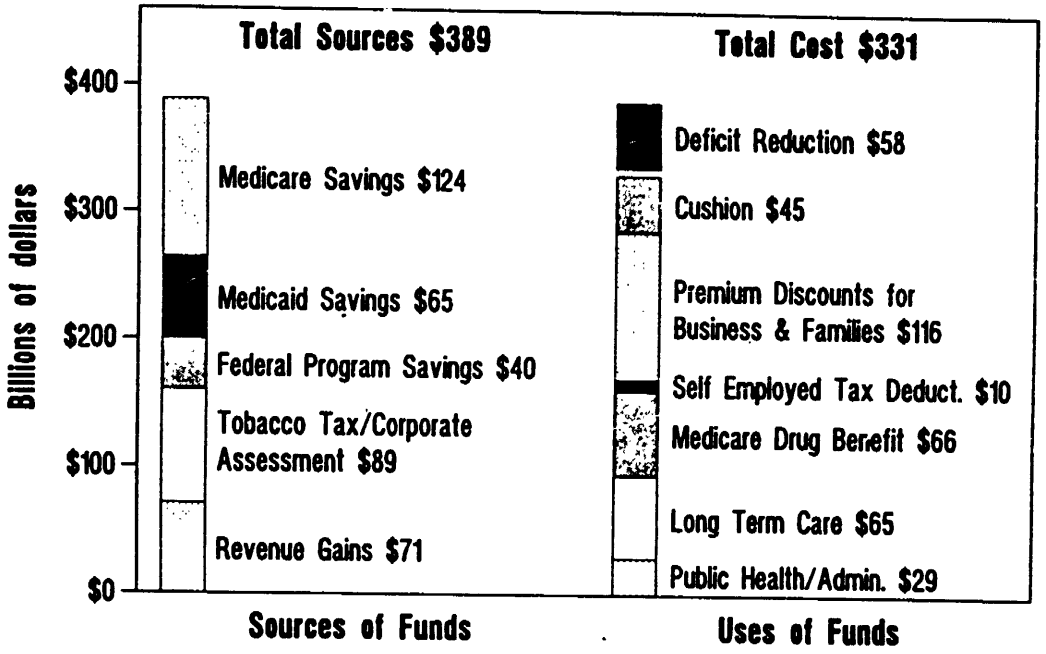



Source: HCFA; Office of the Actuary

CHART 2

# Financing Health Care Reform

Sources and Uses of Federal Funds*




*Seven year totals (1994-2000)

CHART 3

CHART 4

## BENEFITS: THE HEALTH SECURITY PLAN COMPARED WITH CURRENTLY OFFERED PLANS

| BENEFITS | HEALTH SECURITY PLAN | | BLUE CROSS STANDARD, FEHBP | FORTUNE 500 COMPANY |
|---|---|---|---|---|
| | LOW COST SHARING (HMO) / IN-NETWORK COMBINATION PLAN[1] | HIGH COST SHARING (FFS)[2] / OUT-OF-NETWORK COMBINATION PLAN | | |
| Medical Plan Maximum | No lifetime dollar maximum limit | No lifetime dollar maximum limit | Lifetime maximum for organ/tissue transplants, mental health and substance abuse | Lifetime maximum for inpatient substance abuse |
| Out-of-Pocket[3] | $1500 / individual<br>$3000 / family maximum | $1500 / individual<br>$3000 / family maximum | $3000 / individual<br>$3000 / family | $1,000 per covered individual - does not include deductibles |
| Deductibles | None | $200 / individual<br>$400 / family | $200 / individual<br>$400 / family | $300/individual<br>$400/family |
| Inpatient Hospital[4] | Full coverage, no coinsurance<br><br>No dollar or day maximum | 20% coinsurance<br><br>no dollar or day maximum | $250 per admission deductible<br><br>No dollar or day maximum | Full coverage in-network; 20% coinsurance out-of-network |
| Doctors Office Visits, Hospital Outpatient | $10 copay per visit<br><br>No dollar or visit maximum | 20% coinsurance<br><br>no dollar or visit maximum | 25% coinsurance | 20% coinsurance |
| Outpatient Laboratory, Radiology, and Diagnostic Services | Full coverage | 20% coinsurance | 25% coinsurance | Full coverage in-network 20% coinsurance out-of-network |
| Emergency | $25 copay per visit, waived in emergency | 20% coinsurance | Full coverage within 72 hrs. of accident | Full coverage - required plan notification within 48 hours |
| Preventive Services[5] | Full coverage, based on periodicity schedule | Full coverage, based on periodicity schedule | 25% coinsurance<br><br>100% well children | not specified |

1. SSI and AFDC recipients, and families with adjusted family income below 150% of the applicable poverty level, are eligible for reductions in cost sharing, if alliances determine that there are insufficient numbers of low or combination cost sharing plans available.

2. FFS - fee for service.

3. Deductibles counted toward out-of-pocket limits.

4. Mental health and substance abuse have separate provisions, see below.

5. Including well-child and prenatal care, periodic health exams, targeted tests and vaccines.

6. The National Health Board, in consultation with experts in clinical preventive services, will review and define specific services as preventive services for high risk populations, and will ... this appropriate periodicity schedules.

CHART 4 (cont.)

| BENEFITS | LOW COST SHARING (HMO) / IN-NETWORK COMBINATION PLAN | HIGH COST SHARING (FFS) / OUT-OF-NETWORK COMBINATION PLAN | BLUE CROSS STANDARD, FEHBP | FORTUNE 500 |
|---|---|---|---|---|
| Prescription Drugs | $5 per prescription | $250/year deductible<br><br>20% coinsurance | $50 deductible<br><br>40% coinsurance | 20% coinsurance<br><br>50% coinsurance for drugs for treatment of mental or nervous conditions |
| Inpatient Mental Health (MH) and Substance Abuse (SA)[7] | Full coverage<br><br>30 day limit / episode<br>60 day annual limit | 1 day deductible<br>20% coinsurance<br><br>30 day limit / episode<br>60 day annual limit | $250 per admission deductible; 40% coinsurance<br><br>Unlimited days<br><br>$3,000 maximum for substance abuse treatment program - 28 day max.<br><br>$30,000 lifetime maximum | 20% coinsurance pre-certification required<br><br>Substance abuse: Full coverage in-network<br><br>20% coinsurance out-of-network; 30 days per stay; 2 stays maximum |
| Outpatient Mental Health | All outpatient except psychotherapy - $10 / visit<br><br>Psychotherapy - $25 / visit; 30 visits annual maximum; 4 visits / 1 inpatient day at plan's discretion, beyond 30 visits<br><br>Intensive outpatient - full coverage; 120 day annual maximum. Available at plan discretion: first 60 days as trade against inpatient benefit; remaining 60 days subject to plan discretion | All outpatient except psychotherapy - 20% coinsurance<br><br>Psychotherapy - 50% coinsurance; 30 visits annual maximum; 4 visits / 1 inpatient day at plan's discretion, beyond 30 visits<br><br>Intensive outpatient - 20% coinsurance; 120 day annual maximum. Available at plan discretion: first 60 days as trade against inpatient benefit; remaining 60 days subject to plan discretion | 40% coinsurance; 25 visits annual maximum - includes partial hospitalization and visits for outpatient substance abuse<br><br>$30,000 lifetime maximum | 20% coinsurance for employee<br><br>50% coinsurance for dependent |
| Outpatient Substance Abuse | 30 group therapy visits subsequent to treatment in inpatient or intensive outpatient settings<br><br>For individuals not initially treated on an inpatient or intensive outpatient basis, 4 visits for 1 inpatient day trade | 30 group therapy visits subsequent to treatment in inpatient or intensive outpatient settings<br><br>For individuals not initially treated on an inpatient or intensive outpatient basis, 4 visits for 1 inpatient day trade | Subject to mental health limits | 20% coinsurance; 30 visit maximum |
| Hospice for Terminally Ill | Full coverage | 20% coinsurance | 100% coverage for home hospice; $250 per admission for inpatient hospice with 5 consecutive day limit | Not specified |

7. In 2001, inpatient and outpatient MH/SA limitations and higher cost sharing are phased out.

CHART 4(cont.)

| BENEFITS | LOW COST SHARING (HMO) / IN-NETWORK COMBINATION PLAN | HIGH COST SHARING (FFS) / OUT-OF-NETWORK COMBINATION PLAN | BLUE CROSS STANDARD, FEHBP | FORTUNE 500 |
|---|---|---|---|---|
| Home Health (HH)/ Extended Care (ECF - SNF and Rehab Hospitals) | Full coverage as inpatient alternative after acute illness or injury; 60 day reassessment<br><br>100 day annual limit extended care facilities | 20% coinsurance as inpatient alternative after acute illness or injury<br><br>100 day annual limit extended care facilities | 25% coinsurance<br><br>25 visit limit for home nursing care | 20% coinsurance |
| Vision Care, Eyeglasses | $10 per exam, no additional copay for glasses<br><br>Glasses limited to children only | 20% coinsurance<br><br>Glasses limited to children only | Not covered | Not specified |
| Dental Prevention and Treatment for Children<br><br>Emergency Dental for Adults and Children[1] | $10 / visit | 20% coinsurance; $50 deductible for treatment | Covered at the schedule | Not specified |
| Prenatal Care | Full Coverage | Full Coverage | 25% coinsurance | 20% coinsurance |
| Outpatient Rehabilitation | $10 copay per visit; reassessed at 60 days for continuing improvement | 20% coinsurance; reassessed at 60 days for continuing improvement | 25% coinsurance<br><br>25 visit limit | Not specified |
| Home Medical Equipment | Full coverage | 20% coinsurance | 25% coinsurance | Not specified |

1 In 2001, adult prevention and treatment, and orthodontia for severe malocclusion in children are added.

# Cap on Small Firm Payments

Percent of Payroll

| Average wage in thousands | Firm Size | | |
|---|---|---|---|
| | Less than 25 | 25-50 | 50-75 |
| Less than $12 | 3.5% | 4.4% | 5.3% |
| $12-15 | 4.4 | 5.3 | 6.2 |
| $15-18 | 5.3 | 6.2 | 7.1 |
| $18-21 | 6.2 | 7.1 | 7.9 |
| $21-24 | 7.1 | 7.9 | 7.9 |
| More than $24 | 7.9 | 7.9 | 7.9 |

CHART 5

# Discounts for Individuals

**Premium discounts**

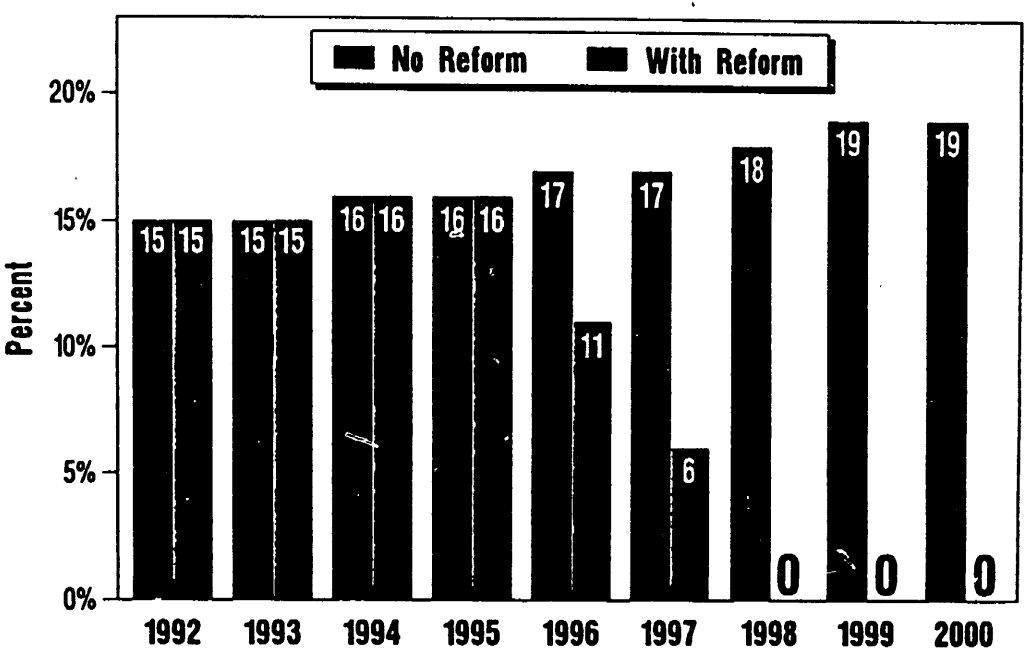
| | Full-time Employees | Self-Employed | Unemployed | Early Retirees |
|---|---|---|---|---|
| 80% Employer Share | Does not apply. | Contribution is capped as a percentage of self-employed income.<br>• The caps are the same as those applied to small businesses. | Discounts available for individuals whose family income is below 250% of poverty.<br>• Only non-wage earnings count as income; unemployment benefits do not.<br>• The first $1000 of earnings is not counted. | Federal government pays the 80% share for non-working early retirees. |
| 20% Individual Share | Individuals and families with incomes below 150% of poverty are eligible for discounts.<br>• These discounts are on a sliding scale, based on income. • The first $1000 of income is not counted.<br><br>For families with total incomes below $40,000, the family share is capped at 3.9% of income. | | | |

**Cost-sharing discounts**

For individuals receiving cash assistance and enrolled in a low cost-sharing plan, cost-sharing responsibilities are discounted by 80%.

# Percentage of Americans Uninsured

By Year, 1992-2000

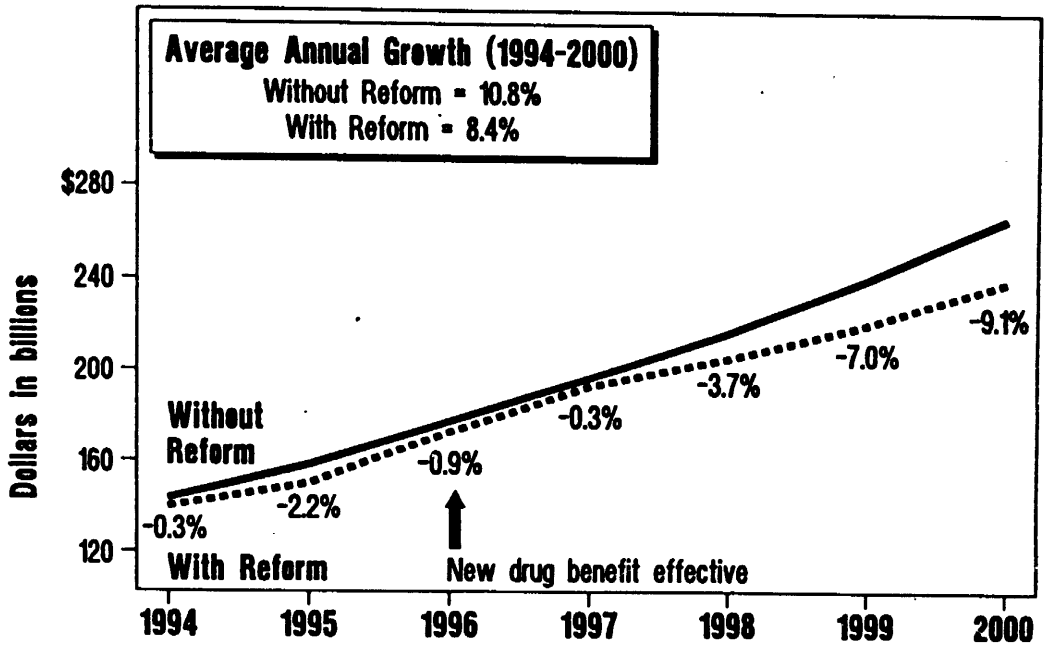



Source: HHS/ASPE projections

CHART 6

# Medicare Benefit Outlays*

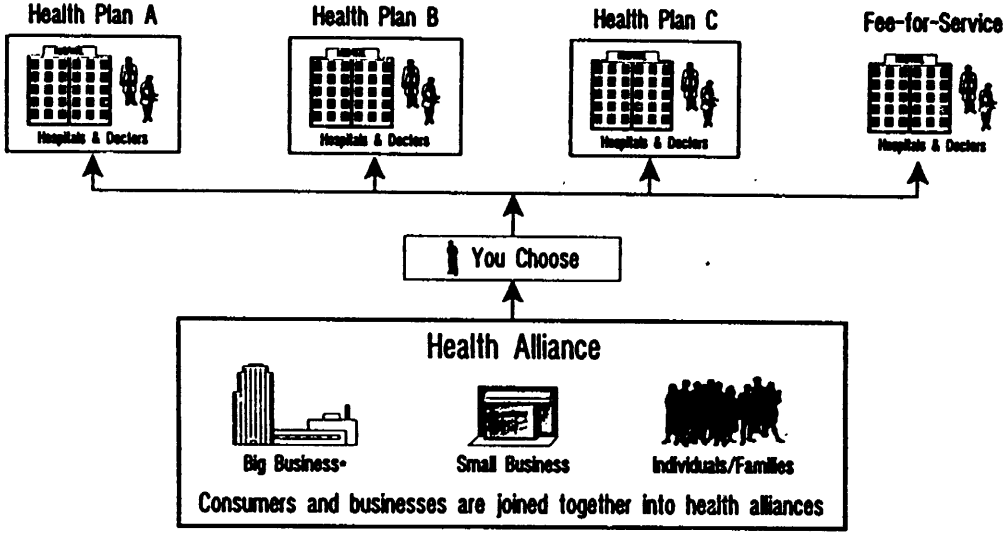
## Growth With and Without President's Health Reform




*Net of offsetting receipts; reflects program savings and effect of drug benefit (does not include effect of state employee revenue proposal)

# How You Get Coverage: The New System

Health care reform brings people closer to their doctors and the high quality, affordable care they deserve.




* Large businesses with 5000 or more employees may form their own corporate alliances.



CHART 8

# Federal, State, and Alliance Responsibilities

**The Federal Government**

Sets the basic system framework

- Federally guaranteed benefits package
- Determines premium caps, increases, and enforcement
- Insurance reform

**The States**

Within federal framework, adopt health reform arrangement of choice

- Establish alliances
- Certify health plans
- Monitor quality of and access to care
- Implement insurance and malpractice reform

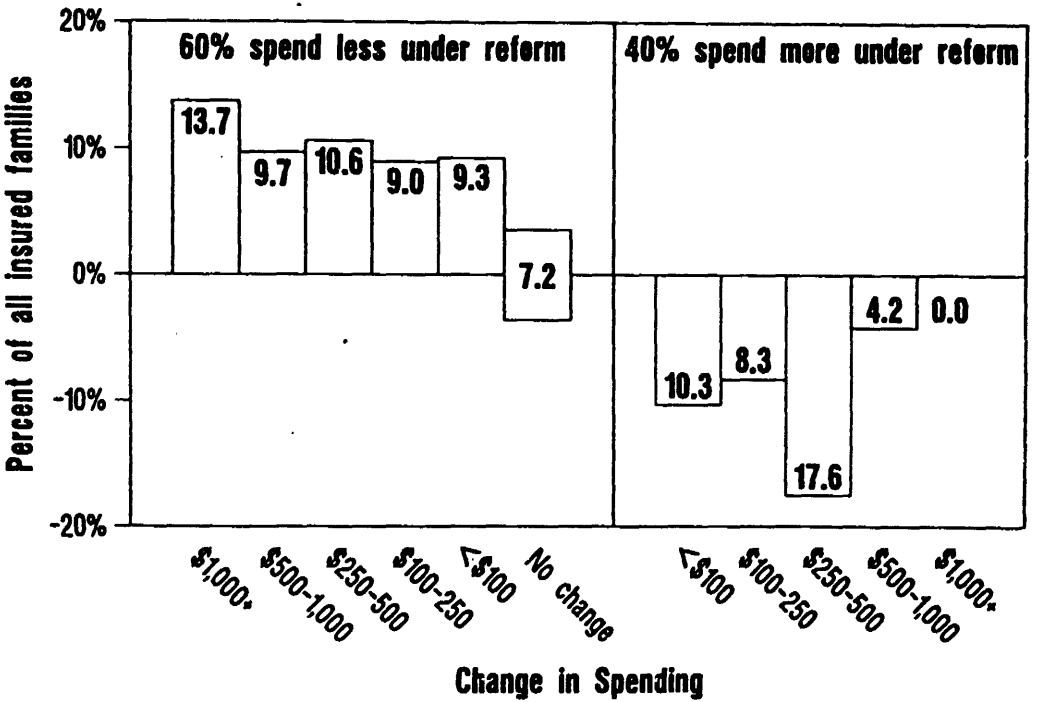
**Alliances**

Serve as collective purchasing agents for employers and consumers at the local level

- Solicit competitive bids from health plans
- Disseminate consumer information materials
- Enroll all eligible residents
- Collect premiums and pay health plans
- Administer employer and family discounts

CHART 9

# Difference in Health Premium Spending for Families




Source: The Urban Institute's TRIM2 microsimulation model, benchmarked to the National Health Expenditures Accounts.

## FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT
## By Current Insurance Type: Year 2000

Under the Health Security Act:

Employer-Sponsored Insurance

- 38 percent of all families which currently have employer-sponsored insurance will experience savings of up to $1,000 in overall health care spending (premiums and out-of-pocket expenditures) in the year 2000. [Chart IV-H]

- 30 percent of all families which currently have employer-sponsored insurance will experience savings of more than $1,000 in overall health care spending in the year 2000. [Chart IV-H]

- On **average**, families which experience savings in overall health care spending will enjoy a **decrease of $109 per month** ($1,309 for the year) in the year 2000. [Chart IV-G]

- 5 percent of all families which currently have employer-sponsored insurance will experience no change in overall health care spending (premiums and out-of-pocket expenditures) in 2000. [Chart IV-H]

- Families which will be spending more on overall health care expenditures will spend on average an additional $31 per month ($367 for the year) in the year 2000. [Chart IV-G]

Individually Purchased Insurance

- The vast majority (85.9 percent) of families which currently purchase health insurance individually will experience savings of more than $1,000 on overall health care spending (premiums and out-of-pocket expenditures) in 2000. [Chart IV-I]

- On average, families which experience savings in overall health care spending will enjoy a decrease of $375 per month ($4,501 for the year) in the year 2000. [Chart IV-G]

- Families which will be spending more on overall health care expenditures will be spending an average of an additional $75 per month ($903 for the year) in 2000. [Chart IV-G]

Currently Uninsured

- 28 percent of all families which are currently uninsured at least part of the year will experience some savings in overall health care

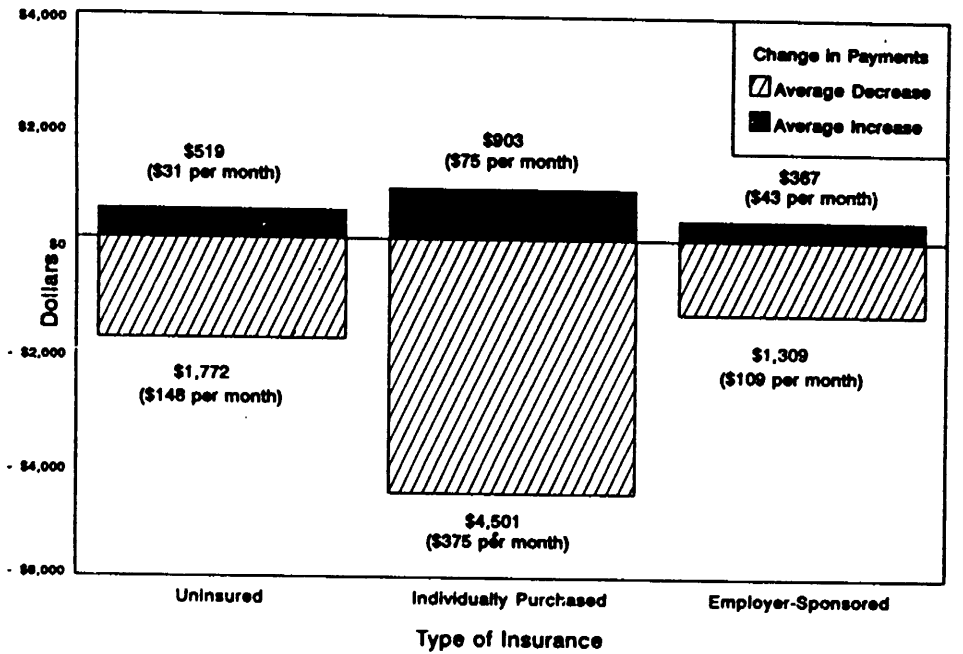
spending in the year 2000, due largely to reductions in high out-of-pocket expenditures. The **average decrease** will be **$148 per month** ($1,772 for the year) in 2000. [Charts IV-G and IV-J]

- 15 percent of all families which are currently uninsured at least part of the year will experience no change in overall health care spending in 2000. [Chart IV-J]

- Families which will be spending more on overall health care expenditures will be spending an average of an additional $43 per month ($519 for the year) in 2000. [Chart IV-G]

# FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

## Average Annual Saving and Spending by Current Insurance Type: Year 2000

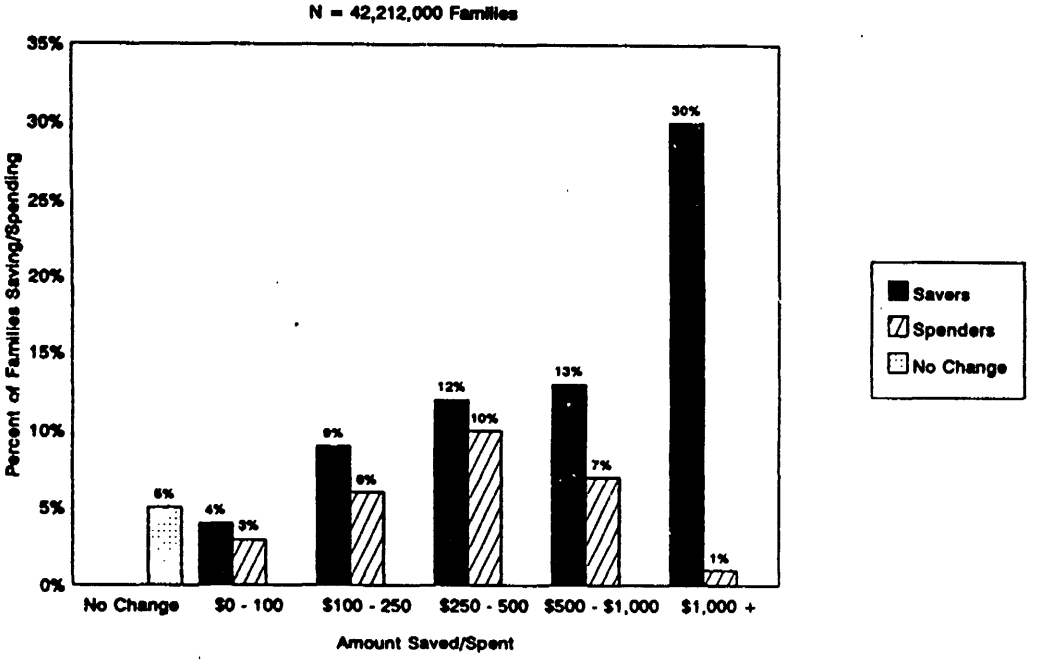



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts
Includes premium and out-of-pocket spending in regional alliances
Uninsured includes 31.8 million persons uninsured part-year

Chart IV (

# FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

## Average Annual Percent Change in Spending
## Families which Currently have Employer-Sponsored Insurance: Year 2000

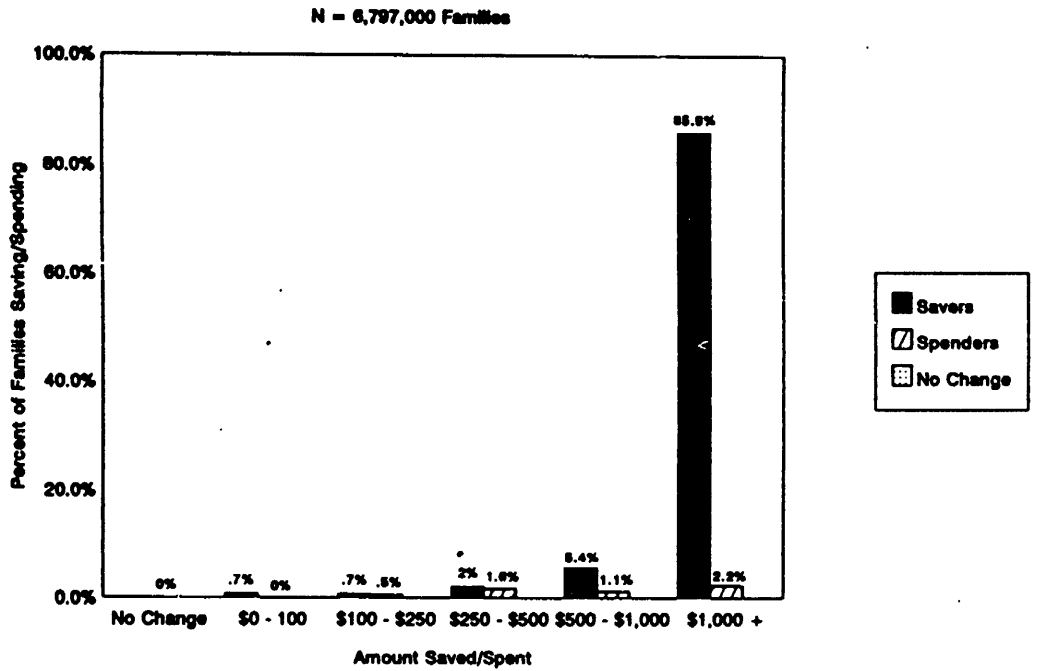



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts
Includes premium and out-of-pocket expenditures for those in regional alliances
Totals may not add to 100% due to rounding

Chart IV-H

# FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

## Average Annual Percent Change in Spending
## Families which Currently Purchase Insurance Individually: Year 2000

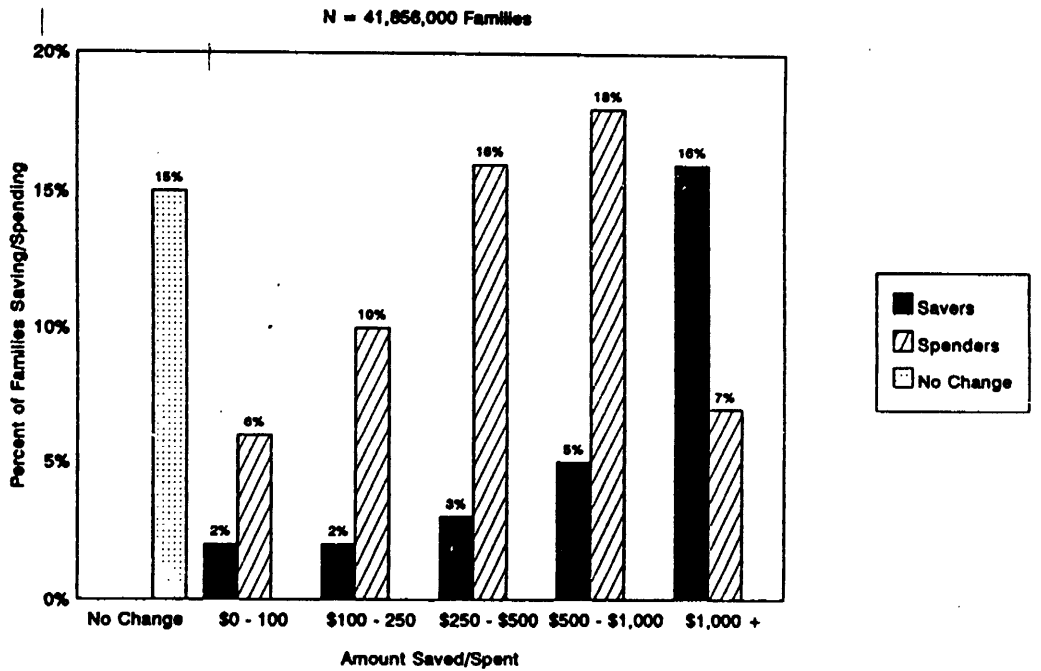



SOURCE: Center for Intramural Research, AHCPR.
Includes premium and out-of-pocket expenditures for those in regional alliances.
Totals may not add to 100% due to rounding

Chart IV I

# FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

## Average Annual Percent Change in Spending
## Families which are Currently Uninsured: Year 2000




SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts
Includes premium and out-of-pocket expenditures for those in regional alliances.
Totals may not = 100% due to rounding. Uninsured includes 31.8 million persons uninsured part-year.

Chart IV .I
51

# COMMUNICATIONS

ALBERT EINSTEIN COLLEGE OF MEDICINE,
BRONX MUNICIPAL HOSPITAL CENTER,
*Bronx, N.Y., August 13, 1993.*

Senator DANIEL PATRICK MOYNIHAN,
*Att: Jack Fowle,*
*Washington, DC*

Dear Senator Moynihan: I am writing to inform you of a serious threat to victims of violent crime: The Black Talon Bullet.

This new hollow point bullet opens on impact to produce six extremely sharp teeth arranged evenly in a circle around it. In twenty years of working in a Municipal Hospital Trauma Center in the Bronx, I have never seen a more lethal projectile. This bullet, which is manufactured by Winchester, is advertised to create more tissue damage and produce "optimum penetration." Unfortunately, this is exactly what it will do. Because of this, I believe that this bullet should not be available to the general public.

Furthermore, in order to prevent other products such as this from entering the marketplace, would strongly suggest that a federal commission be formed which would review all new ammunition intended for public use.

Please give this situation your serious consideration.

Sincerely,

J. GALLAGHER, M.D., *Director, Emergency Medicine.*

## STATEMENT OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

Mr. Chairman and members of the Committee: Good day. My name is Allan Jensen. I am an ophthalmologist in private practice in Baltimore and Secretary for Federal Affairs of the American Academy of Ophthalmology.

On behalf of the Academy's 19,000 ophthalmologists—doctors of medicine who provide primary and comprehensive medical and surgical eye care, I am pleased to have this opportunity to present this statement.

The American Academy of Ophthalmology strongly believes that all Americans should have access to quality health care including appropriate and affordable eye care. We believe that an appropriate level of eye care is necessary in order to promote general well-being, independent daily functioning, enhanced quality of life and increased economic productivity.

The Academy commends the President for making an effort to solve many of the significant problems that prevent health care services from being accessible to millions of Americans. In particular, we applaud his efforts to ensure universal access, develop a standard health benefit package, reduce administrative burdens, and reform the insurance market. We also welcome his interest in reforming antitrust restrictions.

However, like the rest of the medical community, ophthalmology has a number of concerns regarding the President's proposal. My testimony will focus on the most significant of these issues.

### CONSUMER ACCESS TO PROVIDERS

The Academy is concerned about the impact of the President's proposal on consumer access to their provider of choice. While we recognize that "choice" is one of the President's principles for reform, we believe that changes to the Health Secu-

rity Act are necessary to ensure that the results of legislation are consistent with that principle.

Consumers have the most freedom when their health plans allow them to see the provider they prefer. The Academy believes that the President should encourage point-of-service and fee-for-service in order to achieve this goal. These are the only plans that allow patients to see almost any provider they wish.

Point-of-service and fee-for-service options may allow consumers to receive better quality care at a lower cost than traditional managed care plans. These options allow patients direct access to the providers best able to treat their problems. They reduce treatment delays, ineffective visits to gatekeepers, and redundant care, in some cases.

The Academy is pleased that the Health Security Act would require HMOs to offer a point-of-service option, allowing consumers to go outside of their plan to see a physician. However, in order to be real choice, the coinsurance for these patients must not be prohibitive. There is concern that the President's legislation would allow the National Health Board to set coinsurance rates of anywhere from 20 to 100%. The Academy believes that reasonable ceilings should be set on rates to protect consumers from excessive coinsurance and inhibited access to outside-the-network providers.

With regard to fee-for-service, the Academy continues to be concerned about the barriers the Health Security Act creates to physician participation in fee-for-service. Specifically, under the proposal, alliances could set fee-for-service fee schedule amounts inordinately low. A related provision allows alliances to ratchet down fee schedule amounts at any time to meet spending targets. These provisions could result in strong disincentives for physicians to see fee-for-service patients. And without physician participation there can be no fee-for-service and no true choice for consumers.

We urge Congress to scrutinize the President's health system reform proposal and work to ensure the viability of point-of-service and fee-for-service options. Only if these options are truly available, will consumers be empowered to exercise choice.

STANDARD HEALTH BENEFIT PACKAGE

The Academy commends the President on his efforts to develop a standard benefit package. There are, however, two elements of the eye care section of the benefit package that we hope Congress will review when the President's proposal is considered.

The President's proposal currently includes provisions mandating coverage for the diagnosis and treatment of "defects in vision." The Academy appreciates the attention given to this issue; however, we question the cost-effectiveness of the mandate. The "defect in vision" language is unduly vague and may represent an expansion of coverage to techniques and treatments that have yet to be proven medically necessary or cost-effective.

We recommend the inclusion of eye care benefits based on risk factors, patient need and medical necessity. The Academy's Core Eye Care Benefit Package outlines this approach.

The Core Eye Care Benefit Package provides a more cost-effective solution than is provided for in the President's package because it specifies coverage of only appropriate and effective care based on medical necessity. It does not provide for "defects in vision" services that have not been proven medically necessary or cost-effective.

The Core Eye Care Benefit Package includes only services that have been evaluated scientifically in order to determine appropriate clinical indication for use and efficacy. For example, the benefit package outlines an appropriate cost-effective timeline for eye examinations and evaluations, including more frequent periodic examinations for high risk groups such as African-Americans, who face a statistically higher risk of glaucoma, and diabetics, who face a higher risk of diabetic retinopathy. The package outlines less frequent examinations for those individuals with no-risk factors and healthy eyes.

The Academy believes that access to appropriate and timely care will result in better health for Americans and reduced overall national costs for disease treatment. We recommend the use of the Core Eye Care Benefit Package to ensure that the resources allocated for eye care under the President's plan are used effectively and cost-efficiently.

SCOPE OF PRACTICE

The Academy is concerned about the scope-of-practice provisions included in the President's proposal. The proposal defines covered services as those that a physician or provider "is legally authorized to provide . . . in the State." At the same time,

the proposal calls for Federal preemption of State scope-of-practice laws by indicating that "no State may, through licensure or otherwise, restrict the practice of any class of health professional beyond what is justified by the skill or training of such professional."

The Academy opposes any effort by the Federal government to override a State's responsibility to ensure that their citizens receive safe and appropriate care by properly trained providers. The individual States are in the best position to determine their particular health care needs and the professionals who can best meet that need. The vaguely worded provision of the President's plan could result in individuals providing health care services for which they have not been properly educated or trained.

The Academy strongly believes it is inappropriate for the Federal government to intervene in this area and that such involvement could threaten the delivery of quality health care. We urge Congress to protect the authority of States to make these critical scope-of-practice decisions.

EXPANSION OF THE MEDICARE CATARACT SURGERY ALTERNATIVE DEMONSTRATION PROJECT

The Academy opposes the rapid expansion of Medicare's cataract surgery alternative payment system demonstration project. The President proposes locating these facilities in all urban areas in 1995. The legislation calls these facilities "centers of excellence" and mandates that they save the government money, yet the legislation includes no provisions related to quality.

The Academy believes the expansion of the alternative payment demonstration project is unwarranted at this time. Medicare's project is still in its infancy. Little data has been collected by the evaluators of this project and what has been collected has not been analyzed. The first report on the evaluation of this project is not expected for at least a year.

The Academy is concerned that financial savings are the government's only motivation for expanding the demonstration project. Currently, the project is saving only a small portion of the current cost of cataract surgery. This savings margin may evaporate as already scheduled and proposed surgery and facility payment reductions are implemented over the next several years. The government's anticipated savings may never be achieved.

The Academy is concerned that this proposal discourages community-based medicine. Medicine is best practiced when longstanding doctor patient relationships are encouraged and honored. The trust, communication, and historical knowledge that are developed in community-based medicine help patients make the best informed and most appropriate decisions about surgery. The President's proposal would encourage high volume facilities to aggressively market themselves and pluck patients out of longstanding relationships with an artificial designation of a "center of excellence."

The Academy believes that these high-volume mills would not be "centers of excellence." The legislative proposal includes no provisions related to quality. Current, surgical success rates for cataract surgery is already extremely high. The government should carefully evaluate the claims of some facilities that they provide a higher quality of care. Their claims may be primarily designed as a marketing tool to recruit patients. The government has made extensive efforts to develop cataract surgery guidelines and is in the process of updating those guidelines. Perhaps the legislation could mandate that any so-called "centers of excellence" meet or exceed the quality standards in those guidelines.

The Academy is also troubled by the provision of the President's bill that allows a portion of the government's savings to be rebated to the patient. Most patients have secondary insurance to cover coinsurance and deductibles. Because of this rebate provision, patients could actually reap a net financial gain from undergoing surgery. We question whether the government really wants to provide patients with financial incentives to undergo surgery.

The Academy urges the Committee to delay any decisions on the future of the "centers of excellence" until the demonstration project is completed and evaluated. Furthermore, any future effort to expand these facilities must ensure that quality is not sacrificed in order to achieve cost savings. At a minimum, any facility that the government labels as a "center of excellence" should be required to meet or exceed the quality standards set forth in the government's own clinical practice guidelines.

PHYSICIAN WORKFORCE REGULATION

The Academy believes that all Americans share in the benefits reaped from high quality physician training programs. For this reason, we support the President's goal of spreading financial support for graduate medical education across all payers, not just the Federal government.

The Academy also agrees with the President regarding the need for programs that encourage and support physicians to serve in rural and inner city areas. These programs will serve to expand the availability of care in underserved areas, including those areas with minority and disadvantaged populations. The Academy commends the President's proposal in this area, most notably, his efforts to develop mechanisms to provide for adequate recruitment and support of underrepresented minority groups into the physician workforce.

We are, however, troubled by the President's fast-track approach to physician workforce reform given the weaknesses in our current ability to accurately assess the nation's future manpower needs. At this time, there does not appear to be sufficient information with which to base a decision about the exact number and type of physicians and health personnel required under a reformed system. We believe that comprehensive data should be the foundation upon which a long-term national health workforce policy is formed. Without it, all efforts will be premature.

The Academy has taken a leadership role in this issue. We have engaged the RAND Corporation to analyze the country's eye care manpower needs. Once completed this spring, a report of the findings will be delivered to members of Congress.

The Academy is also concerned about the five-year timeline set to achieve a 55:45 ratio of primary care to specialty care physicians-in-training. This timetable is far too brief to preserve the quality of medical training programs and maintain the vital patient care functions of academic medical centers. A more cautious and deliberative approach to bringing the numbers of generalists and specialists into balance is necessary if this route of government intervention in physician supply is chosen.

The Academy's concerns about the effects of the President's proposal to quickly and tightly regulate the physician workforce are not unfounded. We should all recall the lessons learned from the government's past attempts to manipulate the nation's physician workforce which contributed, in part, to the current and projected physician oversupply.

FINANCING

The Academy understands that new resources will be required in any effort to achieve universal access and coverage. However, the Academy believes the Administration is misguided in its effort to finance the reform proposal through significant reductions in payments to Medicare providers.

Since as far back as the Omnibus Budget Reconciliation Act (OBRA) of 1986 and including OBRA 1987, 1989, 1990, the physicians who treat Medicare patients—the nation's oldest and most ill—have been asked to absorb reductions in their fees. As a result of these reductions, physicians who treat Medicare patients currently receive approximately 73% of what private payors reimburse for the same procedure, according to Congress's own Physician Payment Review Commission. The Academy believes that an additional $124 billion in Medicare reductions on top of the $56 billion in reductions already mandated in the President's recent budget bill represents an extraordinarily heavy burden for ophthalmologists and other Medicare providers to bear.

Medicare patients make up a large portion of ophthalmologists' practices. Consequently, we will bear a large share of the burden of the Administration's next spending reductions. The Academy believes it is inappropriate for the Medicare program to be continually used as a "banker." We hope that as Congress considers the President's plan it will look elsewhere for funding resources and act to maintain the strength and integrity of Medicare—the nation's most important health care program.

CONCLUSION

In closing, we commend the President for his leadership in health system reform. His efforts to ensure universal access, develop a basic benefit package, reduce administrative burdens and reform the insurance market have earned the support of the Academy and deserve the support of all Americans.

At the same time, the Academy has strong reservations about provisions which limit consumer access to a provider of their choice, mandate eye care services that are not medically necessary, override State scope-of-practice laws that safeguard the delivery of quality care, expand the cataract alternative payment demonstration

project, abruptly and strictly regulate the physician workforce and finance the reforms through reductions in the Medicare program. We believe these provisions will seriously adversely affect consumer access and the availability of appropriate quality care for our patients.

We thank the members of the Committee for their attention to these issues and we appreciate this opportunity to present this testimony to you.

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AMERICAN ACADEMY OF OPHTHALMOLOGY CORE EYE CARE BENEFIT PACKAGE

I. DEFINITION OF CORE EYE CARE BENEFIT PACKAGE

In order to ensure every American equal opportunity to good vision and eye health, basic eye care services should be made accessible for all, regardless of his/her ability to pay. The core eye care benefit package includes the following:

For healthy patients with no known eye disease:

(1) preventive vision screenings and eye health screenings for children
(2) refrective examinations for children and adults as needed;
(3) preventive basic eye evaluations for adults
(4) periodic comprehensive eye examinations for children and adults in general population; and
(5) periodic comprehensive eye examinations for groups at high (statistically greater) risk for developing eye disease

For patients with eye disease:

(1) periodic comprehensive medical eye examinations and other medical eye exams, including consultant and referral services
(2) medical testing and diagnostic services, including laboratory and radiologic services
(3) medical treatment of eye diseases on an inpatient, outpatient hospital or ambulatory facility basis, including emergency health services
(4) surgical evaluation and treatment on an inpatient, outpatient hospital or ambulatory facility basis, including emergency health services
(5) follow-up and monitoring

II. FUNDAMENTAL SERVICES

The fundamental services provided in the core benefit package are described as:

(1) vision screening and eye health screening;
(2) a refraction;
(3) a basic eye evaluation;
(4) a comprehensive eye examination;
(5) medical and surgical services.

Patient education is an essential component of preventive services to provide patients with information on how to avoid eye injuries, reduce risk factors for disease, develop healthier behaviors and promote the benefits of early disease detection. For care to be optimal, patients need to be made aware of the importance and benefits of early detection and treatment of eye diseases and conditions, and take more responsibility for their own health.

There are two kinds of eye screenings. The **vision screening** consists of a testing of distance Snellen acuity with the patient utilizing the current spectacle correction (if any) for the purpose of detecting visual problems. It is not a truly diagnostic procedure and cannot detect all visual problems nor identify their causes. The screening is usually performed efficiently, as accurately as possible and at the lowest cost in order to serve the general population. It is most useful on a periodic basis for detecting visual problems in the pre-school and school-age population. An **eye health screening** consists of a vision screening with a general, brief history of any symptoms or previous eye diseases, and an abbreviated evaluation of the pupil, ocular alignment and motility, and the fundus. This does not require dilation of the pupil and could involve an ophthalmoscopic examination and intraocular pressure measurement. This is useful in a pediatric population where risks of developing eye disease are fairly low, but more common eye conditions can be screened through simple testing (strabismus and amblyopia). These screenings can be performed by a variety of providers.

**A basic eye evaluation** consists of a general history of the patient, complete history of eye symptoms or previous eye diseases and a brief evaluation of the gross anatomic and physiologic status of the eye. This would include a slit-lamp examina-

tion and ophthalmoscopic examination, but would not include dilation of the pupil. Testing of extraocular muscle motility, including a determination of visual acuity, measurement of intraocular pressure and a pupillary evaluation would be included. The basic eye evaluation should be performed by a qualified eye professional defined as one having competence to take and evaluate an appropriate systemic and eye history, to recognize risk factors, indications by family history and systemic conditions, signs and symptoms of eye disease and conditions and to perform and interpret the components of the evaluation.

A **comprehensive eye examination** is a more thorough medical exam, and consists of three major components: medical history, history of any eye conditions, and evaluation of anatomic function and physiologic status. A thorough history collects demographic data, past history, other systemic conditions, use of systemic and topical medications and other relevant information. During this process, information about the patient's general health status and any systemic symptoms are evaluated and interpreted. The evaluation of the anatomic status of the eye focuses on three major areas: lids, lashes, lacrimal apparatus, orbit and other pertinent features; anterior segment, including the conjunctiva, sclera, cornea, anterior chamber, iris, lens and posterior chamber; and posterior segment, including the retina, vitreous, uvea, vessels and optic nerve. Examination of the posterior segment is best performed and usually done through a dilated pupil and examination with a direct and indirect ophthalmoscope. The evaluation of physiologic function includes, but is not limited to the following: measurement of visual acuity with present correction, measurement of best corrected visual acuity obtained by refraction, testing of ocular alignment and extraocular muscle motility, evaluation of pupillary status and measurement of intraocular pressure. An ophthalmologist, by virtue of his or her M.D. or D.O. training, has the level of skills and knowledge to assess and interpret general medical history and examination, ocular and systemic signs and symptoms related to the patient's condition, and the competence to perform and evaluate this examination.

A **refraction** or examination specifically directed towards prescription of corrective lenses is defined as a fundamental service for the core benefits and should be covered when indicated by a change in the patient's visual function. A diagnostic refraction is an integral part of a comprehensive eye examination that is indicated at appropriate intervals throughout a patients lifetime. A refractive exam consists of a quantitative measurement that yields the data necessary to determine the best visual acuity with corrective lenses and to prescribe these lenses. A refraction constitutes a significant component of eye care to the public. Because it is nearly universally applied to the general healthy population and its costs can be well-quantified, it is not normally considered as an insurable risk. For example, under the Medicare program, refractions have not been routinely covered, and the Academy supports this decision. However, as health care reform seeks to develop a more comprehensive health benefit package, and as refraction is an important component of total care and valued by the American public, it is included in this core eye care benefit package. A refraction is not recommended routinely in the absence of visual symptoms and is not necessarily required more often than outlined in the program of basic and comprehensive examinations. To assure good vision and eye health, any patient who perceives that his or her vision has decreased should be evaluated. These services would not necessarily include any other screening or basic examination.

**Medical and surgical services** include ordering and performing of appropriate supportive testing, prescription of pharmacologic treatment, performance of other medical procedures, evaluation for surgical treatment, performance of surgical procedures, including laser surgery, delivery of post-operative care, follow-up and monitoring of patients with eye diseases. An ophthalmologist, by virtue of their broad medical expertise, school in diagnostic abilities and clinical decisionmaking in general patient management, and their specialized medical study of the visual system and training in treatment methods, should perform medical and surgical services for the diagnosis and treatment of eye diseases.

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### STATEMENT OF THE AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION

The American Academy of Physical Medicine and Rehabilitation is a national medical specialty society of more than 4000 physical medicine and rehabilitation physicians, whose patients include people with physical disabilities and individuals with chronic, disabling illnesses such as spinal cord injury, brain injury, amputations, stroke, chronic pain, musculoskeletal impairments, cerebral palsy, and mul-

tiple sclerosis. The Academy believes that lack of access to appropriate health insurance coverage and resources for physical medicine and rehabilitation services greatly limits opportunities for persons with disabilities. Persons with disabilities have often been refused health insurance because of pre-existing conditions, have had to accept inadequate coverage, and have been most threatened by loss of coverage.

President Clinton's plan to reform the nation's health care delivery system goes a long way toward addressing many of the problems in the current system that discriminate against people with disabilities. However, the Academy believes that any system that relies heavily on the delivery of health services through managed care needs to include protections against underservice of those with severe chronic and disabling conditions. The President's proposal seems to rely heavily on managed care and does not provide for adequate choice of providers or protections against underservice.

COVERAGE

The principles of national coverage in President Clinton's proposal would have a positive impact on people with disabilities since coverage would be available to all individuals. The proposal would prohibit pre-existing condition exclusions, and would extend health care to all Americans regardless of income. The President's proposal would also assure portability of coverage and community rating of premiums, both of which are necessary reforms to enable persons with disabilities to have access to necessary health insurance.

SCOPE OF BENEFITS AND SERVICES

The proposal would also have a positive impact on persons with disabilities because it includes a broad array of services related to the rehabilitation of patients with physical disabilities. We support in particular the inclusion of the following coverage: (a) inpatient medical rehabilitation services that are properly organized, goal directed and furnished in residual settings; (b) properly organized, goal directed outpatient medical rehabilitation services in all appropriate settings; (c) professional services of physicians including physical medicine services for treatment of musculoskeletal, neuromuscular or other conditions; and nonphysician services as authorized by Medicare law including services of psychologists; (d) prosthetic and orthotic devices and essential durable medical equipment; (e) home care such as nursing, physical therapy, occupational therapy, and speech and language therapy; (f) patient education in self-care and preventive measures for persons with disabilities and chronic illness. Such preventive measures are intended to prevent complications and secondary disabilities such as skin problems and infections. Rehabilitation coverage should be related to the goals of improvement in function over time or the prevention of deterioration in function or loss of function over time.

It is the Academy's interpretation of the Clinton Plan that these services are included in it, and we applaud their inclusion. We also support the inclusion in the Clinton Plan of prescription drugs.

The Academy also strongly endorses the inclusion of a long-term care program such as recommended by the President. The lack of community and home based services for persons with disabilities limit their activities of daily living and has long been a serious problem with our system of health care services in the United States.

Finally, we support catastrophic protection such as that proposed by the President. We believe the catastrophic thresholds of $1500 and $3000 are too high for low and moderate income people however. This is a serious problem since the important principle of "choice" is conditioned by very high copayments which many people of modest means cannot meet. Their choice of "their own doctor" will not be a real choice. In order to further real choice of providers, we recommend that the catastrophic thresholds be income related. A lower income family of four could have a $1500 protection while a family earning $200,000 could have a $4500 protection for example.

ELIGIBLE PLANS AND CHOICE

Though fee for service plans may be available, their availability is unnecessarily limited. Why should federal law impose rigid copayment requirements of 20% on all services? The cost of copayments is very high making such plans out of the reach of many Americans, and of most Americans who have disabilities. We have heard many individuals with disabilities express concern to us about this aspect of the President's proposal and about the inadequacy of services for persons with physical disabilities in HMOs and managed care systems.

The Academy strongly supports real choice for consumers, particularly persons with physical disabilities, who often need specialized services from specially trained

professionals. That choice will not be real until the copayment obligations for the plans which allow choice of providers are reduced for individuals with limited financial means, particularly those who also are persons with disabilities.

We also strongly recommend that the HMO and managed care options include a right for persons with disabilities and chronic illness to select a primary physician and "gatekeeper" or case manager from among a panel which includes specialists. Each plan should be obligated to establish panels of physicians, including specialists, from which consumers with disabilities and chronic illness can choose their care manager. A person with cerebral palsy, spinal cord injury or brain injury may desire to have care managed by a physical medicine and rehabilitation specialist rather than by a generalist. This will often be the case where such care has been managed by specialists in the past, where the physician contact will be most frequently with these specialists or where the condition is such that the specialist is able to deal with general needs as well as specialty needs more effectively than the primary care physician. Physicians with specialized knowledge of conditions also know much more about the services and resources needed by the patient with a disability. They may order fewer tests and know better when services aren't working and should be terminated. We believe the best way to deal with potential problems of over use of services is not by plan limits on the number of services or gatekeepers whose incentives are to underserve. The best method is the use of appropriately developed practice guidelines by all plans.

Our current methods of furnishing health care are inadequate in providing for the primary care needs of persons with physical disabilities. This failure has resulted in significant, unnecessary rehospitalization for preventable conditions such as urinary tract infections and skin problems. Specialists in physical medicine and rehabilitation often provide primary care for persons with physical disabilities in both inpatient and outpatient settings. Frequently, this is because general primary care physicians are not comfortable with the management of primary care for persons with brain injury, spinal cord injury, or cerebral palsy. Often the routine medical or primary care problem is related to the disabling condition in a significant way and requires specialist management.

### MEDICAL EDUCATION

As graduate medical education policy is made, the need of persons with physical disabilities for appropriate primary care must be recognized. There should not be reductions in positions for the training of specialists in physical medicine and rehabilitation.

### FINANCING

We are concerned that the Medicare and Medicaid savings intended to finance much of reform will decrease the quality of services for the elderly and persons with disabilities who are eligible for Medicare. We are unclear as to the specific levels of cuts being considered and are equally unclear about the extent to which these savings will finance expanded Medicare benefits. The Academy feels that further Medicare and Medicaid cuts, as opposed to savings obtained because health care reform will now cover services formerly covered by Medicaid, are not appropriate for financing health care reform. Health care reform should enhance coverage and services for all Americans. We believe that Medicare has borne many budget cuts in the last decade to reduce the national deficit. These programs cannot also bear the level of cuts we believe are recommended by the President.

### PURCHASING ALLIANCES

We are concerned about proposals which make the administrative system more complex rather than simplifying the administration of health insurance and services. The Alliances proposed by the Clinton Plan seem very complex and involve major expenditures for new bureaucracy. We are adding Alliances to the current administration of health care through the Health Care Financing Administration, state agencies for Medicaid and insurance, and health insurance carriers, all of which regulate the economics and practice of medical care. While the concept of cooperative purchasing for small businesses and individuals may be a reasonable way to reduce the price of insurance for consumers, including persons with disabilities, the Alliance system proposed by the President seems large and complex. We favor efforts to streamline the functions of the proposed Alliances in order to limit unnecessary bureaucracy.

STATEMENT OF THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

The American Association for Respiratory Care (AARC), a 37,000 member professional association, welcomes the opportunity to submit testimony for the Hearing on President Clinton's Health Plan of the Senate Finance Committee. Respiratory care is an allied health profession whose members care for individuals suffering from diseases and abnormalities of the cardiopulmonary system. These patients range from the premature infant whose lungs are underdeveloped to the elderly patient whose lungs are diseased. Individuals who suffer from such diseases as emphysema, bronchitis, and lung cancer; children who have asthma or cystic fibrosis; and people of all ages who require the use of a ventilator to breathe are all often cared for by the respiratory professional. Respiratory care practitioners are the only allied health professionals educated, trained, and tested in the treatment and diagnosis of lung problems.

The AARC advocates reform which incorporates the principle of universal, nondiscriminatory access to a continuum of comprehensive benefits ranging from preventive to continuing care services. Assured appropriateness and quality of care, improved system efficiency, and equitable cost containment should also be central goals of health reform. While there are many excellent components of the Clinton Administration plan the area of greatest concern to the respiratory community is the utilization of Medicare coverage as a basis for the benefits package.

The AARC supports the Administration's efforts to address the needs of those Americans who are in need of home care and long-term care (LTC) services. There is a growing recognition, supported by extensive cost information and data, that many individuals' health needs can be provided in care sites other than the hospital. For example, over the last few years there has been phenomenal growth in the number of sub-acute care facilities. This type of facility provides the level of care and services that are more intense than the nursing home, yet less complex than an acute care hospital. Ventilator-dependent patients, who require a medically-complex mechanical respirator or ventilator to help them breathe increasingly are being transferred into sub-acute care facilities. These sites can provide an intensive rehabilitative climate, which, for some individuals, can mean weaning from their dependency on a ventilator. For others less fortunate, it means their lives can be made as comfortable as possible in a supportive health environment. While the numbers of ventilator patients in LTC facilities or at home are growing, you will find that few are Medicare patients. Health insurance for these individuals is most often provided by private insurance or, in some cases, by specialized state Medicaid benefits. Private insurance companies recognize the benefits of caring for these ventilator patients in the less costly and more appropriate care setting, yet Medicare does not. That is why Medicare, non-hospitalized LTC patients are few and far between.

The Administration publicly supports and endorses the goal of promoting managed care and site-neutral benefits. In fact, the Administration plan specifically calls for the inclusion of a standard health maintenance organization (HMO) type of accountable health plan to be made available as a consumer option. A guiding tenet of HMO-structured care has been to provide the most appropriate level of care and services in the most appropriate care site. That is not always the acute care hospital. The Administration, though, is at odds with its own policy when it comes to respiratory care services. Without altering the way Medicare covers respiratory therapy or without an explicit clarification in the benefits package which would permit respiratory care services to be provided in the most appropriate site, non-hospital respiratory patients will be unable to benefit from the goals of Mr. Clinton's health reform initiative. They will remain tied to the acute care hospital, whether or not their medical condition warrants this level of care. The following information illustrates the current problems facing respiratory patients on Medicare. If changes are not made, similar problems will be faced by all respiratory-disabled patients regardless of age.

The following are examples of successful medical outcomes aided by respiratory interventions. Neither of the two individuals are Medicare beneficiaries. Jared Landry, age 10, from Thompson, Connecticut, was born with muscular dystrophy complicated by under-developed lungs. He required hospital ventilatory support 24 hours a day for the first three years of his life. Through intensive respiratory care, Jared's medical condition improved to a level where he only requires ventilatory support at night while sleeping. Jared has been home and with his family since 1986. He is fully integrated into the fifth grade in the public school system.

Another example is Mr. Billy Sutton, 57 years old from Jackson, Georgia. His lung disease deteriorated to the point where he required a ventilator to live. Instead of remaining hospital-bound, Mr. Sutton, with the help of his caregiver team, worked

toward the goal of returning to his home, which is where is today. He regularly participates in church and civic activities.

These two stories are typical of the thousands of Americans who are respiratory-disabled and in need of long-term care services. By adopting Medicare respiratory policy unchanged, these individuals will no longer be able to receive their cost-effective, life-enhancing care outside of the hospital. While these stories are anecdotal the data and information on both the barriers to, and the cost-effectiveness of non-hospital respiratory care services are extensive.

A recent Gallup survey calculated the cost of providing hospital care to chronic ventilator patients. The survey estimates that on any given day, there is a census of over 11,500 chronic ventilator patients in U.S. hospitals. At a cost of about $789 per patient per day, this totals over $9 million a day for care of chronic ventilator patients. Once a patient is pronounced medically stable and able to be discharged, it takes an average of 35 days to place them in an alternate care site such as the home or skilled nursing facility. That translates to an excess of $27,000 per patient in unnecessary hospital costs.

An additional barrier to appropriate respiratory long-term care service is found in the antiquated Medicare restriction that permits only those respiratory care practitioners who are employed by a transferring hospital to provide covered respiratory therapy services to Medicare skilled nursing facility patients. This provision prohibits nursing homes from negotiating with other health care staffing entities to provide qualified therapists. This lack of access to other qualified RCPs hampers the ability of the nursing home from contracting for the most affordable and cost-effective therapy services.

Every study that looks at the cost effectiveness and appropriateness of respiratory care services outside of the hospital has indicated substantial cost savings. For example, a 1991 Lewin/ICF analysis estimated that treating cardiopulmonary disease patients (COPD) at home rather than the hospital would save the health care system $48 million per year.

In the early 1980s, the Department of Health, Education and Welfare (HEW) sponsored a study that tracked 775 COPD patients, who received home respiratory services from a qualified respiratory therapist. The results of the study showed that hospital re-admissions for these patients were reduced from 1.28 per year to .55 per year. Furthermore, for the patients who were re-admitted to the hospital, the length of stay was decreased from 18.2 days to 5.7 days. The savings estimated for these 775 patients totaled $1,097,250 (1980 dollars).

A 1982 conference on home care alternatives, headed by former Surgeon General C. Everett Koop, resulted in the initiation of three pilot home care studies. One pilot program in Maryland provided home care to respirator-dependent children and compared hospital costs and home care costs. The savings provided by home respiratory care were more than $15,000 per patient per month. Over the 34-month period of the pilot program, $3.1 million in savings were realized due to the availability of home care for these children.

A consensus conference on respiratory home oxygen care, cosponsored by the Health Care Financing Administration (HCFA) and the Food and Drug Administration (FDA), and attended by consumers and providers, recommended that when necessary, home-bound respiratory patients should receive their care from respiratory professionals.

The AARC recognizes that there is a problem with waste and overutilization of services outside of the hospital. Yet, the health reform proposal is basing cost control on limitations of benefits, rather than limitations on utilization of health care resources. Utilization control is an area where respiratory care practitioners excel. In the hospital, it is accepted practice for the respiratory care practitioner to evaluate and assess the patient's response to therapy. This leads to timely modification of the course of treatment for a patient, which is beneficial to the health of the patient, and saves money through the wise use of health care resources. This role of assessment and utilization monitor is a role the respiratory care practitioner should be playing in the alternate care site as well. Our profession has well-researched and accepted clinical practice guidelines that spell out appropriate levels of respiratory care. In the hospital, the use of therapist-driven protocols that allow the respiratory care professional latitude in monitoring patient response to therapy has been shown to be cost effective.

These kinds of utilization controls, coupled with the fact that every study ever done on home respiratory care services documents cost savings and enhanced quality of life for patients, leads us to strongly urge the inclusion of respiratory care services in all appropriate non-hospital settings.

Please do not perpetuate the medical coverage of the 1960s and limit Americans in need of respiratory care to the most expensive care sites, such as the hospital,

in lieu of other cost-effective alternatives such as the home, sub-acute care, or nursing home care.

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STATEMENT OF AMERICAN NATURAL SODA ASH CORPORATION

This statement is submitted on behalf of the American Natural Soda Ash Corporation ("ANSAC") and responds to the Committee on Finance request for comments relevant to the Uruguay Round of Multilateral Trade Negotiations as they may affect specific U.S. commercial interests. ANSAC is the sole authorized exporter of soda ash.* These comments express the company's concerns over the outcome of the market access negotiations relevant to the elimination and/or significant reduction of foreign government tariffs facing U.S. soda ash exports.

In summary, ANSAC is extremely concerned that the Agreement will not provide any new market access opportunities or, at the most, only minimal access well after the turn of the century.

**ANSAC continues to vigorously endorse soda ash as a zero-for-zero candidate in the market access negotiations.** While the Chemical Harmonization Proposal would eventually reduce soda ash tariffs to 5.5 percent ad valorem, the Proposal also permits countries to negotiate the elimination of tariffs on specific products. Increased market access opportunities for this highly competitive U.S. industry can only be realized if U.S. officials bilaterally negotiate tariff eliminations or deeper and faster tariff reductions than those provided for in the Harmonization formulae. Further, GATT bindings to zero or, at the minimum, at Harmonized tariff levels, are critical, particularly in Brazil, Korea, South Africa, Indonesia and Thailand.

BACKGROUND

ANSAC is a Webb-Pomerene Association wholly-owned by the six U.S. producers of soda ash, namely, General Chemical Corporation; FMC Corporation; North American Chemical Corp.; Rhone-Poulenc Basic Chemicals Co.; Solvay Minerals Corporation; and Texasgulf Chemical Company. These companies produce 100 percent U.S. soda ash. Generally, soda ash accounts for one half of the cost of glass production.

Soda ash (disodium carbonate) is the principal raw material for making glass. Mixing eight parts sand to one part soda ash and heating it 2800 degrees yields molten glass which can be formed into any common application. The United States is blessed with a unique natural deposit of a raw material (trona) for soda ash located in Green River, Wyoming, from which this country could supply world demand for 1300 years. Most other countries produce soda ash through a synthetic process at costs many times higher and with major environmental pollution.

ANSAC has committed nearly seven years vigorously pursuing its goal of opening-up foreign markets in the context of the multilateral market access negotiations. The company's priority markets and the precise goals in each market are summarized in the attached chart.

NEGOTIATING PRIORITIES

A. Zero-for-Zero Tariff Negotiating Initiative.

**ANSAC fully supports both the USTR and the Chemical ISAC's designation of soda ash as a zero-for-zero negotiation priority and continues to press that this be achieved in the Uruguay Round market access negotiations.**

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* ANSAC does not export to the European Community. Such exports are made by the individual member companies.

As former Trade Representative Carla Hills said on October 29, 1990, the zero-for-zero initiative would "...promote the most efficient production patterns worldwide and strengthen competitiveness of the industries involved." Soda ash is a textbook candidate for zero-for-zero. U.S. soda ash exports are already the most competitive in the world. But these exports will not increase in the face of high tariffs. Reciprocal duty elimination will greatly contribute to the U.S. industry's ability to better compete abroad and will result in the increase of nearly $1 billion in additional U.S. exports and thousands of new U.S. jobs.

While ANSAC continues to urge U.S. negotiators to seek an across-the-board, zero-for-zero tariff elimination, GATT bindings to zero are essential in the following countries:

| ZERO-FOR-ZERO MUST HAVE COUNTRIES | | | |
|---|---|---|---|
| Country | HTS No. | Current Duty Rate | Estimated Increase in U.S. Exports |
| 1. Brazil | 2836.20.00.00 | 10% | $46 Million |
| 2. Korea | 2836.20.00.00 | 9% | $36 Million |
| 3. Japan | 2836.20.20.00 | 3.9% | $61 million |

B. The Chemical Harmonization Proposal.

While the "Chemical Harmonization Proposal" may offer significant opportunities for reducing tariffs facing some U.S. chemical exports, ANSAC's interests are far better served by a more targeted, line-by-line, bilateral approach. This is particularly the case in Brazil and South Africa where immediate duty elimination and zero GATT-bindings are a high priority in the Uruguay Round.

ANSAC has four major concerns over the Harmonization Proposal that must be fully addressed in the Uruguay Round Agreement.

The first is the issue of what base period will be used for the harmonization tariff levels, an issue which is still unresolved. U.S. negotiators should insist that the period be based on applied tariff levels existing in 1993. This is extremely important to ANSAC in view of the fact that many of ANSAC's priority country markets have "unilaterally" reduced tariffs on soda ash since 1986. For example, if the base period is 1990 rather than 1993, an actual reduction in the Brazilian duty from current levels (10 percent) would not take place until 2002. The Korean tariff (currently 9 percent) would not be reduced until 2001. This result would be unacceptable to ANSAC and serves as an illustration in support of ANSAC's request for duty elimination or, at the minimum, deeper and more immediate tariff cuts on soda ash as permitted under the Harmonization Proposal.

A second and related issue involves the precise month for which the base period is calculated. This is a somewhat unique issue relevant to ANSAC's longstanding effort to eliminate Brazil's soda ash tariff.

More specifically, the Brazilian tariff was reduced from 20 to 15 percent ad valorem effective October 1, 1992. If the base period is January 1, 1992 rather than December 31, 1992 the outcome would affect the level of market access. Obviously, this is an important distinction for ANSAC since the lower the applied tariff rate that is used the sooner ANSAC will achieve a tariff reduction and therefore be able to increase its exports.

Third is the issue of GATT bindings. ANSAC's understanding is that each country adopting the Harmonization Proposal will be required to GATT-bind its tariffs at the harmonized rate which, in the case of soda ash, is scheduled to be 5.5 percent for each country adopting the proposal. In Brazil, as well as Indonesia, South Africa, Thailand and the Philippines, ANSAC is concerned that either current soda ash producers or prospective producers may seek to increase their country's applied tariff rates. Consequently, GATT bindings to zero or, at the minimum, at Harmonized levels are vital to ANSAC. Similarly, ANSAC requires assurances that GATT Signatories will not increase their tariffs above current levels during the tariff reduction period set forth in the harmonization schedule.

Last is the issue of country coverage. It is key to ANSAC's ability to increase U.S. soda ash exports that (in order of priority): (1) Brazil, (2) Korea, (3) India, (4) Philippines, (5) Thailand, and (6) South Africa adopt the Harmonization Proposal and that bilateral negotiations result in tariff elimination or significantly reduced tariff levels than those set forth in the Harmonization Proposal. In the case of India, the 85 percent applied tariff and 112.75 percent net effective import fee act as an embargo to U.S. soda ash exports, resulting in the annual loss of $20 million in exports to India.

Overall, ANSAC estimates that if the GATT Signatories were to adopt the zero-for-zero initiative, there would be an increase of nearly $1 billion in U.S. soda ash exports and an increase of thousands of jobs in Wyoming, Oregon, California and elsewhere.

We respectfully request that this statement be included in the printed record of the hearing.

**ANSAC'S URUGUAY ROUND MARKET ACCESS PRIORITIES**

| ZERO-FOR-ZERO MUST HAVE COUNTRIES | | |
|---|---|---|
| Country | HTS No. | Current Duty Rate |
| 1. Brazil | 2836.20.00.00 | 10% |
| 2. Korea | 2836.20.00.00 | 9% |
| 3. Japan | 2836.20.20.00 | 3.9% |
| 4. South Africa | 2836.20 | 10% |

IF NO ZERO-FOR-ZERO
CHEMICAL HARMONISATION TOP PRIORITIES

| Country (in order of priority) | Current Duty Rate | ANSAC Request |
|---|---|---|
| 1. Brazil | 10% ad valorem (effective July 1, 1993) | Duty elimination and GATT binding to zero or alternatively to 10% (GATT binding is of critical importance) |
| 2. Korea | 9% | Immediate to zero and GATT bound; Harmonization Proposal will not provide additional, minimum access until 2001; Korea misclassified soda ash to keep tariff high when Trade Action Plan implemented in 1989. |
| 3. India | 85% ad valorem 112% net effective import fee | India adoption of Harmonization Proposal or alternatively "front end" bilateral reduction of duty to 15% and GATT binding |
| 4. Indonesia | 5% | Priority is GATT binding to 5% in view of threat of local production and increase of duty to 30% |
| 5. South Africa | 10% | Priority is immediate tariff elimination and GATT binding to zero |
| 6. Thailand | 13% | Immediate tariff elimination; priority is GATT binding to zero or Harmonization rate, 5.5% |
| 7. Philippines | 10% | Immediate tariff elimination; priority is GATT binding to zero or Harmonization rate, 5.5% |

STATEMENT OF THE AMERICAN STATE OF THE ART PROSTHETIC ASSOCIATION

The American State of the Art Prosthetic Association (ASOTAPA) is a national non-profit organization comprised of prosthetic and orthotic practitioners who design, fit, and fabricate artificial limbs (prostheses) and orthopedic braces (orthoses) for this nation's two million amputees and millions of people with physical disabilities. Although ASOTAPA is primarily a provider organization, we are very supportive of the prosthetic and orthotic consumers' health care reform agenda represented by the Amputee Coalition of America which has also submitted written testimony to this Committee.

Quality prosthetic and orthotic care can virtually neutralize the disabling effects of physical impairments and maximize an individual's ability to function at the job, in school, and in the home. The cost effectiveness of good prosthetic and orthotic care cannot be understated. A recent study conducted by the University of Miami School of Medicine found that a $6,000 investment in a functional, modern artificial limb saves an estimated $430,000 over a five year period in medical expenses due to other debilitating complications, lost productivity, and government income maintenance, to say nothing of the quality of life. In a very real way, modern prosthetic and orthotic care can mean the difference between a life of dependency and independency.

The American State of the Art Prosthetic Association strongly supports health care reform, particularly those reforms that will increase access to quality prosthetic and orthotic devices for those who need them. An overarching concern of the ASOTAPA, however, is that the quality and technological superiority of recent generations of artificial limbs and orthopaedic braces are not placed in jeopardy as this nation attempts to reform its health care system.

I. THE SPECIALIZED NATURE OF PROSTHETICS AND ORTHOTICS:

Prosthetics and orthotics are often inappropriately considered under the broader category of durable medical equipment (DME). Unfortunately, this has resulted in widespread confusion and limited understanding of this small but critical component of rehabilitation in our health care delivery system. Quality prosthetic and orthotic care is as much a professional service as it is a device that results from this service. All prostheses and most orthoses are custom designed and fit to the particular medical and functional needs of the patient. These highly specialized services combine the disciplines of medicine and engineering like almost no other area of health care. The successful custom replication and restoration of functional human body parts, which are in a multitude of shapes, sizes, and complex contours, is fundamentally different from most types of durable medical equipment and should be treated separately from DME in legislation and in regulation.

In addition, significant variations exist in the delivery of quality prosthetic and orthotic services, primarily due to the explosion in technology over the past decade. The prosthetic and orthotic profession has a defined body of clinical and technical knowledge and a core of 2,800 specially credentialed practitioners with formalized education provided by well-established baccalaureate and post-baccalaureate education programs offered at eight major American universities. These factors justify specialized treatment for prosthetic and orthotic services in health care reform legislation. Before we explore these issues in the context of President Clinton's health care reform proposal, however, let us state our positions on several key aspects of health care reform.

II. COMPREHENSIVE REFORM MUST INCLUDE UNIVERSAL COVERAGE:

ASOTAPA believes that this nation has a historic opportunity to comprehensively reform our health care system that must not be missed. Too many of our fellow citizens are unable to access the quality health care they need when they need it most. We must not let partisanship or pride in authorship of particular proposals impede the goal of better health care for all Americans. ASOTAPA believes that aspects of several proposals have great merit, but is committed to the goal of universal coverage. Health care proposals that do not contemplate universal coverage of a standard package of benefits within the next few years simply do not go far enough in terms of reform. We must build on our current system with an employer mandate, with appropriate subsidies for small businesses and lower-income individuals, and significantly alter current insurance practices which impede access and quality of health care services. We also strongly support annual limits on out-of-pocket medical expenses.

We applaud the Clinton Administration for its enormous effort and commitment to comprehensive national health care reform. We also applaud the Members and

staff of this Subcommittee for their health care reform efforts and look forward to working with you in the coming year to pass legislation that fixes the problems but retains best aspects of our health care delivery system.

III. ORTHOTIC AND PROSTHETIC PRIORITIES UNDER THE CLINTON PLAN:

ASOTAPA believes that the Clinton Plan, as currently understood, represents the most comprehensive and viable approach to accomplishing the goals of universal coverage, increased access and enhanced quality of health care services. Overall, the Clinton Plan has the potential to greatly enhance health care for people with mental and physical disabilities. The prosthetic and orthotic community, however, has several areas of concern in the two general areas of coverage and quality that we would like to see addressed in the Congress.

*A. Coverage*

*Maintaining a Comprehensive Benefit Package.* A comprehensive standard benefit package is critical to the success of a reformed health care system under the Clinton Plan. As pressure mounts in Congress to limit the cost of health care reform, ASOTAPA urges the Members of this Subcommittee to resist efforts to limit the nature, scope, and duration of the Clinton Plan's standard benefit package. Prosthetics and orthotics are currently included as standard benefits in the Administration's proposal.

According to the legislation, "leg, arm, back and neck braces, artificial legs, arms and eyes" including "replacements if required due to a change in physical condition" are included as standard benefits. Training for the use of prostheses and orthoses is also included which recognizes one important aspect of the service component of prosthetic and orthotic care. Additionally, the Clinton Plan includes the standard benefit package "accessories and supplies used directly with a prosthetic device to achieve the therapeutic benefits of the prosthesis or to assure the proper functioning of the device." We strongly support this language and urge an explicit extension to orthotic accessories and supplies.

*Replacements of Prostheses and Orthoses.* Many private insurance policies currently do not cover replacements of prostheses and orthoses. This results in the absurd situation where an amputee, for instance, is expected to function on one artificial limb per lifetime, with no regard to age, growth, changes in medical or functional needs, simple wear and tear or significant advancements in technology. The Clinton Plan effectively eliminates this unscrupulous practice whenever a change in a person's physical condition exists. ASOTAPA believes that prosthetic and orthotic replacements should also be covered as a standard benefit due to normal wear and tear and if advancements in technology have the strong potential to improve prosthetic and orthotic outcomes.

*B. Quality*

*Quality Care Under Capitated Health Plans.* Under the Clinton Plan, every employer would be required to offer three different types of health plans to their employees; an HMO-type plan, a PPO-type plan, and a fee-for-service plan, with varying levels of premiums, co-payments, and deductibles. There would be an open enrollment period each year for consumers to switch from one plan to another if they are not satisfied with the level of care. This would afford many Americans with greater choice than they now have to choose the type of plan that suits their needs. ASOTAPA is very concerned, however, that the Clinton Plan's heavy reliance on managed care will result in compromised quality of prosthetic and orthotic care. Because the health insurance industry is heading toward greater use of managed care on its own account, the health care reform debate is an excellent opportunity to establish industry standards that will both hold down costs and preserve the quality of health care in managed care arrangements.

Simply stated, capitated health care delivery systems create great incentives to underserve participants in the plan, particularly individuals needing specialized or expensive health care services. Presumably, a risk adjustment mechanism will attempt to compensate health plans for high-cost users of care. If this risk adjustment does not adequately reflect and account for the true costs of care for specialized or costly services, health plans will have an incentive to develop a poor reputation for servicing the needs of these populations, so as not to attract additional participants requiring these services. It is critical that any prospective risk adjustment is set at levels that adequately compensate health plans for the true costs of specialized services to all participants in a plan, but particularly to individuals requiring prosthetic and orthotic devices.

*Selection of Qualified Orthotic and Prosthetic Practitioners.* An alarming trend in managed care is that health networks are contracting with one or two prosthetic

and orthotic providers in a geographical region in order to achieve efficiency and bulk purchasing power. This often disrupts long-standing patient-practitioner relationships and does not adequately recognize the specialized nature of prosthetic and orthotic services. A decrease in quality care and patient satisfaction is often the result. The Clinton Plan currently preempts State laws that prohibit health plans from establishing "single source providers" such as pharmacies and providers of "medical equipment." Accountable Health Plans should not be allowed to contract with single source providers in the area of prosthetics and orthotics. In order to ensure quality, specialized prosthetic and orthotic care in capitated health care plans, each plan should be required to offer a wide selection of qualified prosthetists and orthotists who are certified to practice in accredited facilities. Because of the specialized nature of these services and to protect health care consumers, the credentialing body for these functions must be the American Board for Certification in Orthotics and Prosthetics.

All health plans should be required to offer a "point of service" option to plan participants and cover prosthetic and orthotic services from qualified providers outside of a plan's geographical area, especially if the practitioner is willing to provide the service at an equivalent fee of a provider within the plan's geographic area. Even if the fee for an out-of-network provider is not equivalent to the network provider, prosthetic and orthotic consumers should be able to access providers outside of their network if it is medically and functionally necessary to do so, without financial penalty. A prosthetic or orthotic consumer should not be required to exhaust every provider within the network before being able to access care outside of the network. This practice is wasteful and costly. This treatment for prosthetic and orthotic providers is justified by the specialized nature and individuality of prosthetic and orthotic services, the expertise of which often lies in different states and regions of the country.

*Competitive Bidding Should Not Apply to Prosthetics and Orthotics.* The Clinton Plan does not subject prosthetics and orthotics to competitive bidding in the Medicare program, but allows the Secretary of HHS to determine which services under Medicare will be competitively bid in the future. Due to the highly specialized and customized nature of prosthetic and orthotic services, competitive bidding for these services would directly and immediately result in a decrease in quality. Standard items and off-the-shelf devices lend themselves more readily to competitive bidding because providers can compete based on efficiency of their business operation. This is not the case with customized devices. Lesser quality services and lesser functional devices will be the inevitable and immediate result of competitive bidding in the provision of prosthetics and orthotics, whether it be in the Medicare program or in private health plans.

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STATEMENT OF THE AMPUTEE COALITION OF AMERICA

Distinguished Chairman and Members of the Committee: The Amputee Coalition of America (ACA), is a national non-profit coalition of amputee support groups and related organizations representing the interests of over 10,000 consumer members. The ACA serves as the national voice for over 2 million amputees and millions of people with physical disabilities. Most of our members utilize artificial limbs (protheses) and orthopaedic braces (orthoses) in order to maintain mobility, employment, and a high quality of life.

Modern artificial limbs allow amputees to perform employment, fitness, and recreational activities in ways they only dreamed about just a few short years ago. The Amputee Coalition of America strongly supports health care reform, particularly those reforms that will increase access to quality prosthetic and orthotic devices for those who need them. An overarching concern of the ACA, however, is that the quality and technological superiority of recent generations of artificial limbs and orthopaedic braces are not placed in jeopardy as this nation attempts to reform its health care system.

The cost effectiveness of good prosthetic and orthotic management cannot be understated. Quality prosthetic and orthotic care can virtually neutralize the disabling effects of physical impairments and maximize an individual's ability to function at the job, in school, and in the home. A recent study conducted by the University of Miami School of Medicine found that a $6,000 investment in a functional, modern artificial limb saves an estimated $430,000 over a five year period in medical expenses due to other debilitating complications, lost productivity, and government income maintenance, to say nothing of the quality of life. In a very real way, modern prosthetic and orthotic care can mean the difference between a life of dependency and independency.

I. THE SPECIALIZED NATURE OF PROSTHETICS AND ORTHOTICS:

Prosthetics and orthotics are often inappropriately considered under the broader category of durable medical equipment (DME). Unfortunately, this has resulted in widespread confusion and limited understanding of this small but critical component of rehabilitation in our health care delivery system. Quality prosthetic and orthotic care is as much a professional service as it is a device that results from this service. All prostheses and most orthoses are custom designed and fit to the particular medical and functional needs of the patient. These highly specialized services combine the disciplines of medicine and engineering like almost no other area of health care. The successful custom replication and restoration of functional human body parts, which are in a multitude of shapes, sizes, and complex contours, is fundamentally different from most types of durable medical equipment and should be treated separately from DME in legislation and in regulation.

In addition, significant variations exist in the delivery of quality prosthetic and orthotic services, primarily due to the explosion in technology over the past decade. The prosthetic and orthotic profession has a defined body of clinical and technical knowledge and a core of 2,800 specially credentialed practitioners with formalized education provided by well-established baccalaureate and post-baccalaureate education programs offered at eight major American universities. All of these factors justify specialized treatment for prosthetic and orthotic services in health care reform legislation. Before we explore prosthetic and orthotic issues in the context of President Clinton's health care reform proposal, however, let us state our positions on several key aspects of health system reform.

II. UNIVERSAL COVERAGE IS THE KEY TO REFORM:

The Amputee Coalition of America strongly favors health care reform that provides universal coverage of comprehensive benefits. As President Clinton has stated, universal coverage and comprehensive benefits should not be negotiable issues throughout the health care reform debate. ACA believes that this nation has a historic opportunity to reform our health care system that must not be missed. Too many of our fellow citizens are unable to access the quality health care they need when they need it most. This is particularly true in the case of people with disabilities who have been systematically discriminated against in the provision of health insurance throughout this century. The ACA believes, however, that universal coverage, not simply universal access, is a key component of successful health care reform. Health care proposals that do not contemplate universal coverage of a comprehensive package of benefits within the next few years simply do not go far enough in terms of reform.

III. REFORMING INEQUITABLE INSURANCE PRACTICES:

We must build on our current health insurance system with an employer mandate, with appropriate subsidies for small businesses and low income individuals, and significantly alter the current insurance practices which impede access to quality health care services. Pre-existing condition exclusions have long been the nemesis of people with disabilities, particularly users of orthotic and prosthetic devices. These inequitable exclusions must be eliminated in a reformed health care system. Community rating with appropriate risk adjustments must replace the inequities of experience-based premium rating. This method of insurance premium rating has long been used to exclude people with disabilities from sufficient health insurance coverage. Health insurers must no longer be able to "cherry pick" the best health customers with the lowest health care risks, excluding frequent users of health care from coverage. Risk adjustments must be properly and accurately determined in order to appropriately compensate health care providers and insurance companies for additional costs associated with frequent users of health care services. Calculating an accurate risk adjustment to reflect the true costs of specialized care is critical to the success of health care reform.

The ACA strongly supports the Clinton Plan's annual out-of-pocket spending limit of $1,500 per individual and $3,000 per family. This goes a long way toward the provision of health security for all Americans. The ACA is concerned, however, that these spending levels may be out of reach of many lower-income Americans. The ACA would prefer that these annual spending limits be adjusted to a person's level of income.

IV. ORTHOTIC AND PROSTHETIC PRIORITIES UNDER THE CLINTON PLAN:

The ACA believes that the Clinton Plan represents the most comprehensive and viable approach to accomplishing the goals of universal coverage, increased access,

and enhanced quality of health care services. Overall, the Clinton Plan has the potential to greatly enhance health care for people with disabilities. The prosthetic and orthotic community, however, has several areas of concern in the two general areas of coverage and quality that we would like to see addressed in the Congress.

*A. Maintaining a Comprehensive Benefit Package.*

A comprehensive standard benefit package is critical to the success of a reformed health care system under the Clinton Plan. As pressure mounts in Congress to limit the cost of health care reform, ACA urges the Members of this Subcommittee to resist efforts to limit the nature, scope, and duration of the Clinton Plan's standard benefit package. Prosthetics and orthotics are currently included as standard benefits in the Clinton Plan. According to the legislation, "leg, arm, back and neck braces, artificial legs, arms and eyes" including "replacements if required due to a change in physical condition" are included as standard benefits. Training for the use of prostheses and orthoses is also included which recognizes one important aspect of the service component of prosthetic and orthotic care. Additionally, the Clinton Plan includes in the standard benefit package "accessories and supplies used directly with a prosthetic device to achieve the therapeutic benefits of the prosthesis or to assure the proper functioning of the device." We strongly support this language and urge an explicit extension to orthotic accessories and supplies.

*B. Replacements of Prostheses and Orthoses.*

Many private insurance policies currently do not cover replacements of prostheses and orthoses. This results in the absurd situation where an amputee, for instance, is expected to function on one artificial limb per lifetime, with no regard to age, growth, changes in medical or functional needs, simple wear and tear or significant advancements in technology. The Clinton legislation effectively eliminates this unscrupulous practice whenever a change in a person's physical condition exists. The ACA believes that prosthetic and orthotic replacements should also be covered as a standard benefit due to normal wear and tear and if advancements in technology have the potential to significantly improve prosthetic and orthotic outcomes.

*C. Quality Care Under Capitated Health Plans.*

Under the Clinton Plan, every employer would be required to offer three different types of health plans to their employees; an HMO-type plan, a PPO-type plan, and a fee-for-service plan, with varying levels of premiums, co-payments, and deductibles. There would be an open enrollment period each year for consumers to switch from one plan to another if they are not satisfied with the level of care. This would afford many Americans with greater choice than they now have to choose the type of plan that suits their needs. ACA is very concerned, however, that the Clinton Plan's heavy reliance on managed care will result in compromised quality of prosthetic and orthotic care. Because the health insurance industry is heading toward greater use of managed care on its own account, the health care reform debate is an excellent opportunity to establish industry standards that will both hold down costs and preserve the quality of health care in managed care arrangements.

Simply stated, capitated health care delivery systems create great incentives to underserve participants in the plan, particularly individuals needing specialized or expensive health care services. Presumably, a risk adjustment mechanism will attempt to compensate health plans for high-cost users of care. If this risk adjustment does not adequately reflect and account for the true costs of care for specialized or costly services, health plans will have an incentive to develop a poor reputation for servicing the needs of these populations, so as not to attract additional participants requiring these services. It is critical that any prospective risk adjustment is set at levels that adequately compensate health plans for the true costs of specialized services to all participants in a plan, but particularly to individuals requiring prosthetic and orthotic services.

*D. Competitive Bidding Should Not Apply to Prosthetics and Orthotics.*

The Clinton Plan does not subject prosthetics and orthotics to competitive bidding in the Medicare program, but allows the Secretary of HHS to determine which services under Medicare will be competitively bid in the future. Due to the highly specialized and customized nature of prosthetic and orthotic services, competitive bidding for these services would directly and immediately result in a decrease in quality. Standard items and off-the-shelf devices lend themselves more readily to competitive bidding because providers can compete based on efficiency of their business operation. This is not the case with customized devices. Lesser quality services and lesser functional devices will be the inevitable and immediate result of competitive bidding in the provision of prosthetics and orthotics, whether it be in the Medicare program or in private health plans.

*E. Selection of Qualified Orthotic and Prosthetic Practitioners.*

An alarming trend in managed care is that health networks are contracting with one or two prosthetic and orthotic providers in a geographical region in order to achieve efficiency and bulk purchasing power. This often disrupts long-standing patient-practitioner relationships and does not adequately recognize the specialized nature of prosthetic and orthotic services. A decrease in quality care and patient satisfaction is often the result. The Clinton Plan currently preempts State laws that prohibit health plans from establishing "single source providers" such as pharmacies and providers of "medical equipment." Accountable Health Plans should not be allowed to contract with single source providers in the area of prosthetics and orthotics. In order to ensure quality, specialized prosthetic and orthotic care in capitated health care plans, each plan should be required to offer a wide selection of qualified prosthetists and orthotists who are certified to practice in accredited facilities. Because of the specialized nature of these services and to protect health care consumers, the credentialing body for these functions must be the American Board for Certification in Orthotics and Prosthetics.

All health plans should be required to offer a "point of service" option to plan participants and cover prosthetic and orthotic services from qualified providers outside of a plan's geographical area. This is especially true if the practitioner is willing to provide the service at an equivalent fee of a provider within the plan's geographic area. Even if the fee for an out-of-network provider is not equivalent to the network provider, prosthetic and orthotic consumers should be able to access providers outside of their network if it is medically and functionally necessary to do so, without financial penalty. A prosthetic or orthotic consumer should not be required to exhaust every provider within the network before being able to access care outside of the network. This practice is wasteful and costly. This special treatment for prosthetic and orthotic providers is justified by the specialized nature and individuality of prosthetic and orthotic services, the expertise of which often lies in different states and regions of the country.

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# CAL/ACEP

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
STATE CHAPTER OF CALIFORNIA, INC.



August 10, 1993

The Honorable Daniel Patrick Moynihan
Attn: Jack Fowle
464 Senate Russell Office Building
Washington, D.C. 20510-3201

Dear Senator Moynihan:

I am writing this letter on behalf of the almost 2100 Emergency Physicians in California represented by our organization, CAL/ACEP.

We recently became aware of a new threat to Emergency Physicians as well as other trauma care providers - The Black Talon Bullet.

You may have already received a sample of this new hollow point "horror". Imagine sticking your fingers into the wound made by this bullet as it expands and forms razor sharp projections. Cuts will expose us to the blood-borne infections carried by the shooting victim, including hepatitis and the HIV virus.

We willingly provide 24-hour a day care to all who seek our services, without regard to ability to pay. But with such technological advances, Emergency Physicians become victims of our increasingly violent society. In addition, surgeons that provide definitive trauma care for these shooting victims are scarce, and will become unavailable if exposed to such hazards.

We request this bullet not be made available to the public. In addition there should be a federal review process for all new ammunition, perhaps consisting of an agency composed of health care providers, consumers, law enforcement officials and appropriate federal officials.

Thank you for your time. If you require further information, please contact me at the above number.

Sincerely,

Frederick T. Dennis, M.D., FACEP
President

the
children's
memorial
hospital

2300 children's plaza
chicago, illinois 60614
312 880-4000

August 20, 1993

Senator Daniel Patrick Moynihan
Attention: Jack Fowle
464 Senate Russell Office Building
Washington, D.C. 20510-3201

Dear Mr. Moynihan:

We would like to echo others' concern about a grave threat to trauma surgeons, emergency physicians, and emergency medical services personnel: The Black Talon Bullet.

This new, hollow-point bullet constitutes a threat not only to its victims but also to the many professionals who assist in taking care of these unfortunate victims. After explosion, it has sharp projections that maximize tissue damage and endanger treating physicians. I feel strongly that this bullet should not be available to the general public.

To prevent other products such as this from entering the marketplace, a federal commission should review all new ammunition intended for public use. This commission should be composed of consumers, health professionals, law enforcement officials, and federal agency officials.

Please give this grave situation your immediate consideration.

Sincerely,

Katherine Kaufer Christoffel

Katherine Kaufer Christoffel, M.D., M.P.H.
Professor, Pediatrics and Community
Health & Preventive Medicine
Northwestern University Medical School
Attending Physician, Division of
General & Emergency Pediatrics
Children's Memorial Hospital

KKC/lrg

THOMAS R. OULOTTA
COUNTY EXECUTIVE

RENA IACONO
COMMISSIONER

COUNTY OF NASSAU
DEPARTMENT OF SENIOR CITIZEN AFFAIRS
400 COUNTY SEAT DRIVE
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516-571-5814

November 17, 1993

Mr. Wayne Hosier
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Hosier:

This is in response to Senator Daniel P. Moynihan's request for written comments concerning President Clinton's Health Plan.

Concerns on behalf of the senior citizens in Nassau County have been addressed by our Legislative Technical Advisory Committee. This committee representing seniors from all walks of Nassau County life, assists in fulfilling the mandated responsibility of our Department as an Area Agency on Aging, under the Older Americans Act of 1965 to advocate on behalf of older persons. All members are 60 years of age or over and many are actively involved in senior clubs, centers, retirees and advocacy organizations. They meet on a continuing basis, consider legislation at all levels of government, and submit recommendations to the legislators representing our County.

The implementation of a new health program is not an easy matter. The debate regarding nationalization of our health care system is turning out to be the most challenging issue ever undertaken by our society. Although difficult, the process to change the health care system must be undertaken and a national policy, enacted. We believe a universal health care plan should include the following benefits: All medically necessary inpatient and outpatient services; mental health services; long-term care services; community based and home health services; hospice care; nursing home services; preventive care; dental and vision care; and prescription drugs. The plan should be financed by a broad based progressive tax on all segments of the population and offer free choice of providers.

Thank you for giving us this opportunity to comment on the Health Plan.

Sincerely,

Rena Iacono
Commissioner

## STATEMENT ON THE JOINT COUNCIL ON ALLERGY AND IMMUNOLOGY

The Joint Council of Allergy and Immunology is a professional, nonprofit organization that is sponsored by the American Academy of Allergy and Immunology and the American College of Allergy and Immunology. We represent over 4,000 clinicians and researchers in allergy and immunology who are working to alleviate the suffering of the 35 million Americans with allergic and immune disorders.

We are pleased to have been given this opportunity to submit written testimony on our views of President Clinton's Health Care Reform Plan. In general, we feel that this plan represents a strong beginning to the needed reform of our health care system. We are very supportive of many aspects of the President's plan.

We support the guarantee of universal access and the prohibition on pre-existing condition exclusions. We are also very pleased with the comprehensiveness of the standard benefit package which bases coverage on medical need without arbitrary numerical limits on coverage.

### ACCESS TO SPECIALTY CARE

We are concerned, however, that the President's proposal would create an economic climate in which managed care may be the only economically viable model for providing care at the expense of fee-for-service medicine. We believe it is important to preserve individual choice and access to specialty care under a reformed health care system.

There are 12 million Americans with asthma. The prevalence of asthma and the death rate due to asthma are both increasing especially among the indigent and inner-city families. Direct medical expenditures due to asthma are estimated at $3.6 billion annually with indirect costs including lost wages accounting for an additional $3 billion. Asthma is the most frequent cause for hospital admissions for chronic illness in children. Scientific studies of asthma care in this country demonstrate that when patients receive necessary and timely care, which includes referral to a specialist when appropriate, there are significant reductions in hospitalizations and emergency room visits as well as other associated costs. It should be noted that the allergist/immunologist focuses on prevention of allergic diseases through education, environmental controls, drugs, and allergy immunotherapy (injections) when necessary, rather than simply managing symptoms.

In two recently published studies, it was clearly demonstrated that those asthmatic patients referred to an allergist/immunologist had fewer lost school and work days, a better quality of life, and in one study, a 50% reduction in emergency room visits. Thus, proper specialty care can actually reduce costs, not to mention increasing the quality of life. We believe this fact has been largely ignored in the current health care reform debate.

This does not mean that there is no role for the primary care physician in treating asthma and allergic disease. We believe one of the goals of health care reform should be the development of practice parameters and clinical guidelines to help primary care physicians effectively diagnose asthma and allergic diseases, and know when to refer a patient for a work-up and treatment by a specialist. We have seen much unnecessary patient suffering because of ineffective treatment and/or delay in necessary referrals to specialists. This has been associated with rising costs as well as increased emergency room visits and hospitalizations.

With this background in mind, we are opposed to any health care delivery model which creates inappropriate barriers to specialty care. We are not opposed to gatekeepers and managed care generally. However, we are concerned that in some cases, patients in managed care systems do not receive appropriate and timely access to specialty care. We would hope that as part of any health care reform package, managed care plans would be required to work with specialties to create effective, efficient systems of referral to decrease unnecessary costs and increase the quality of care. We, as a specialty, would welcome the opportunity to work with the health plans to develop appropriate referral practices for Americans with allergic, immunologic, and asthmatic diseases.

It should be noted that we are extremely concerned about a practice now common among HMOs of rewarding gatekeeper physicians for withholding specialty care by means of direct incentive payments, excessive risk withholds and the like. We believe this type of practice is not in the best interests of patient care and is contrary to the concepts of medicine that we all ascribe to. In this regard, we support the general approach taken by Medicare in its proposed rule limiting risk withhold and other types of incentives in HMOs with Medicare contracts. We believe that any health care reform legislation must regulate this practice. We believe there are ways to curb inappropriate utilization short of financial rewards for not referring and we would be pleased to discuss them further with this Committee or with the Congress.

FINANCING OF HEALTH CARE REFORM

We think it is important that fee-for-service medicine be preserved as a choice. While the Clinton proposal states that fee-for-service delivery systems and freedom of choice are important, we question whether, given the overall structure of the package including premium regulation, budget targets, and strict regulation of health care plans, fee-for-service medicine will be able to survive.

Thus, we are opposed to global budgeting through regulation of premiums and the restrictions on the types of policies that plans can offer. While we recognize the need to control escalating health care costs, we believe the harm that would come from this approach would outweigh any benefits. We believe a better approach is to use market controls to keep the costs of premiums down. Under a managed care system, if plans want to effectively compete they will have to offer low premiums and this will result in limits on payments to providers. We believe that there should be direct negotiation between providers and plans which would result in cost effective therapy.

We also believe that costs can be significantly reduced through the development and implementation of practice parameters and clinical guidelines so that only necessary and effective treatments are paid for and wasteful and inefficient medicine is reduced.

We are also opposed to the aspect of the fee-for-service option that requires providers to negotiate with the alliance for an alliance-wide fee schedule. We question whether negotiating with the alliance will be true negotiation since providers will likely not have any option but to take the fee schedule the alliance adopts. We also believe plans should have more flexibility to offer a variety of different cost-sharing options rather than being limited to only three, as the President's plan would do. We think that fewer restrictions in this area would allow for more innovation on the part of both insurance plans and providers in coming up with cost saving mechanisms without sacrificing quality. Therefore, we believe providers should be allowed to negotiate directly with the plans.

We also believe the limits on balance billing are unwarranted. We would support a means-tested right to balance bill and, at least speaking for our own specialty, do not believe this would be abused.

PHYSICIAN SUPPLY

With respect to the Clinton proposal on the physician work force, we view with alarm the presumption that American medicine will be better off if we only increase the number of primary care physicians and decrease the number of specialists. While we support efforts to increase the number and distribution of primary care physicians, especially in rural and inner city areas, we believe that any reductions in the number of specialists should be undertaken with great caution and only after careful study. We are not opposed to a national approach to work force planning, including limits on the number of residency slots and allocation by specialty. However, we believe the specialties must have substantial input into and control over this process. We are also concerned that the projections as to the number of physicians needed in a given specialty will be based on utilization of specialists in managed care delivery systems and that this may result in inappropriately low allocations of specialty residency slots.

The study by the Graduate Medical Education National Advisory Committee (GMENAC) indicated that there was not and would not be an oversupply of specialists in many areas including allergy and immunology in the foreseeable future. We believe reducing the number of allergy training programs when we are undergoing an increase in the incidence, morbidity and mortality of asthma would be detrimental to the needs of the American people.

TORT REFORM

We are very pleased that the President recognizes the need for tort reform and we are very supportive of his proposals. We fully agree with the need for limits on attorneys' fees, the collateral source offset when computing compensatory damages, allowing for periodic payments of damage awards, the use of practice guidelines as a defense against malpractice, and the affidavit of a medical specialist as a prerequisite to filing a lawsuit.

However, we would like to see reform in this area go further. Specifically, we support a limit of $250,000 on non-economic damages. In addition, we oppose the general use of alternative dispute mechanisms although we would not oppose demonstration projects to determine whether these systems are actually useful.

We specifically oppose the idea of enterprise liability. We believe it will create adversary relationships between the physician and the hospital or insurer and that it will lead to controls on the independent medical judgment of the physician. Physicians should be required to provide care within established guidelines and to justify care that is outside the guidelines. This is, in our view, the best way to protect the patient and the enterprise without limiting physician freedom and judgment.

ANTITRUST REFORM

We were very happy to see that the President's plan includes reform in the antitrust areas. Reform of the antitrust laws and enforcement policies are genuinely needed if physicians are to negotiate on a level playing field with health plans and alliances. We believe reform in this area would be pro-competitive and is essential if physicians are to effectively compete. This is particularly true in our own specialty which is relatively small, and in which mergers frequently result in market power and thus run the risk of antitrust enforcement.

In closing, we want to emphasize that we are very supportive of efforts by the President, the Congress, and this Subcommittee to enact meaningful health reform legislation. We believe it is critical that physicians play an active role in this process which will so greatly affect their profession. Thank you for the opportunity to present our views.


Stephen W. Hargarten, M.D., MPH
Assistant Professor
Vice Chairman

Department of Emergency Medicine

July 16, 1993

Senator Daniel P. Moynihan
464 Senate Russell Office Bldg.
Washington, DC 20510-3201

Dear Senator Moynihan:

We would like to inform you about a grave threat to trauma surgeons, emergency physicians, and emergency medical services personnel: The Black Talon Bullet.

This new hollow point bullet constitutes a threat not only to its victims but also to the many professionals who assist in taking care of these unfortunate victims. Enclosed is a sample of this hollow point bullet before and after explosion with its dangerously sharp projections. We believe its dangers are self-evident. We feel strongly that this bullet should not be available to the general public (see enclosed editorial).

In addition, in order to prevent other products such as this from entering the marketplace, we feel that a federal commission should review all new ammunition intended for public use. This commission should be composed of consumers, health professionals, law enforcement officials, and federal agency officials.

Please give this grave situation your immediate consideration.

Sincerely,

Stephen W. Hargarten, MD, MPH
Assistant Professor
Vice Chairman
Department of Emergency Medicine
Member, Injury Control Committee - ACEP

Edward J. Quebbeman, MD, Ph.D.
Professor of Surgery
ACS Committee on Trauma - Member

Joseph C. Darin, MD
Professor and Chairman
Department of Emergency Medicine

Charles Aprahamian, MD
Professor of Surgery
Chief, Section of Trauma & Emergency Surgery

Jack M. Bergstein, MD
Assistant Professor, Trauma & Emergency Surgery
President, American Trauma Society,
Wisconsin Division

James Wallace, MD, Ph.D.
Assistant Professor, Trauma & Emergency Surgery

SWH/lak

## STATEMENT OF PEPSI-COLA INTERNATIONAL

This written statement responds to the Committee on Finance request for comments relevant to the Uruguay Round of Multilateral Trade Negotiations as they may affect specific U.S. commercial interests.

These comments are submitted on behalf of Pepsi-Cola International and address the company's priorities and concerns relevant to the agricultural and industrial market access negotiations.

Since 1988, Pepsi has worked closely with USTR officials to achieve better market access for the company's exports through the Uruguay Round of multilateral trade negotiations. These efforts have included detailed written submissions requesting the elimination or substantial reduction of tariff and non-tariff trade barriers in 21 priority countries on soft drink concentrate and the raw materials required to produce concentrate. Moreover, Pepsi has urged U.S. negotiators to eliminate the U.S. duty on cola-based soft drink concentrate entering under HTS No. 2106.90.60 and fully supports the "zero-for-zero" agreement reached at the Tokyo Summit to eliminate tariffs on flavor-based concentrate entering under Chapter 33 of the Harmonized Tariff System.

### BACKGROUND SUMMARY

Pepsi-Cola International encompasses more than 700 bottling plants in 155 countries and territories and includes the business of Seven-Up International. Pepsi accounts for approximately 15 percent of all soft drinks sold internationally.

Most international brand soft drinks are distributed under the rights of a franchising system. Pepsi's international brand franchises are owned and operated by local businessmen, who are, in many cases, local nationals. There are no licensing and/or royalty fees charged to franchisees by Pepsi for use of its trademark. In return for using the Pepsi trademark, franchisees purchase concentrate and other raw materials from the company.

In 1988, when Pepsi first began participating in the Uruguay Round, nearly $65 million in Customs duties were paid worldwide by Pepsi alone on exports of soft drink concentrate and the raw materials to manufacture concentrate. Unconscionably high tariffs on soft drink concentrate are not confined to developing countries such as Thailand where the duty is 60 percent ad valorem. In Japan, for example, the 22 percent tariff acts as a major impediment to U.S. exports. Moreover, in many developing countries the inability to obtain import licenses and related restrictions have directly influenced Pepsi's decision whether to establish manufacturing operations abroad.

### EFFECT OF CURRENT MARKET ACCESS NEGOTIATIONS ON PEPSI-COLA INTERNATIONAL

A. Foreign Tariff and Non-Tariff Trade Barriers

Cola-based soft drink concentrate exports fall within the agricultural market access negotiations, under HTS No. 2106.90.60. Other agricultural products of interest to Pepsi include the raw materials required to produce concentrate abroad such as gum arabic (HTS No. 1301.20) and caramel (HTS No. 1702.90).

These exports as they relate to the agricultural provisions of the Dunkel Text would be reduced on a "simple average basis" by 36 percent over 6 years. PCI is extremely concerned that the reductions are based on either bound duty levels or, in the case of unbound duties, on applied rates applicable as of September 1, 1986.

In many instances, a 36 percent reduction on bound rates will mean no additional market access to Pepsi since these bound rates are much higher than the applied rate. Examples of this include Korea where the GATT binding on soft drink concentrate (HTS 2106.90) is 40 percent ad valorem, but the applied rate is 20 percent. A 36 percent tariff reduction by Korea would not result in any new market access opportunities for Pepsi.

Similarly, of the priority countries listed in the attached charts, very few have GATT-bound their tariffs on products of interest to Pepsi. Country examples include Thailand, Turkey, Pakistan, and Egypt. The applied tariff rates in these and other countries of interest to Pepsi as of September 1, 1986 were extremely high. Again, in nearly all cases a 36 percent reduction would be of little, if any, export value to our company.

Therefore, it is vital that the market access agricultural negotiations achieve deeper tariff cuts than those proposed in the Dunkel Text.

Finally, PCI has considerable interest in seeing foreign government tariffs significantly reduced on U.S. exports of plastic preforms required to produce plastic bottles. These intermediate products enter under Chapter 39 of the HTS (HTS No. 3923.30 and 3916.10) and face extraordinarily high tariff barriers in several countries such as Thailand, the Philippines and Hungary. Since these products fall under the Chemical Harmonization Proposal, PCI is urging U.S. negotiations to take whatever steps it can to include these countries in the Harmonization Proposal.

B. U.S. Tariff Elimination

Regarding the elimination or substantial reduction of U.S. tariffs, Pepsi urges U.S. negotiators to immediately eliminate the U.S. duty on soft drink concentrate governing both "flavors" (U.S. HTS 3302.10.10 and 3302.10.20) and cola-based concentrate (U.S. HTS No. 2106.90.65 - previously U.S. HTS No. 2106.90.60). Pepsi further supports the immediate elimination of the U.S. 6 percent ad valorem duty on caffeine imports (HTS No. 2939.30).

Regarding concentrate imports entering under HTS No. 3302.10, Pepsi supports the agreement reached at the July 7-9 1993 Tokyo Summit to immediately eliminate tariff and non-tariff measures on products entering under Chapter 33 of the Harmonized Tariff System, including HTS No. 3302.10. If for some unforeseen reason Chapter 33 products are in whole or in part removed from the "zero-for-zero" Quadrilateral agreement, PCI is urging U.S. negotiators to unilaterally eliminate U.S. tariffs applicable to imports entering under HTS No. 3302.10.

Regarding cola-based soft drink concentrate entering under HTS No. 2106.90.65, there is no reason why their immediate elimination should not be "offered" by the United States in the context of the agricultural market access negotiations.

Regarding elimination of the U.S. duty on caffeine, PCI supports the agreement reached at the Tokyo Summit for a caffeine "zero-for-zero".

## SPECIFIC PRIORITY REQUESTS IN THE CONTEXT OF THE MARKET ACCESS NEGOTIATIONS

Twenty-one countries were initially identified by Pepsi as having particularly high tariff and restrictive non-tariff measures. The attached charts identify the highest priorities for trade liberalization for soft drink concentrate and the raw materials required to produce concentrate.

Pepsi has actively supported the Uruguay Round negotiations. The company is concerned, however, that unless efforts are made by U.S. negotiators to achieve deeper and more immediate tariff cuts than those agreed to by the across-the-board tariff reduction formula, the agreement will not result in any increased market access. Regarding U.S. tariffs, PCI fully supports the "zero-for-zero" agreement governing flavor-based concentrate and caffeine and encourages U.S. negotiators to immediately eliminate the U.S. duty on cola-based concentrate.

We appreciate the Subcommittee's interest in hearing industry views relevant to the multilateral trade negotiations and respectfully request that this statement be included in the printed record of the hearing.

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## STATEMENT OF POLAROID CORPORATION

On behalf of Polaroid Corporation ("Polaroid"), headquartered in Cambridge, Massachusetts, this statement responds to the Committee on Finance request for comments relevant to the Uruguay Round of Multilateral Trade Negotiations as they may affect specific U.S. commercial interests.

Polaroid has since the inception of the Uruguay Round market access negotiations sought an agreement that will significantly improve its ability to increase U.S. exports through the reduction of tariff barriers abroad.

## BACKGROUND SUMMARY

Polaroid is the world's largest supplier of instant photography, including instant cameras and instant print film. The company's products are distributed in 150 countries and territories located in every region of the world.

Where Polaroid is able to export, it is successful. There is only one other instant photographic producer in the world, namely, Fuji of Japan. But even where Polaroid faces competition from Fuji it is able to successfully compete. For example, Polaroid has over 70 percent of the Japanese instant photographic market.

The Senate Committee on Finance should be aware of the following four critically important points.

First, in virtually all cases there is no local producer of instant photographic film or cameras in the countries identified by Polaroid in its market access requests to the Executive Branch. As concluded by the ITC in a Section 201 investigation, instant and conventional (e.g., 35 mm) film do not directly compete;

Second, Polaroid's products are to a large extent no longer products destined to retail consumers and therefore goods which might be perceived as luxury items. Nearly 60 percent of the company's cameras and film today are for industrial (e.g., hospitals, identification card systems) rather than consumer use;

Third, the HTS specifically identifies instant print film and cameras at the 6-digit level (i.e., 3701.20 and 9006.40, respectively). Therefore, tariff elimination will not hurt any local producers and will have only minimal trade effect on our trading partners; and

Fourth, the U.S. will be the overwhelming beneficiary of trade liberalization.

## TOP NEGOTIATING PRIORITIES

### Zero-for-Zero Governing Instant Print Film and Negatives

Polaroid understands the Government of Japan has proposed a zero-for-zero approach on products covered under Chapter 37. Instant print film enters under HTS No. 3701.20 and instant print film negatives enter under 3702.31.

Polaroid continues to urge U.S. trade negotiators to support the Government of Japan's proposal. This initiative would offer significant new U.S. export opportunities for the United States in the following high priority countries:

| Country | HTS No. | Applied Rate | U.S. Duty | Request |
|---|---|---|---|---|
| 1. EC | 3702.31.90 | 7.1% | 3.7% | 0% |
| 2. Korea | 3701.20 | 11% | 3.7% | 0% |
| 3. India | 3701.20 | 65% | 3.7% | 0% |
| 4. Egypt | 3701.20 | 30% | 3.7% | 0% |
| 5. Thailand | 3701.20 | 10% | 3.7% | 0% |
| 6. Venezuela | 3701.20 | 20% | 3.7% | 0% |
| 7. Brazil | 3701.20 | 10% | 3.7% | 0% |

U.S.-EC Request/Offer

Polaroid is also requesting the EC to eliminate its 8.9% duty on instant print film batteries (HTS 8506.19.90) and elimination of its 7.1% duty on negatives (3702.31.90) in return for the elimination of the 4 and 3% U.S. duty on fixed and variable focused instant photographic cameras (U.S. 9006.4040 and 9006.40.90, respectively).

Tariff Elimination/Reduction on Instant Print Cameras

Polaroid is also seeking significantly improved access for its instant print cameras in the following priority countries.

| Country | HTS No. | Applied Rate | U.S. Duty | Request |
|---|---|---|---|---|
| 1. India | 9006.40 | 65% | 4 and 3% | 10% |
| 2. Korea | 9006.40 | 13% | 4 and 3% | 0% |
| 3. Egypt | 9006.40 | 42% | 4 and 3% | 0% |
| 4. Argentina | 9006.40 | 20% | 4 and 3% | 10% |
| 5. Venezuela | 9006.40 | 20% | 4 and 3% | 0% |

Polaroid appreciates this opportunity to comment on the importance of a successful Uruguay Round market access agreement to Polaroid's export operations.

STANFORD UNIVERSITY HOSPITAL • TRAUMA SERVICE
STANFORD UNIVERSITY MEDICAL CENTER STANFORD, CALIFORNIA 94305 • (415) 723-7570

August 9, 1993

Dear Senator Moynihan:

We would like to share our concerns about a grave threat to trauma surgeons, emergency physicians, and emergency medical services personnel: The Black Talon Bullet.

This new hollow point bullet constitutes a threat not only to its victims but also to the many professionals who assist in taking care of these unfortunate victims. Enclosed is a photocopy of this hollow point bullet after explosion with its dangerously sharp projections -- the dangers of which are self-evident. We feel strongly that this bullet should not be available to the general public.

In addition, in order to prevent other products such as this from entering the marketplace, it could be beneficial to have a federal commission to review all new ammunition intended for public use. This commission should be composed of consumers, health professionals, law enforcement officials, and federal agency officials.

Please give this situation your immediate consideration.

Sincerely,

James Stone, M.D.
Trauma Director

Ricardo Martinez, M.D.
Associate Director of Trauma

Janet Neff, R.N.
Trauma Coordinator

Kathy Montgomery
Administrative Assistant

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