Health Security Act of 1994

ORIGINAL

Sturgis, C.
105 pp.
6-29-94

1 EXECUTIVE COMMITTEE MEETING

2 WEDNESDAY, JUNE 29, 1994

3 U.S. Senate,

4 Committee on Finance,

5 Washington, DC.

6 The hearing was convened, pursuant to notice, at 1:30

7 p.m., in Room SD-215, Dirksen Senate Office Building, Hon.

8 Daniel Patrick Moynihan, Chairman of the Committee,

9 presiding.

10 Also present: Senators Baucus, Boren, Bradley,

11 Mitchell, Pryor, Riegle, Rockefeller, Daschle, Breaux,

12 Conrad, Packwood, Dole, Roth, Danforth, Chafee,

13 Durenberger, Grassley, Hatch and Wallop.

14 Also present: Lawrence O'Donnell, Jr., Staff

15 Director; Lindy Paull, Chief of Staff, Minority.

16 Also present: Mr. Les Samuels, Assistant Secretary

17 for Tax Policy, Treasury Department; Dr. David Podoff,

18 Economist; Peter B. Rudetti, Congressional Fellow,

19 Majority; Dr. Karen Hein, Congressional Fellow, Majority;

20 Dr. Bill Braithwaite, Congressional Fellow, Majority; Mr.

21 Chuck Konigsburg, Chief Counsel; Mr. Joseph Gale, Chief

22 Tax Counsel; Ms. Mary Schmitt, Assistant Chief of Staff,

23 Joint Tax Counsel; Mr. Mark Prater, Minority Tax Counsel;

24 Ms. Margaret Malone, Ms. Jane Horvath, Ms. Kathy King and

25 Ms. Sheila O'Doughery, Professional Staff Members; and Ms.

1 Julie James, Professional Staff Member, Minority.
2 [The press release announcing the meeting follows:]
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 The Chairman. A very good afternoon to our guests.
2 We are now to take up the Chairman's mark as it is so-
3 called of the Health Security Act of 1944. 1944 is when
4 we began this effort and it is now culminating. That is
5 literally the case.

6 On November 22 of last year I introduced President
7 Clinton's Health Security Act in the Senate. The
8 President's Task Force, some 500 strong -- Secretary Fader
9 is here representing them in spirit I am sure -- had
10 produced this bill in the course of a long year effort.

11 Now we, seven months later, have produced what we
12 hope will be a bipartisan measure, a measure with support
13 on both sides of our aisle, which reflects the best as we
14 think, as I have judged, of the bills introduced in this
15 committee by our colleagues, Senator Breaux, Senator
16 Durenberger and Senator Chafee.

17 This mark achieves universal coverage. It would
18 provide over 100 million people with financial assistance
19 to reach that goal. Let me say it once again. This is a
20 bill that declares that the policy of the United States
21 Government to have universal coverage of medical care for
22 its citizens and it is a bill that will provide subsidies
23 for almost half for a 100 million persons. Families under
24 the poverty line will have a complete subsidy and it would
25 be phased out thereafter.

1 For the first time ever we will have a trust fund for
2 academic health centers and for biomedical and behavioral
3 research. We have included special programs to address
4 the singular access problems of underserved populations in
5 both urban and rural settings. We established parity as
6 between mental health care and health care generally.
7 As I remarked, or misremarked earlier, President
8 Roosevelt had in mind to provide health insurance in the
9 Social Security Act, which was enacted in 1935. The work
10 began in 1935. He had asked Frances Perkins to do just
11 that. President Truman picked up the effort in 1945 and
12 with one way, one detail or another we have been expanding
13 this program under President Eisenhower with disability
14 benefits, under President Johnson with Medicaid and
15 Medicare, and now to this epic effort, the first of its
16 kind since President Nixon in 1971.
17 As we have progressed through a long series of
18 hearings -- we have had 31 hearings, many of you have been
19 present -- we have had long discussions within the
20 committee on a fully bipartisan basis. We have tried to
21 be guided by that first principal of the hippocratic oath,
22 which says primum non nocheri, first do no harm and we are
23 convinced that indeed we are going to do a very
24 considerable amount of good.
25 President Clinton called midday to wish us well and

1 to say that he will have a statement encouraging us in
2 these labors later this afternoon. And in order that we
3 might get forward with them, I thank you all for your
4 courteous attention and presence.
5 I turn to my esteemed colleague, the Ranking Member,
6 Senator Packwood.
7 Senator Packwood. Mr. Chairman, first I want to
8 thank you for the 31 hearings. These have been for me an
9 educational experience in the best sense of what hearings
10 ought to be and I think you have planned them better than
11 any series of hearings that I have ever been involved in.
12 They have changed my mind. I realize, at least I
13 think I realize, that I was operating on facts that were
14 outdated. In this particular field circumstances and
15 facts change faster than telecommunications.
16 We started out with two principal goals -- cost
17 containment and universal coverage. This committee was
18 stunned, startled and frightened I think by the statement
19 of Dr. Reischauer when he was testifying about the
20 President's bill, that said if the President's bill passes
21 it will reduce medical costs by one percent less than they
22 would have been. It would reduce them from 20.5 percent
23 of our gross national product to 19.5 percent of our gross
24 national product. We are currently spending 14 percent.
25 I think many members thought that is going in the

1 wrong direction. That was if the President's plan worked
2 perfectly. We were not going to succeed in cost
3 containment with that bill.
4 However, the circumstances that are changing more
5 rapidly than we realize are the growth of managed care,
6 health maintenance organizations, preferred provider, call
7 them what you want. Let me give a little bit of my
8 background because we are all colored by what has happened
9 to us in the past.
10 During World War II Kaiser, Henry J. Kaiser, opened
11 three immense shipyards in the Portland, Oregon area,
12 employing about 40,000 people in the three of them. In
13 the Zenith of World War II they were 30 percent of all the
14 adult employment in the Portland area.
15 With the Kaiser yards came Kaiser Permanente. It
16 started in California in the 1930s. My uncle worked in
17 the yards. He was 4-F because he had a hernia and it was
18 his first experience with health coverage. He was very
19 pleased by it in the sense of an employer that provided
20 it.
21 Kaiser and the Permanente plan were so despised by
22 the elite of the medical profession that in the 1940s Dr.
23 Ernest Salyard was hauled before the Washington State
24 Medical Society for unethical practices because he put up
25 a sign over the shipyard entrance that said, ''A community

1 health plan, Northwest Permanente Foundation.'' He was
2 not advertising for himself, just a sign that indicated
3 what the plan was at the company.
4 In 1960 in Noma County -- this was the Portland area
5 -- Medical Society precluded as members any doctor that
6 worked for Kaiser. These people were sub-human doctors,
7 guilty probably of unethical medicine or certainly
8 malpractice medicine.
9 Now it is interesting how things have changed. In
10 the Washington Post today, ''D.C. doctors' group sues Blue
11 Cross.'' The gist of the suit is this. I will just read
12 two paragraphs. ''The District Chapter of the American
13 Medical Association filed suit yesterday against the
14 region's largest medical insurance company. The suit
15 seeks to force Blue Cross to abandon the plan and to pay
16 $3 million in damages to the Society and to the several
17 physicians who were excluded from the plan.''
18 Thirty years ago the elite of the medical societies
19 did not want to let the plan doctors in. Now the elite
20 wants in. That is what has changed. In every area where
21 we now have managed care we see moderating prices. That
22 cannot continue forever. I am not so foolish as to think
23 you can cut, and cut, and cut, and cut, and cut. At some
24 stage hospitals reach a place below which they cannot
25 provide service. Doctors reach a place below which it is

1 not worthwhile to practice.
2 But in every city, in every State where you have
3 managed care, it is working; and the trend is moving us in
4 that direction unless Congress and the President stop it.
5 Statistics. Oregon has 2.8 million people. Blue
6 Cross/Blue Shield covers 1.1 million of those. Four years
7 ago 5 percent of the coverage was health maintenance
8 organization. Four years later it is 67 percent. It is
9 34 percent HMO, 33 percent preferred provider. Blue Cross
10 predicts that in four more years it will be 70 percent
11 HMO, 20 percent preferred provider, 10 percent indemnity.
12 You will all recall the testimony of Dr. Schultz, the
13 Dean of the UCLA Medical School, when he sat right in that
14 corner up there and said, ''there is no indemnity payment
15 left in Southern California.''
16 This competition works. Lots of hospitals do not
17 like it. Lots of doctors do not like it. A fascinating
18 story about the Georgetown University Hospital two or
19 three, four weeks ago, maybe more than that now, involving
20 what they charged HMOs versus fee-for-service for -- I
21 cannot remember the procedure -- I believe it was a heart
22 procedure -- $10,000 for HMOs and $28,000 for fee-for-
23 service. They were using the fee-for-service to offset
24 the loss that they were paying in the HMOs.
25 They said they could afford to do that when the HMO

1 patients were 5 percent of their business. It is now
2 approaching 50 percent of their business. This is what I
3 say, you reach a place where eventually they cannot afford
4 to do it.
5 But for the next three to four years if we do
6 nothing, you will see cost containments continue. We do
7 not have to pass any bill. At the end of that three to
8 four years, we may have to face up to the problem that
9 Senator Danforth has mentioned so often in this committee,
10 and what Oregon has tried to face in its Medicaid program
11 and its mandate.
12 Oregon has an employer mandate that goes into effect
13 in the future that says all employers will have to provide
14 the same level of health coverage that the Oregon Medical
15 Medicaid people get. But Oregon finally said, we cannot
16 afford to give everybody at public expense all of the
17 health delivery they would want. We just do not have the
18 money.
19 In three or four years when health maintenance
20 organizations have squeezed out almost all of the cost
21 excesses that you can squeeze out and we are spending --
22 not 14 percent, but perhaps 16 or 17 percent of our gross
23 national product on medicine, not 14 percent, and we want
24 to get down to 12 or 11 percent, we are going to have to
25 face the problems that Senator Danforth has raised so

1 often.

2 We are not prepared to do that this year. I
3 understand that. We are here. We will face those
4 problems. And Dick Lamm, the Governor of Colorado, raised
5 those problems a number of years ago.

6 I now turn my attention, if I might, to universal
7 coverage. I was a supporter of an employer mandate. When
8 I bargained labor contracts 35 years ago I was a young
9 labor attorney in a large Portland law firm. I was low
10 man on the totem pole. I was a relative blip in their
11 labor law business, but I was allowed to bargain some
12 contracts and negotiate, arbitrate differences.

13 We negotiated employer coverage. In those days a
14 plan was about $30 a month and employers, indeed, realized
15 that the total package was the cost they were interested
16 in. And in those days the wages of $5 or $6 an hour were
17 not uncommon. The employer would say, all right, I will
18 go to $6 an hour. If you want to make that $.30 an hour
19 health; and $.20 an hour worker's compensation; and $.10
20 an hour unemployment; and $5.40 wages, that is fine, or
21 any combination thereof, so long as it is no more than $6
22 and I will take a strike over $6.

23 So, indeed, the health plan was part of the cost.
24 But, of course, the union agents understood that the value
25 of the health plan was not taxable to the employee. It

1 did not make much difference to the employer, it was
2 deductible in any event.
3 When I introduced President Nixon's bill in 1973, the
4 Comprehensive Health Insurance Plan, it had a mandate in
5 it, employer mandate -- 75 percent employer; 25 percent
6 employee. The bill was killed by a combination of the
7 right and the left. The right did not want any bill; the
8 left wanted single-payer.
9 But there still was not overwhelming complaint about
10 the mandate at the time. I think it is because the costs
11 had not yet exploded. In the last 10 years they exploded.
12 All you have to do is go home now -- thank God we do and
13 have hearings, and listen to the passion of those who are
14 opposed to the mandate.
15 Listen to the 43-year-old woman who owns a restaurant
16 with 13 employees, 10 of whom are minimum wage. You
17 cannot tell her you can take health insurance out of their
18 wages. You cannot lower their wages. She says it is
19 going to cost me a $1 or $1.25 an hour and she is netting
20 maybe $30,000 a year herself and she looks at bankruptcy.
21 You talk to any small business, any retailer large or
22 small, any restaurateur large or small and the passion
23 that they feel for this mandate is the equivalent of those
24 who are opposed to gun registration or abortion. There
25 might be, or there might have been -- I do not think there

1 are now -- the votes to jam through this Congress an
2 employer mandate against the wishes of a determined
3 minority.
4 Mr. Chairman, it is not worth a candle. John
5 Williams, Bill Roth's predecessor in this body, was a
6 wonderful gentleman. He and I overlapped for only two
7 years. He retired in 1970. He had been here four terms.
8 In 1969 we were having a debate on changing the
9 filibuster rules -- should we lower the threshold for
10 cutting off a debate from two-thirds present and voting to
11 60. I was in favor; he was opposed. Today I would be
12 opposed.
13 I should have listened to his wisdom. He said, Bob,
14 anything that the public really wants badly we will get.
15 It may take two or three Congresses. That is not a long
16 time in the history of the Republic. But on occasion we
17 act more rapidly than we should and then trying to undo
18 what we have done rips at the fabric, he said, and he used
19 a wonderful expression, we make more mistakes in haste
20 than we lose opportunities in delay.
21 Do you remember four or five years ago when the
22 Supreme Court passed its decision that flag burning was
23 speech? Congress was up in arms. We would have passed a
24 constitutional amendment on the spur of the moment.
25 Fortunately, the recess intervened and we went home and we

1 discovered that the public was not as nearly upset as we
2 were.
3 We came back and passed a clearly unconstitutional
4 law, knowing the Supreme Court would strike it down, and
5 that was the end of it.
6 We are going to come to universal coverage in this
7 country. We will come to it in five to seven years, six
8 to eight years, instead of with a mandate two to four
9 years or three to five years. That is not a long time in
10 the history of this Republic. So I think we should get
11 off the thought right now of mandates or compelling
12 universal coverage. I think we should follow the
13 Chairman's admonition about do no harm. I think we should
14 realize that cost containment is going to happen if we do
15 not deter it.
16 Thank you, Mr. Chairman.
17 The Chairman. Thank you, Senator Packwood, most
18 assuredly and kindly.
19 Our Majority Leader and Republican Leader are
20 present. We are happy to defer to their eminence.
21 Senator Mitchell?
22 This may be the end of this hearing after you.
23 (Laughter.)
24 The Chairman. I guess the Chairman has to rule. The
25 Chair has to rule that it is Senator Mitchell.

1 Senator Mitchell. Mr. Chairman, thank you very much.
2 I begin by commending you, Mr. Chairman, for proceeding
3 with this legislation. There have been extensive
4 hearings. They have been extremely informative. There
5 has been detailed discussion among the members of the
6 committee on virtually every aspect of this matter and you
7 are now proceeding to mark-up. So I thank you and commend
8 you for the leadership you have demonstrated on this
9 important matter.
10 It is a very important subject, not just to the
11 members of this committee, but to all Americans. There
12 are many controversial provisions in each of the bills
13 that have been offered and each of the various marks that
14 have been discussed in this committee.
15 It is unlikely that any one of the 20 members of this
16 committee will agree with every provision in any bill
17 other than our own we happen to have offered the bill.
18 Therefore, Mr. Chairman, it will take open minds,
19 willingness to consider other points of view, a
20 willingness to engage in principal compromise if we are to
21 achieve our objective.
22 I believe that while this committee's action is not
23 the final step in the legislative process it is a very
24 important step and that it is important that we do achieve
25 our objective. Our goal has been from the outset, and I

1 take this to be the goal of virtually every member of this
2 committee, to provide health insurance for every American,
3 to provide effective cost containment and to shift the
4 emphasis within our system to preventive and primary care.
5 At the very least, to increase the emphasis on preventive
6 and primary care.
7 I look forward to working with you, Mr. Chairman, and
8 with the other members of the committee to achieve those
9 goals. I will reserve time for debating the substance of
10 the issue for consideration in the mark-up and on the
11 floor.
12 I would like to comment on one point that has been
13 made here today and on several occasions previously. It
14 was stated that costs will go up by about 20 percent if
15 the President's plan is not adopted.
16 The Chairman. To about.
17 Senator Mitchell. To about 20 percent from the
18 current 14 percent, by a specified time in the future and
19 19 percent if it is adopted. Others have made the same
20 point using the figures 18 percent and 17 percent.
21 Whatever the figures used, I believe the point was that
22 the President's plan will not make much difference in cost
23 containment because if it does not pass it will go up only
24 slightly higher.
25 I merely want to note that the comparison is not apt

1 because it omits a central fact, which is that the
2 President's plan includes everyone within coverage. It
3 provides health insurance for everyone and that is being
4 compared to a system in which 35 or 37 million people do
5 not have health insurance and, therefore, do not have full
6 access.
7 So it is comparing apples and oranges to compare the
8 two and to suggest that the affect will therefore be
9 minimal to be sure many of those who do not have insurance
10 have access to the system in ways that drive up costs.
11 Therefore, I conclude by saying that I believe that the
12 apparently contradictory objectives of health insurance
13 for every American and cost containment are, in fact, not
14 contradictory and are complimentary.
15 I believe that both are essential and that each
16 contributes to the other and that the most effective way
17 we can achieve cost containment is to have a system in
18 which all Americans are insured.
19 I thank you, Mr. Chairman, and I thank my colleagues.
20 The Chairman. I thank the distinguished Majority
21 Leader. And now to the ever courteous Republican Leader.
22 Senator Dole. Thank you, Mr. Chairman, and thank all
23 the members. I guess it has been about 18 months, almost
24 18 months, since you assumed the Chairmanship and we all
25 started down this road of health care reform.

1 I think it is fair to say that we began the journey
2 in a bipartisan spirit and I think that spirit is still
3 present today. We may have some differences, but I think
4 there is still a lot of bipartisanship around when it
5 comes to health care and how we are going to achieve it.
6 In a large part, Mr. Chairman, that has been due to
7 your willingness to hear us out and to have, as you say,
8 31 hearings. I thought they were very productive
9 hearings. We have in this committee a history of
10 considering all points of view. We also have in this
11 committee a history of generally coming together.
12 Maybe this issue is so vast that we cannot do it in
13 this case, but I think if someone wanted to research and
14 go back and look at major legislation in the past, say, 20
15 or 30 years they would find the votes to be either
16 unanimous or 18 to 2, 17 to 3, whatever.
17 I think it is in that spirit that I make very brief
18 remarks. There is no doubt about it, I do not know of any
19 issue that has been discussed more, debated more across
20 America than health care in town meetings or by the
21 President or by members of Congress or by providers or by
22 consumers, by people who meet us as we come into the
23 hearing room each day. I do not think a day has gone by
24 that probably any of us have not been asked a question
25 about health care by some individual or group. I am

1 certain that is the same for all of my colleagues.
2 The discussion has been lengthy for several reasons.
3 I think they are having difficulty in the House for the
4 same basic reasons. This issue is very complex. Anybody
5 who fully understands it certainly should be rewarded --
6 if they fully understand it and understand every issue.
7 I think even more important what we do will probably
8 affect in due course, as Bob Packwood just said, affect
9 every American, because I think everybody has a goal that
10 everybody ought to be covered. That is the goal.
11 So through the letters and meetings I think it is
12 fair to say the American people have played a part in this
13 debate, too. They have not been sitting on the sidelines.
14 They did for a few months. It was so complex they did not
15 want to get involved in it. But then they know how much
16 it would affect them and their families and they started
17 to look at it and watch television, to read the newspaper,
18 to listen to the radio, whatever, tune into talk shows and
19 they learned very quickly how complex the issue was.
20 So I think what I would say is, we have to get it
21 right. I think that is the bottom line. I hope we are
22 not going to set any artificial deadlines. I think as we
23 took the time, as we have taken the time, most Americans
24 arrived at similar conclusions.
25 I think the first conclusion was, we have the best

1 health care delivery system in the world right now in the
2 United States of America and we want to preserve it and
3 strengthen it. That is what this debate is all about.
4 Whenever someone from another country wants to
5 receive the best care or study at the best hospital or
6 whatever, I think it is fair to say that more often than
7 not they come to America.
8 Whatever action we take, let us not confuse this
9 debate with the upcoming welfare debate. We do not want
10 to end health care as we know it. We want to keep the
11 best system in the world. As I said, we want to do it
12 without reducing the quality of care Americans have come
13 to respect.
14 I think the second conclusion is that while the
15 system may be the best in the world there are people in
16 real need. They live in farm areas -- in Kansas, and
17 North and South Dakota, and Utah, wherever, in Minnesota.
18 And they come from urban areas -- Chicago, and L.A. and
19 New York. And they are shut out of the system and they
20 need our help.
21 I have to believe that every Senator on this
22 committee is committed to doing just that. I think it is
23 fair to say without being critical, I really believe that
24 the President's plan is in difficulty because it is too
25 big, and it is too bureaucratic, and it is too expensive,

1 and it would put too many people out of work. I think
2 that is a conclusion many Americans have reached as I
3 travel around the country.
4 Your proposal, Mr. Chairman, as well as the one
5 developed by Senator Chafee, reject the notions contained
6 in the administration's proposal, whether it is price
7 controls or mandatory alliances, and in a large part the
8 employer mandate -- and I share Senator Packwood's view on
9 that.
10 Just an hour ago Senator Packwood and I, and other of
11 my colleagues, I think 40 of our colleagues total, put a
12 package on the table that also rejects these notions as
13 well. As we said at the press conference, Senator
14 Packwood, who kicked the press conference off, and as I
15 said and others said following, our effort is the real
16 effort. It was not offered as a Republican effort; it was
17 offered as an effort to start some more dialogue with our
18 friends on the other side the aisle.
19 We believe -- I have always believed -- that timing
20 is important around this place. I think we are getting to
21 the time where we may have some movement in one direction
22 or the other. So I would urge my colleagues to take a
23 serious look at our proposal -- $100 billion. It is not a
24 cheap effort. It is an effort to reach out to many
25 people. It takes care of many of the things that are

1 taken care of in other bills.

2 But there is one basic difference. It has no price
3 controls and no mandates and no taxes. i think the
4 American people understand all three of those terms about
5 this time.

6 So, Mr. Chairman, I do not know what the Chairman's
7 wish is today, tomorrow, Saturday, whatever, but I do
8 think that if there is anything most of us learn out there
9 is that we have to do it right. I do not know what
10 happens. Obviously, this is a very important document.
11 It is over 140 pages that we received last night at 6:00.
12 Much of it is similar to the thing we have been discussing
13 in the committee.

14 I know that -- I think they just dropped it. That
15 will probably take another day to pick it up.

16 (Laughter.)

17 Senator Dole. But in any event, I hope we will have
18 an opportunity to go through this today and at some
19 appropriate time offer amendments and continue our efforts
20 to reach some bipartisan consensus.

21 The Chairman. I thank the Republican Leader most
22 especially for that last remark. Our purpose will be to
23 walk through the bill today. I believe, Senator Packwood,
24 you have a request.

25 Senator Packwood. I have a request. We only got the

1 bill, as you stated, about 5:00 or 6:00 last night.
2 The Chairman. Yes.
3 Senator Packwood. I would hope, Mr. Chairman, that
4 we would have no votes today. I think it is going to take
5 us all day to walk through it anyway.
6 The Chairman. Agreed without any question at all.
7 We will have time enough to hear it out. We have our very
8 excellent staff here, bipartisan staff, and we will do
9 just that.
10 We are now going to hear from every member of the
11 committee. Each member is free to speak as long as they
12 wish. But I think the exemplary example of the Majority
13 Leader and the Republican Leader will certainly commend
14 itself to others.
15 Just in order of arrival, Senator Roth.
16 Senator Roth. Well, thank you, Mr. Chairman. This
17 is, indeed, a momentous occasion. What our committee has
18 before it is a document that will affect every man, woman
19 and child in America.
20 There has been a great deal of anticipation
21 concerning the meeting today and rightly so. What we
22 propose to do will not only affect people, but almost $1
23 trillion in professional services and goods.
24 Four points must be kept in mind as we work on health
25 care reform. First, while major improvements need to be

1 made in our health care system, while we must put the
2 needs of the people first, these improvements must be made
3 without risking the many good features working in our
4 current system.
5 Our health care system has shortcomings, but it is
6 not broken. Consequently, it needs to be fixed or
7 improved, not eliminated and substituted. The health care
8 industry is fluid, constantly changing, developing new
9 technologies, new ways of delivering service. This change
10 has been manifest by the fact that in the past year alone
11 growth in health costs have been at a 20-year low.
12 Delivery of care is changing and efforts are being
13 made from within the health care industries to create
14 greater efficiency. We must move forward with
15 legislation, but we must move carefully. And we must, of
16 course, obey the often repeated rule of medicine -- first
17 do no harm.
18 Second, acknowledging improvements can and should be
19 made, though we must get beyond political differences to
20 make these improvements. Areas that must be improved
21 concern removing the barriers that now exist in insurance
22 coverage. Reform should eliminate pre-existing condition
23 exclusions and it should guarantee portability. Reform
24 should empower our families and small businesses in the
25 marketplace and make coverage more affordable.

1 This is critical to the millions who have no
2 insurance, many who have worked in small businesses and
3 who are poor.
4 The third point we must keep in mind is that
5 competition and choice have been fundamental influences in
6 making our health care delivery system the world's
7 flagship. Reform must build on fair market principles.
8 Injecting more government, creating more mandates and
9 hiring more bureaucrats is no way to make the system more
10 efficient and effective. This is not what Americans want.
11 Does this mean that government has no place in this
12 debate? Absolutely not. In fact, I have introduced a
13 proposal that would put government to work to benefit
14 families and employees of small business.
15 At this point in the health care reform debate, as
16 the many different proposed programs are being studied and
17 compared, it might be asked what do the Kennedy, Moynihan
18 and Dole plans all have in common. The answer is, they
19 all support my proposal to put the federal employees
20 health benefit program to work for Americans coast-to-
21 coast.
22 The Federal Government has the largest pool of
23 privately insured individuals in our current health
24 system; 9 million federal employees, retirees and their
25 dependents participate in FEHBP. My proposal would put

1 this enormous proposal to work by opening it up to others.
2 Small businesses and groups could buy into the federal
3 program, receiving roughly the same rates that federal
4 employees receive.
5 The fourth and final point we must remember is that
6 America and Americans can ill afford new and higher taxes,
7 new mandates and new bureaucracies. The bureaucratic age
8 is over. Small, lean and efficient organizations are the
9 future; and it is no surprise the engine of economic
10 growth in America is small business.
11 These businesses and the trends they set must be
12 nurtured. This will be to the advantage of all Americans.
13 Creating more government will not do that. What will
14 nurture these business and trends is to open the benefits
15 of a government program already in place.
16 To create new taxes and to increase taxes that are
17 now on the books will be exactly what our economy does not
18 need. We must promote conditions that create jobs,
19 increase taxes, new mandates, overbearing regulations.
20 These are certain job destroyers and they will put people
21 out of work.
22 Let me conclude by saying, there are problems in our
23 health care delivery system. People are rightly concerned
24 about the need to control costs, the need to have
25 affordable access, the need to ensure over 38 million

1 uninsured. Our answers to these problems must be
2 innovative.
3 But again, they must build on those principles within
4 the system that are working. That is what I hope we will
5 do as we move forward today, Mr. Chairman.
6 The Chairman. Thank you, Senator Roth. I think we
7 all want to acknowledge your initiative in proposing that
8 the existing federal employees health plan be made
9 available universally. Obviously, we are going to do
10 that.
11 Senator Breaux, one of the authors of one of the
12 bills before us.
13 Senator Breaux. Thank you very much, Mr. Chairman.
14 I want to first recognize the major contribution that
15 President Clinton and Mrs. Clinton have made in getting us
16 to this point. I remember the early days when Mrs.
17 Clinton was going around seeing individual Senators, both
18 Democratic Senators and Republican Senators, both in
19 public and in private.
20 I think because of the President's call for making
21 this a priority issue, it has become a priority issue. I
22 think that is one of the reasons, because of their work,
23 that we are here today in a mark-up session in what is
24 truly in my opinion a remarkable course for us to embark
25 on -- reforming the health system for all Americans.

1 And to you, Mr. Chairman, let me say how much I
2 appreciate the good work that you have been doing in
3 trying to keep the committee together and trying to
4 fashion a bipartisan coalition that can pass not just the
5 committee, but also the floor of the United States
6 Senator. Because unless we do that, we have not done very
7 much.
8 I think there are two ways that Congress can go about
9 reforming health care. Number one, we can try more
10 bureaucracy, more regulation, more mandates or we can take
11 a second approach, which relies on reforming the
12 marketplace and removing those impediments in the
13 marketplace that have not allowed the system to work very
14 well and has contributed to the massive problems that we
15 have in America when you talk about health reform.
16 I prefer reforming the system. Let us reform it
17 before we start mandating it. If mandates are necessary,
18 they should come only after the system has been reformed
19 by actions of the Congress and they should only come at
20 some point in the future, not at the beginning of the
21 process.
22 I think the big news should be not the differences
23 that the various proposals have, but rather the things in
24 common that all of the main proposals pending, in fact,
25 have in common.

1 If you look at the major proposals, we all call for a
2 standardized health plan, a major improvement over the
3 current system with 2,000 different plans, with 20,000
4 different exemptions.
5 All of the plans basically call for purchasing
6 cooperatives, to give small individuals the same
7 purchasing strength of an IBM or a Xerox or some large
8 multi-national corporation. All of the bills call for a
9 major insurance reform, something that is essential,
10 absolutely, if we are going to ever see to it that all
11 people have health insurance coverage in this country.
12 All of them really recommend some type of subsidies
13 for poor people to make sure that they have the dollars
14 necessary to pay for the premiums in order to insure
15 themselves and their families. All of the bills call for
16 some form of major medical malpractice reform, which has
17 contributed to the cost in this country and in every State
18 and most of them call for forms of antitrust reforms and
19 most of them call for some kind of tax help for self-
20 employed people so that they can deduct the cost of their
21 insurance.
22 So there is so much more in common than we have in
23 differences. I think that that indicates how far we,
24 indeed, have come. Controversial features -- you bet.
25 Some of them like premium caps or price controls, which I

1 would suggest have not worked in other areas where we have
2 tried them, like in Medicare, like in wage and price
3 controls, where they have not worked in the past. We have
4 a record of them not working in the past. I would suggest
5 to start with price controls in this bill is the wrong way
6 to go.
7 The second controversy is the mandates, whether they
8 be individual mandates or employer mandates. Again, I
9 think we ought to try reform before we try mandating
10 something. Let us get the reforms in place and see what
11 they accomplish before we start leading off with mandates,
12 because both of those are regulatory approaches which do
13 nothing to reform the system.
14 Now the President said that he will veto any bill
15 that does not provide universal coverage. Two questions I
16 think immediate arise. Number one, what is it; and number
17 two, when do we have to have it.
18 Now if you look at other countries that profess to
19 have universal coverage like France and Canada, we see
20 they have about 95 or 97 percent coverage. That plan in
21 those countries have been in place for decades. Decades.
22 I would suggest that we will not be able to get
23 universal coverage as the beginning point of health
24 reform. It should be the end result of what we are trying
25 to reach, not the beginning of the process. So I think

1 the President has a great deal of flexibility in terms of
2 what actually is universal coverage.
3 I think 95 percent coverage of individuals with maybe
4 98 percent of the cost covered is truly universal in the
5 sense of what we are trying to achieve. it does not have
6 to be done immediately, but can be done in a phased-in
7 fashion, which is what I suggest we do.
8 So I think bottom line is, if the President has
9 proposed what is on a scale of 1 to 10, I think Congress
10 can do about a 7 or an 8; and I think that would be a
11 major success. It would be major regulatory reform that
12 affects everybody in this country. I think that people
13 would look back and say that when we had the chance to do
14 it right we did it and we took our time to do it.
15 Even the good Lord took seven days for creation.
16 Certainly Congress can take a few years in making sure we
17 do it step-by-step and do it right, rather than trying to
18 do it all at once and just hope that we get it right. I
19 think we can do it.
20 Thank you, Mr. Chairman.
21 The Chairman. You got yours under time. Thank you
22 for those thoughtful statements, Senator Breaux.
23 Senator Conrad?
24 Senator Conrad. Thank you, Mr. Chairman.
25 I also want to acknowledge the extraordinary efforts

1 of the President and First Lady in putting health care at
2 the top of the American political agenda in a way that I
3 think has brought us to this point today and I think they
4 deserve the thanks of every American for that
5 extraordinary effort.
6 I also, Mr. Chairman, want to acknowledge your
7 efforts because I think you have been extraordinarily
8 patient in holding us all together, working on a
9 bipartisan basis to try to achieve a result. If we look
10 back we find that in the past efforts have been made and
11 they have fallen apart because various forces adopted the
12 notion ''my way or no way.''
13 Mr. Chairman, I have just come from a meeting with a
14 group who feels passionately about universal coverage,
15 about the plan the President has put before us, and they
16 have said to me if it is anything less they are not so
17 sure we should have anything.
18 Mr. Chairman, there are others who believe we should
19 do nothing. There are others who believe we should do
20 next to nothing. I do not think that is what the American
21 people want us to do.
22 In my visits across North Dakota we want, Senator,
23 you to do something to help contain the cost explosion.
24 Senator Packwood correctly notes there are forces at work
25 that may well help contain the cost explosion without

1 Congressional action.

2 Mr. Chairman, I do not count myself in the number
3 that believes that is the complete answer. I can remember
4 very well visiting with a farm couple from south of
5 Mandan, North Dakota, who told me their premium is now
6 $518 a month and they are earning about $20,000 a year;
7 and they are telling me they do not know how much longer
8 they can keep up with health care premiums.

9 I remember on the question of coverage so well a
10 young couple who was at a hearing of mine in Minot, North
11 Dakota, a young professional couple, both of them
12 excellent jobs, both of them exceptional health care
13 coverage plans, and then the woman contracted a very
14 serious illness and a very costly illness and within
15 months she had been notified her firm was bought out and
16 she had lost her job and her health care coverage as well.

17 Next, the same thing happened to her husband. He
18 lost his job because of downsizing and then lost his
19 health care coverage. And this young, professional
20 couple, hard-working, well-educated were then faced with a
21 circumstance where they could not get coverage from new
22 carriers because of a pre-existing condition. Coverage is
23 an issue.

24 For those who say we do not really need to worry
25 about universal coverage, I wish they could have attended

1 the hearings across my State with me and look into the
2 faces of people who do not have coverage and who are in
3 desperate circumstances because they do not.
4 Mr. Chairman, this is an extraordinarily difficult
5 undertaking. All of us know that we were at loggerheads
6 some days ago. That there were not the votes on this
7 committee to produce a result. You, Mr. Chairman, allowed
8 a group of us on a bipartisan basis to work together and
9 we worked very hard.
10 I do not assert for one moment that we produced a
11 perfect package. I do not think there are many perfect
12 packages that emerge from the legislative process. We did
13 produce a serious package that will dramatically expand
14 coverage in this country, that will contribute to
15 controlling costs, that will preserve choice, that will
16 maintain quality, and that will emphasize prevention. It
17 is a serious substantive proposal.
18 Mr. Chairman, I would hope that we can vote out of
19 this committee something that takes steps that are
20 substantial and significant and do it on a bipartisan
21 basis and something that we can be proud of that will take
22 the test of time and something that our colleagues on the
23 floor can support.
24 Thank you.
25 The Chairman. Thank you, Senator Conrad. The one

1 thing we are surely going to do is address the issues of
2 that couple in Minot. We can see the previous condition
3 is longer a bar to insurance. I think we are probably in
4 complete agreement in this committee on that.
5 Senator Hatch?
6 Senator Hatch. Thank you, Mr. Chairman.
7 In many ways up to now the process have been very
8 gratifying. It is clear to me, Mr. Chairman, that you and
9 Senator Packwood have really done your best to try and
10 push this process along. You have shown extraordinary
11 dedication to this goal, as have many other committee
12 members.
13 The committee has held a total of 30 hearings with
14 143 witnesses and so experts from all walks of life, and I
15 really think you have done a good job.
16 I commend the President and the First Lady for
17 pushing this issue and trying to get some sort of a
18 solution; and I commend you, and Senator Packwood, and all
19 on this committee for working towards it. I look forward
20 to this process going forward.
21 Thank you.
22 The Chairman. Thank you very much, Senator.
23 Senator Pryor?
24 Senator Pryor. Thank you, Mr. Chairman. I will not
25 use all of my time, sir. But I want to commend you. I

1 want to thank all of our colleagues on this committee for
2 working up until this point and presenting this case to
3 the American people at this point.
4 I think, Mr. Chairman, it goes without saying that
5 during our life time we are presented with very few, very
6 few, opportunities to really do something. This is one of
7 those rare opportunities.
8 As my colleagues on the other side and this side have
9 said, this is, in fact, a milestone. This is an important
10 moment. I only hope that when these hearings are
11 concluded we can look back and say that, yes, we have met
12 our responsibility. We have lived up to our obligation,
13 that the American people see and have placed us in this
14 great position to accomplish.
15 Mr. Chairman, these people in this room do not have a
16 vote; and the people watching C-SPAN do not have a vote.
17 Only we have that vote and only we can make this happen;
18 and only we can cease this opportunity.
19 I remember when we started meeting with our informal
20 sessions out there, the back room, weeks and weeks ago.
21 It seems like years ago. I remember you said, let us see
22 what we can agree on. I hope that we will continue in
23 that spirit this afternoon and the days to come as to what
24 we can agree on.
25 There are many areas and many issues I know that are

1 unresolved. For example, I would like to see in this
2 legislation, and I am going to propose it, something
3 dealing with prescription drugs for Medicare
4 beneficiaries. I hope some of my colleagues will join me;
5 and I also hope that I can offer several options for our
6 colleagues to study.
7 Second, I think in any meaningful health care reform
8 we must consider -- we must consider, Mr. Chairman --
9 long-term care. I am not talking just about long-term
10 care needs for the elderly, I am talking about the million
11 children in our country today who have severe
12 disabilities, who need long-term care, a fourth of the
13 long-term care needy population, our children. Not
14 elderly, children.
15 I am going to be presenting at the proper time, Mr.
16 Chairman, a proposal or two with options. Joining with me
17 I hope will be some of my colleagues.
18 But finally, once again, I repeat, that we will just
19 cease this opportunity and make it count for the good.
20 I thank you, Mr. Chairman.
21 The Chairman. Well said, Senator Pryor, and we look
22 forward to those proposals which will be forthcoming.
23 Senator Chafee, who has been immensely active in this
24 matter.
25 Senator Chafee. Thank you very much, Mr. Chairman.

1 Mr. Chairman, I join in recognizing the major
2 contribution that the President and Mrs. Clinton have
3 given to the cause of health care reform. Because of
4 their efforts, there is no question but what this subject
5 has moved up to the front burner.
6 I also wish to praise you, Mr. Chairman, and your
7 staff, and Senator Packwood's staff, and Senator Packwood,
8 for the wonderful work you have both done. As Senator
9 Packwood said, I think these series of hearings we have
10 had have really been just outstanding. Each day you are
11 able to match what happened the prior day, and that is
12 significant.
13 I also want to praise the significant effort that
14 Senator Dole has made in presenting legislation and all of
15 that I believe will help advance the cause we are
16 interested in.
17 The principles I see, Mr. Chairman, are two-fold.
18 First, to cover more people and everyone as soon as
19 possible. And second, to constrain the cost growth that
20 are occurring in health care.
21 Mr. Chairman, this is an important crossroads. But I
22 think we need to recognize that one of the roads we could
23 possibly end up taking is one that will not include health
24 care reform because as has been mentioned here today, you
25 have forces on one side who seek everything -- perfection

1 as it were in their eyes -- and there are some who are
2 perfectly content if nothing be done and if the whole
3 thing goes down to defeat.
4 Our challenge, it seems to me, is to make certain
5 that that doe snot happen. I and others who spent quite a
6 few years at hearings, and my situations, conversations
7 with Rhode Islanders, people with no insurance, families
8 in trouble, talking with nurses and doctors and hospitals
9 and businesses have come to the conclusion that we must
10 have measured appropriate reform now.
11 Those of us who have served in this mainstream group
12 that has been referred to believe in that and certainly we
13 will do all we can to make it happen.
14 Thank you.
15 The Chairman. Well, Senator Chafee, you have already
16 done enormous amounts. I am confident that that is going
17 to happen. We are with you in that mainstream, as is our
18 colleague Senator Danforth.
19 Senator Danforth. Mr. Chairman, something like four
20 years ago Senator Chafee began convening a group of
21 Republican Senators, a large group of Republican Senators,
22 for Thursday morning breakfasts. We met for an hour
23 virtually every Thursday that the Senate was in session
24 over that period of years to try to educate ourselves on
25 the issue of health care and to try to come up with what

1 we thought were constructive ideas.

2 When President Clinton and Mrs. Clinton gave us such
3 an enormous push forward, with the emphasis on health care
4 legislation, I had no doubt right from the beginning that
5 Congress would end up enacting legislation and that the
6 legislation that we enacted would be somewhere in the
7 neighborhood of what Senator Chafee had been talking about
8 over these years.

9 I believe that the answer to health care legislation
10 is somewhere in the center. Therefore, I think that the
11 effort that was put forth last week by the so-called
12 mainstream group -- Republicans and Democrats -- was
13 enormously significant. It was bipartisan. It had the
14 same spirit that has typified the Senate Finance Committee
15 over the years that I have been on this committee. I
16 think that this is the best committee in the Congress in
17 the United States.

18 I want to say to our committee that I think that the
19 most important emphasis that was given in our meetings
20 last week was to the question of cost containment.
21 Clearly, universal coverage is something that is a very
22 important goal and no one minimized its importance at all.

23 But in those meetings the one issue that came up over
24 and over again was the question of cost containment
25 because we believed that we could do the country real

1 damage if we simply created another entitlement program
2 and we were not sure that we could contain costs.
3 So we considered various ways to contain costs. The
4 idea of a premium cap or price controls is one that did
5 not find favor. I do not think it has found much favor in
6 the Congress.
7 The idea of tax caps which I personally prefer and
8 which Senator Chafee personally prefers certainly has its
9 detractors. So the idea that we came up with is this idea
10 that Senator Bradley has talked about, which is this so-
11 called premium tax. And also fail safe mechanisms so that
12 we would be sure that if we did not meet the targets that
13 we hoped to meet through managed competition there would
14 be something that would keep control of the explosion of
15 the federal budget.
16 I heard, I listened very carefully, the Majority
17 Leader and his comments about the need to try to reach
18 accommodation on various issues. I think that that is
19 generally the case. But I also believe that it would do
20 an enormous disservice to this country were we to report
21 out of this committee legislation which did not do an
22 adequate job of containing costs.
23 Therefore, I would hope that as we proceed we bear
24 the question of cost containment in mind. There has been
25 so much emphasis in the press on universal coverage and on

1 the question of mandates that the most important issue in
2 the opinion of this Senator by far is whether we can be
3 totally confident that whatever we do maintains some sort
4 of control of the explosion of cost of health care.
5 The Chairman. Thank you, Senator Danforth, for a
6 very cogent message.
7 I have to report that there is a roll call in
8 progress. But we have time to hear from Senator Daschle.
9 Senator Daschle?
10 Senator Daschle. Thank you, Mr. Chairman. I will
11 try to be very brief. Let me also --
12 The Chairman. You have your time, too.
13 Senator Daschle. -- commend you for the tremendous
14 effort that you have made over the past many months in
15 bringing us to this point, and in showing the leadership
16 and diplomacy you have in your successful tenure as
17 Chairman here. I speak as just one Senator. But I know
18 that that sentiment is shared by virtually every member of
19 this committee.
20 I also want to thank every member of this committee
21 for the work that they have done. As I look across this
22 room, I do not know that anybody has put more effort, more
23 time, more of their own personal selves into this effort
24 than the group that is now organized in this room as
25 members of this committee. I respect them immensely for

1 the dedication that they have shown to this issue.
2 When I arrived here more than 14 years ago a
3 Congressman from the south made a comment that I guess I
4 have never forgotten. His comment was that when all is
5 said and done, often times there is more said than done.
6 I get to be very concerned about that when I think of
7 health reform.
8 We have talked. We have proposed. We have
9 negotiated and we have talked some more. Now is the time,
10 Mr. Chairman and members of the committee, that I think we
11 have to do the real work of decision making. We all agree
12 that something must be done. We all agree that our system
13 needs repair.
14 While we have the best doctors and providers and the
15 best hospitals, as the Chairman has indicated, we have the
16 worst system of financing perhaps in the world. Sheiks
17 may come to the United States for health care, but you
18 should not have to be a Sheik to get it. We agree on
19 that.
20 In fact, there is much upon which we do agree. There
21 are issues which divide us deeply. The only way that we
22 can build upon our agreements and work through our
23 disagreements is to begin voting.
24 I would be prepared to stay as long as it takes to do
25 so. There remains roughly 70 days left in this

1 legislative session. Three out of the five committees of
2 jurisdiction have now acted. The Chairman has
3 demonstrated remarkable patience in bringing us to this
4 point and I commend him for it. So let us get on with it.
5 Let us measure our time here not by the number of
6 speeches, but by the number of decisions we make. The
7 American people are waiting. Let us now demonstrate our
8 ability to govern.
9 Thank you, Mr. Chairman.
10 The Chairman. May I say thank you. Meaning no play
11 on words, well said.
12 Senator Daschle. Thank you.
13 The Chairman. We will stand in recess for a very
14 brief period. Everyone will go off and vote.
15 I have to note that Senator Chafee must be in Rhode
16 Island this evening to receive his party's nomination for
17 a fourth term. Is that correct?
18 Senator Chafee. Well, we hope it works out that way.
19 (Laughter.)
20 The Chairman. We hope it works out that way.
21 (Whereupon, at 3:06 p.m., the above-entitled meeting
22 recessed, resuming at 3:28 p.m.)
23 The Chairman. The committee will come to order.
24 Senator Durenberger, one of our most knowledgeable
25 and concerned members of our committee in this area.

1 Senator Durenberger. Mr. Chairman, thank you. As
2 wee left the vote, Tom was giving us advice on speeches
3 and doing and I am anxious to get to the doing. But I do
4 have a couple of thoughts and a remark.
5 The first is on the assumption that there is an
6 audience beyond this room. The interesting observation
7 that there are committees in this Congress on agriculture.
8 There is a committee for banking. There is a committee
9 for labor. There is a committee for transportation.
10 There is a committee for education. But there is no
11 committee for health. The biggest problem we perceive, or
12 one that affects everybody in this country, we do not have
13 a congressional committee that is devoted to health
14 policy.
15 I understand we have 40 some committees or
16 subcommittees that touch on it one way or another. But
17 that makes health care reform a real challenge and it also
18 makes it an important leadership issue. But it is not the
19 committees that get the work done; it is people that get
20 the work done.
21 So my second comment would be to thank the people of
22 Minnesota for giving me the opportunity over 16 years to
23 work on it and to come to the point where I believe by
24 August 15 we will see the President signing a health care
25 reform bill. I have no doubt about that in my mind. I

1 should say almost no doubt in my mind about that.
2 The Chairman. No doubts.
3 Senator Durenberger. Almost no doubt in my mind
4 about this. It is not so much the optimism in me that
5 comes with knowing there is a life after the Senate, but
6 an instinct for the policy itself and for the people.
7 Mr. Chairman, I think what Bob Dole and 40, I guess
8 it was, 39 other Republicans did today has a significance
9 beyond a sort of inside baseball politics, the ring that
10 might be put to it. I think it is a fact now that as we
11 approach decision making time that all 44 Republican
12 members of the Senate are positioned somewhere in favor of
13 health care reform.
14 There may be some if it does not happen would be just
15 as happy, because of a political issue or something like
16 that. But the reality is, there should be no doubt in
17 anybody's mind where the 44 Republican members of the
18 United States Senate are today on the issue of health care
19 reform.
20 There are a fairly healthy number of Democrats who
21 are positioned similarly around many of these same
22 positions. Some of us have worked on the mainstream bill
23 or whatever we have been calling that. The reality is,
24 there is much more of a consensus on what we need to do
25 than the confusion inherent in the process might lead us

1 to believe.

2 I think that to me is very, very critical. I think a

3 lot of Democrats and Republicans have agreed to support

4 cost containment as a way to get to universal coverage. I

5 heard some Republicans say, not today but in the past, we

6 do not believe in universal coverage, something like that.

7 But what I see today is a commitment to go to

8 universal coverage through cost containment. I believe

9 that of the Dole-Packwood bill. I strongly believe that

10 of the bill that we have worked to craft, or the so-called

11 middle ground that we have worked to craft, and of other

12 bills.

13 So I say, Mr. Chairman, it is now President Clinton's

14 turn. Oprah Winfrey told me a couple years ago when she

15 was trying to get me to take my bill off the small crime

16 bill because Biden had an amendment for her that she had

17 to get passed for somebody and I said, I am doing this for

18 a kid who has been kidnapped and I have never met this

19 young man and I know I am going to meet him someday and I

20 am doing this bill for him.

21 She said, well, Senator, sometimes you do not get

22 what you want, but you always get what you need. I hope

23 that that is the message that the President gets fairly

24 soon out of this mark-up. It is not that you have to have

25 universal coverage to get cost containment. It is clear

1 to a majority of people you have to get cost containment
2 in order to go with universal coverage.
3 With all due respect to our Democratic Leader and our
4 good friend on this committee, he is right when he says
5 COB said if we do nothing we are going to be at 20 percent
6 of the GDP 10 years from now. What CBO also said is, if
7 we do the Clinton approach to it as the Clinton bill
8 proposed, we would be at 19 percent of GDP.
9 If that is the cost of universal coverage, we will
10 never make it. So at 14 percent of GDP we are not dealing
11 with the real health problems that people in this country
12 face. If we are going to take it up to 19 percent just to
13 get the universal coverage and leave behind the behavioral
14 problems, the social problems, the community-based public
15 health problems we have in this country, we are not going
16 to make it.
17 We have to make it our goal to get those costs down
18 10 years from now to at least where they are today as a
19 percent of the GDP or lower. That has to be our
20 commitment. And we can get to universal coverage as we do
21 it.
22 There are cost differentials in the country today
23 that we discovered, and essentially this is doable, and
24 the value of the hearings in this committee shows you that
25 today there are 100, 200, 300 percent differences from one

1 part of the country to the other to do the very same
2 thing.
3 I mean, changing the practice of medicine in this
4 country, changing the way we buy that service and they
5 deliver it is critical. We can be below 14 percent. That
6 needs to be our objective and that in effect, Mr.
7 Chairman, is what I hope that kind of bill comes out of
8 this committee.
9 The Chairman. Well, sir, if it does, it will be in
10 no small measure because of your resolve.
11 Senator Durenberger. Thank you, Mr. Chairman.
12 The Chairman. I pay tribute to it here and now.
13 Senator Durenberger. I appreciate that.
14 The Chairman. Senator Wallop, another enthusiast.
15 (Laughter.)
16 Senator Wallop. A curious characterization, Mr.
17 Chairman, but I accept it.
18 Let me begin by tipping my hat to you as well,
19 because you have been creative, ingenious and very fair to
20 all of us. I appreciate that.
21 Mr. Chairman, you amongst all of us would be the one
22 that recognize the name Detotville and the warning that he
23 laid to this country in 1935, more or less, when he said,
24 in our democracy we would be asked constantly to seed a
25 little freedom, to buy a little security.

1 If you take a look at the plan that the President
2 sent down to us, in order to cover all he wanted, it
3 included prison terms and felony charges and constraints
4 on the choices of Americans. When the President was asked
5 by the press the other day to define ''all'' they could
6 not define all. In other words, in line with his veto
7 threat.

8 What I think is agreed upon here is that Americans
9 must have access, someone want it to have more than just
10 access. But everybody believes that Americans ought to
11 have access. And that can be done without reordering one-
12 seventh of the economy.

13 Americans I think must be allowed to maintain
14 coverage that at least is as adequate as that which they
15 now possess, which is not part of the concept of the
16 President's plan.

17 I do not think that Americans can be ordered to
18 choose more than they wish and I do not think that they
19 can be denied as much as they wish. We can all cite the
20 faults of the present system and it is very easy, as NBC
21 did, to drag in weeping people and show Americans how
22 terrified they must be just to pass yet another day in
23 this dreadful country.

24 But nobody has spent any time talking about the
25 wonderful miracles of modern American medicine and the

1 people whose lives have been bettered and saved and
2 enhanced by it. And nobody has pointed to them crying
3 tears of happiness with the results of a medical system
4 second to none in the world, albeit it has flaws.
5 Our Senator from Arkansas suggested we have an
6 opportunity really to do something and I agree with that.
7 But what we ought to keep in mind, I suggest, is that what
8 we do is something for Americans, not to Americans. I
9 also suggest that freedom counts and coercion counts. I
10 hope the committee and the Congress opts on the side of
11 freedom.
12 If you look at the list of mandates, orders, dues,
13 prohibitions, and other things that came down in most of
14 the bills, there are too many for us to be satisfied with
15 that. There is an opportunity to control costs and to
16 create a market in which Americans can operate quite
17 freely.
18 Thank you.
19 The Chairman. And very properly said, sir, and with
20 great respect for what you say. I would note that Tofield
21 came to the United States to visit the New York State
22 Penitentiary at Auburn to learn how we had reformed penal
23 care. A century and a half has gone by and we are still
24 working on that one, too.
25 Senator Wallop. It was not for medical research.

1 The Chairman. It was not for medical research.
2 Now, I think Senator Riegle -- Senator Rockefeller,
3 you are here. I am sorry. Excuse me.
4 Senator Rockefeller. Thank you, Mr. Chairman, very
5 much. I, as everybody else, thank you very much for what
6 you have done on this. I recall in fact almost back in
7 November, with your permission, we started bipartisan
8 meetings of just the Senators on this committee in my
9 office.
10 Then I suggested the idea of retreat, which of course
11 you took hold of. We had a very interesting retreat in
12 March of just the Senate Finance Committee alone. It was
13 a signal event, in my judgment, all sitting down together
14 for an entire weekend to talk about nothing but health
15 care. I think every member there expressed a genuine
16 interest in trying to reach a result and to enact health
17 care reform that could be called comprehensive and worthy
18 of ourselves and the American people.
19 Interestingly, our moderator at that panel was agreed
20 upon by the Chairman and the Ranking Member, Senator
21 Packwood, was a fellow named Jim Mongum, who is a
22 physician. He kind of kept the flow of conversation going
23 and was very good. He is the Dean -- he is a doctor and
24 he is the Dean of the Medical School at the University of
25 Missouri, Kansas City, and once served on the staff of the

1 White House.

2 He recently wrote an article in the Washington Post
3 which I want to just quote one part from, because he kind
4 of pulled us together in spirit at that meeting. He said,
5 ''During the pull and the tug of congressional action, the
6 moral compass to guide us through health insurance debate
7 and lead us to a successful conclusion must not be lost or
8 set aside. That moral compass is the attainment by a date
9 certain of universal coverage. In the quest to gain broad
10 bipartisan support, there is the danger,'' he said, ''that
11 the goals of avoiding taxes and mandates will again take
12 precedence over the goal of achieving universal coverage
13 and we will again fail to meet the major moral test of the
14 debate.''

15 He continued and ended, ''You can negotiate on the
16 types and mix of taxes and mandates, but a guaranteed date
17 for universal coverage must be non-negotiable if we are to
18 avoid the mistakes of the past and cease this historic
19 opportunity.''

20 And his final sentence was compelling, in my
21 judgment, ''The test of history will be simple -- is
22 everybody covered.'' That is what he said.

23 I thank the Chairman for the opportunity to speak.

24 The Chairman. And for a very clarifying point.

25 Senator Rockefeller. Thank you, Sir.

1 The Chairman. Senator Riegle?
2 Senator Riegle. Mr. Chairman, first let me
3 congratulate you for presenting this bill today. It has
4 been a long, hard journey. No one who is not the Chairman
5 understands exactly what the vicissitudes and burdens are
6 of a chairman. But I really appreciate your leadership on
7 this and the key elements of the bill, including the
8 commitment to universal coverage.
9 I also want to acknowledge the leadership of the
10 President and the First Lady in helping us to get to this
11 point. There are a lot of problems in the system that
12 need fixing. We have heard about some of them today. But
13 I think the main problem, and the problem that we are not
14 sufficiently addressing in my view, are the people who do
15 not have health insurance and cannot afford to get it.
16 Most of them work. They work as hard as they can, but
17 they cannot earn enough to be able to afford to get the
18 insurance for themselves and for their family members and
19 particularly for their children.
20 I have seen more cases than I can keep track of in
21 Michigan of that situation. When they get sick, or a
22 member of their family gets sick, they have to go broke
23 and go on welfare in order to get the medical bills paid.
24 Now that is not the way it ought to work in America.
25 Now a reference was made earlier to foreigners who

1 come to America for health care. That is quite true.
2 Wealthy foreigners do come to America for health care. I
3 remember the Sheik of Iran coming. And I remember other
4 heads of foreign governments coming here. They come all
5 the time.
6 But that is hardly a measure of whether our system is
7 doing the job it needs to do for our own people. I would
8 rather take care of somebody here, frankly, who needs
9 medical care and attention, who does not have insurance,
10 than I would some wealth Head of State from a foreign
11 country who wants to come here and take advantage of our
12 system.
13 It is a great system if you can afford it. The
14 problem is there are at least 38 million people out there,
15 most of them working, who cannot afford it. That has to
16 be fixed.
17 I was struck earlier just thinking about it. I think
18 virtually everybody in the room here today has health
19 insurance. Not everyone. I know there are some people
20 here that may not, but most do. There are about 160
21 people in this room. That is what there were earlier when
22 it was a little more crowded.
23 If you were to put 38 million uninsured in this room
24 and rooms like this, it would take a quarter of a million
25 rooms like this. Not just this room. We would have to

1 have 250,000 rooms like this just to hold the people who
2 this minute do not have a penny of health insurance.
3 Now, are we going to do something about it? When, in
4 the next century? Or even then will we do something about
5 it? I am struck by the fact that, you know, we all drive.
6 If we are driving down the road -- and it has happened to
7 me, probably to many of you -- and you come upon an
8 accident scene that has happened just ahead of you, and
9 people have been hurt, and they are by the side of the
10 road, and there is the need to stop and help them, do you
11 stop and help them or do you just drive right on by and
12 let the next person help them or maybe nobody helps them.
13 I think part of America has been the idea that we
14 stop and we help. We get out. We do not have to know who
15 they are and we help them in that particular moment. We
16 have all these people in the country without health care.
17 One woman that comes to mind is Cheryl Eikler in my
18 State who died of Chrons Disease at 29 years old, was an
19 office manager at a 7-Eleven, being paid $12,000 a year,
20 had no health insurance, could not buy it in the private
21 market, even with these reforms could not afford it on her
22 income. She is in an early grave. I think she would be
23 alive today if she had gotten the care she needed. She is
24 just one.
25 There are millions of people who are in that

1 situation. So I think we ought to be trying now to do
2 something about that problem. I know there are some who
3 say, we do not have the money. Well, we have the money
4 for everything else.
5 Anything the Defense Department dreams up, as Senator
6 Grassley has pointed out any number of times, we find the
7 money for. We buy battleships we do not need. We buy
8 this and that we do not need. We can afford to cover at
9 least the children in this country under the age of 18,
10 and expectant mothers, with a rather modest amount of
11 money. Most of the money we would spend to do it, we
12 would get back in savings later on down the line because
13 they do not get sick from things that could be prevented
14 and then have to have higher cost care that gets spread
15 out through the welfare system and picked up by the
16 taxpayers.
17 Now that is what we ought to do. I will tell you
18 this, there is not anybody in this room that wants to go
19 without health care for a day or a week or a month or
20 until the end of the decade into the next century. There
21 is no one here that wants to go without it. And there is
22 no one in this room or in America that ought to go without
23 it, because these are real problems. These are life and
24 death problems.
25 This is not make believe. This is the real hard

1 realities of people and their lives. We ought to be
2 providing it. I am going to offer at a minimum an
3 amendment, Mr. Chairman, to extend that coverage to
4 children under the age of 18, to expectant mothers,
5 because I think it is time America faced up to at least
6 that part of the problem.
7 Thank you.
8 The Chairman. Thank you, Senator Riegle. We look
9 forward to the amendment which will come early tomorrow or
10 one point along there.
11 You mentioned Senator Grassley who is next.
12 Senator Grassley. Well, I thank you, Mr. Chairman.
13 Obviously, there is a very strong desire to produce a
14 health care reform bill this year. I think that that is
15 legitimate, because everybody in this room wants to start
16 down the road to controlling health care costs and to make
17 sure that everyone has insurance coverage.
18 That desire is nowhere stronger, it seems to me, than
19 by a lot of outstanding members of this committee who have
20 worked very hard on this issue. I am not one of those who
21 have worked the hardest on it, so they all deserve
22 compliments for laboring in support of getting this ball
23 rolling and trying to find an appropriate compromise. So
24 I am pleased that the Finance Committee is finally
25 beginning consideration of a health care reform measure.

1 But my thinking on this subject, just like I suppose
2 all of you to some extent, not everybody, but all of you
3 to some extent, has evolved somewhat over the eight months
4 since the President gave his speech, I think that there is
5 a change of opinion in the Congress as a whole to some
6 extent. Not towards these goals that I just stated that
7 we all share, but exactly over how long of a period of
8 time to get there.
9 I think you have seen those change opinions reflected
10 in polls, because that is the way grassroots of America is
11 and I think you have seen it expressed with a lot of the
12 members, maybe a majority of the members, of Congress. I
13 think it is one of dramatic support for the President's
14 approach, not to lack of support for the President's
15 approach, but exactly how to get there over a period of
16 time with some major steps or all at once.
17 I think there has developed a healthy skepticism at
18 the grassroots reflected now on the Congress of just being
19 a little more slow about it. I think it is reflected in
20 the 85 percent of the people that have insurance who are
21 not totally satisfied with the situation, but they are
22 more or less saying to us, we know you have a problem out
23 there about cost, we know you have a problem out there
24 about the 15 percent of the people that do not have
25 coverage. By the way, in my State that is 8 percent, but

1 15 percent nationally.

2 They are in a sense saying, do not screw up my
3 insurance as you try to take care of these problems. So I
4 think that the Chairman's mark, Senator Dole's attempt,
5 Senator Durenberger, Chafee, Danforth reflects this
6 caution. I think the fact that the Labor Committee in the
7 other body decided not to bring a bill out reflects some
8 of that caution.

9 So with what we have before us now, Mr. Chairman, I
10 hope that this committee is not missing an opportunity to
11 produce a plan that can reflect what we hear at the
12 grassroots and consequently then to gain the support of
13 the entire Senate.

14 I say this because I am troubled first by key
15 proponents of the proposal that the Chairman has offered;
16 and second, by the very short time that we have been given
17 to have consideration before this committee. There are
18 some things that you would not expect me to support or
19 other people on this side, like the hard triggers or the
20 burden of employers which will result if these hard
21 triggers are invoked. It seems to me unlikely that such
22 triggers will have the support of a majority of the
23 members, at least on the floor.

24 I think that some of us will also have problems with
25 the cost containment procedures outlined in the bill. The

1 National Commission called for in the bill will have
2 altogether in my judgment too much authority. It also
3 seems that the procedures outlined in this section
4 completely bypass the congressional committee structure.
5 The budget control provisions are particularly
6 troubling. These provisions add a whole new layer of
7 budget control procedures on top of that that we already
8 have for, I think you would agree, a complicated budget
9 process for the rest of the budget. There is no guarantee
10 that any spending reductions will come out of the health
11 care accounts, even though it may be those health care
12 accounts that trigger the fail safe procedures.
13 It seems to me that the Budget Committee -- I am not
14 the only one on the Budget Committee here -- but I think
15 the Budget Committee is bypassed. As I said earlier, I do
16 not think we have enough time to deal with this.
17 I realize that the leadership is very pressed for
18 time and they want to get something out of committee. I
19 do want to say that I do think the Chairman has done a
20 very good job generally with reflecting some of our
21 concerns -- like consumer protection provisions, also very
22 strong provisions for rural, underserved areas. These
23 will help a State like mine and I thank you for including
24 those in the bill.
25 Let me stop. But let me say something that is half

1 serious and half somewhat to have fun with you, Mr.
2 Chairman. But there is something that is not included in
3 this bill, and that is the nurse practitioner and the
4 physician's assistants. That is not included in the bill,
5 right?
6 I would expect that I would be able to offer that as
7 the very first amendment. Why? Because I can show you
8 from the record a year ago when I offered it, on that side
9 of the aisle they asked me not to offer it. Everybody on
10 that side of the aisle supports it. And the Chairman made
11 a remark just before that was defeated by a very narrow
12 margin, he says, ''I think you have offered the very first
13 amendment of health care reform.''
14 So I want to be able to follow through on that
15 promise that the Chairman gave me last year, reflecting
16 the importance of that bill, the importance of it to rural
17 America, even to inner city America. And also because the
18 Chairman has kind of stolen my offset. It is in your
19 mark, but not my provisions.
20 So I want to make sure that you cannot take my
21 dollars without taking my program with it. So I would
22 like to have the Chairman's consideration of that. I will
23 put the rest of my statement in the record.
24 The Chairman. Thank you. Senator Grassley, I saw
25 you working up an enthusiasm for this legislation that I

1 had not earlier noted.

2 (Laughter.)

3 Senator Grassley. Well, I did not want to signal any
4 quid pro quo. I just want to keep the Chairman to his
5 word of what he said a year ago.

6 The Chairman. Just be sure that we are always open.

7 Senator Pryor. If Senator Grassley gets his
8 amendment in, then does he vote for the bill?

9 Senator Grassley. I know it is always dangerous.

10 The Chairman. Well, that is all right. Come on.

11 (Laughter.)

12 Senator Grassley. I hope I am not sorry I brought it
13 up.

14 (Laughter.)

15 Senator Grassley. I would quickly yield the floor.

16 The Chairman. Thank you, Senator Grassley.

17 Senator Baucus?

18 Senator Baucus. Thank you, Mr. Chairman. Mr.
19 Chairman, I want to join others, particularly taking my
20 hat off to the President. He did not shirk from this
21 problem, this responsibility. I mean, the President could
22 have come up with a mild program or if a program at all.
23 This President jumped into the fray, proposed a very
24 ambitious program, a very ambitious plan, and I think all
25 of America should be very grateful for it.

1 We may not agree with all of it. We may not pass all
2 of it. But he has shown what leaders should show, that is
3 come up with a major solution to a major problem facing
4 America. I very much compliment him and the First Lady
5 for doing so.
6 I also, Mr. Chairman, thank you. It has been said
7 many times because it is true -- you have done a terrific
8 job in keeping a tone of collegiality, of good cheer. You
9 are a great cheerleader. You keep us all together. You
10 do keep us on a bipartisan basis. You do not let any
11 rancor, any bitterness, any division, any personal
12 division to every occur in this committee. You are to be
13 commended for it.
14 That is why I think over the years there has been
15 such a tone of bipartisanship and collegiality on this
16 committee. You have a terrific job of doing so.
17 I also take my hat off to many other Senators --
18 Senator Durenberger, Senator Danforth, Senator Chafee,
19 Senator Breaux, Senator Daschle, Rockefeller, our Leader,
20 all Senators have been very actively involved -- Senator
21 Packwood, obviously -- in working to help make this a
22 solution that can pass the Senate and serve the American
23 people. I compliment all the Senators that have worked in
24 that regard.
25 Mr. Chairman, I have several concerns and several

1 efforts I am going to be pursuing. The guess the number
2 one is cost. I am just worried more about rate of
3 increase in health care costs generally in this country
4 than I am about any other single component.
5 It is critical to have universal coverage. I think
6 that that is a part of cost control eventually. I think
7 it is critical to pass all these insurance reforms. That
8 is part of it too, to eliminate pre-existing conditions,
9 work toward community rating, et cetera. All that is
10 critical.
11 But I do think that we have to work a little harder,
12 dig down a little bit deeper, and to try to find a way, a
13 common sense way, just to address this cost problem.
14 Senator Packwood mentioned that managed care is bringing
15 down cost. That is true. Managed care is bringing down
16 the cost in this country, very significantly.
17 But he also suggested, and I think that is also true,
18 that probably a few years from now we are going to be
19 facing the cost problem because managed care alone in my
20 judgment will be more of a blip. It will level off for
21 awhile, the rate of cost increases. My thought is that
22 after several years, were we to rely only on managed care
23 and competition, that pretty soon we are going to be back
24 in the soup again because all these HMOs and PPOs and
25 other organizations are going to be basically together,

1 not in concert, not because they are working to ferry a
2 scheme at all, just the nature of the beast, just raising
3 costs.
4 I think it would be important, if we can, to try and
5 find a way to address that in some way, in some reasonable
6 way, here.
7 In my State of Montana, I must say that health care
8 costs for the average Montana citizen is rising 400
9 percent faster than wages in the last 10 years. Small
10 business health care costs are rising 300 percent faster
11 than wages in my State in the last 10 years. I was
12 talking to a small businessman when I was home just a
13 couple weeks ago. I asked him what his health care costs
14 are, what his health insurance costs are. He said for his
15 lower wage employees, $24,000. It is an 18 percent over
16 the prior year.
17 And for his high wage, and by high wage he meant
18 $35,000 to $36,000, it was a 40 percent increase in health
19 care insurance costs. I asked if he was representative of
20 a typical business in his community and he said yes he is.
21 He just volunteered. He has no ideas how many more years
22 he can continue to do this.
23 I have talked to families. We all have talked to
24 families. We have all kinds of examples of people back in
25 our State who are just paying, frankly, much more than

1 they should. I just strongly urge us as much as we can
2 during this week and when we are back after the recess, to
3 focus on a common sense way to begin to deal with costs,
4 because I do think that is the major problem facing all of
5 us, most Americans in this country.
6 Bottom line, I want to thank you for your exemplary
7 work.
8 The Chairman. We thank you, sir. Thank you for a
9 very cogent statement.
10 And now to wrap up, Senator -- soon to be President -
11 - Boren.
12 Senator Boren. Thank you very much, Mr. Chairman.
13 As the concluding speaker of this round much of what I
14 intended to say has already been said. But I do think it
15 is appropriate that we close as we began with the remarks
16 of the members of this committee again in expressing our
17 appreciation to you. I do so as others have, with true
18 feeling. You have been fair. You have been patient. You
19 have prodded us to think about those issues that are truly
20 important through the mechanism of the retreat and other
21 discussions we have had.
22 And most of all, you have tried to reach out to sense
23 where the consensus is in this committee so that we can
24 get together and pass a plan that will not only be enacted
25 by this Congress this year, but one that will be a

1 sustainable road map for us in the years ahead -- the
2 decade or so that it is going to take us to finally
3 accomplish health care reform.
4 I really salute you for that effort. That has been a
5 difficult effort. It has been an effort well worth
6 making. I hope when we conclude our deliberations we
7 will, indeed, reflect a broad consensus in the way that
8 you have sought to help us find it.
9 I agree with much of what has been said. All of us
10 support the basic goals announced by the President in the
11 beginning. We want to see more people have health care
12 coverage. We do not want to see people lose their health
13 care coverage when they change jobs. We do not want to
14 see people denied health care coverage because they have
15 pre-existing medical conditions.
16 We all want to move toward full coverage of all of
17 our people. I think Senator Danforth said it right when
18 he said we must keep our eye on the ball. We will never
19 achieve -- we will never be able to afford to achieve
20 these changes if we do not pass a bill that is effective
21 in terms of controlling costs.
22 There are many small businesses in this country
23 today, for example -- and I have talked to many of those
24 who operate those small businesses -- who want to provide
25 better health care coverage for their employees but they

1 cannot afford it or they are being forced to give up the
2 coverage they have provided in the past because the costs
3 of escalated so quickly.
4 So if we are going to have true reform, we do have to
5 continue to be focused on methods that will bring about
6 cost containment. We tried to do that with the so-called
7 Moderates group. There were some proposals to penalize
8 high cost plans in the proposal which we made. I hope the
9 ultimate bill reported from this committee will include
10 some of those key proposals to keep costs down.
11 I think we have to be cautious. We are dealing with
12 one-seventh of the national economy. The government does
13 not have a very good track record, being able to operate
14 large programs and do it effectively and efficiently and
15 on a basis in which we pay as we go. We could bankrupt
16 this country. We could destroy the economy if we make
17 severe mistakes here.
18 Therefore, I think we need to phase in our changes on
19 a pay-as-you-go basis and a way in which we can make mid-
20 course corrections if they are necessary.
21 But finally, let me add one point. And you have
22 heard me say this before. Sometimes it is I think
23 misunderstood. I read one newspaper account that said,
24 well, Senator Boren has in essence joined the Republicans
25 on the committee on the health care issue because he has

1 said he will not be a party to passing a partisan bill.
2 That is not the point, Mr. Chairman. The point is
3 that we must have a bipartisan solution. I think it shows
4 how far we have moved away in this country from embracing
5 the value of bipartisanship that we tend to think that you
6 should stand with one party or the other on an issue like
7 this.
8 I believe this very ferverently -- for us to pass a
9 health care reform program by a bare majority or one vote
10 margin in this committee along party lines, or to follow
11 the same practice in the full Senate would really be, I
12 believe, setting up the country for a disaster to follow.
13 We have seen it in other countries. If we do that,
14 we are going to leave the future course of health care in
15 doubt. Every two years when we have an election and there
16 is a sharp shift in the direction of one party or another,
17 we will see major changes in the health care program. We
18 are going to see major turns. Perhaps U-turns in the
19 course of where we are headed in the next 10 years.
20 If we do not have a program that is sustainable, one
21 on which people can rely, so that we know where we are
22 headed over the next 10 years, it will be impossible for
23 health care providers to make those long-range investment
24 decisions that they must make.
25 I witnessed, and during the time that I was studying

1 in England and as a student of British politics, the off
2 again, on again policy of nationalization of British
3 steel. One party got the power; they nationalized it.
4 The next part denationalized it. The next party
5 renationalized it. There were so many changes in
6 direction that finally at the end of all of it, they had
7 virtually destroyed that industry in that country.
8 If we are not careful, unless we pass a plan that is
9 sustainable by at least a large consensus in both parties
10 in this Congress -- not unanimity, we will never achieve
11 unanimity -- but a substantial consensus that makes it
12 certain that we will stay on the same path largely over a
13 10-year period, will create such uncertainty that we will
14 truly destroy the quality of health care for all
15 Americans.
16 So I again end where I began in our private
17 deliberations, Mr. Chairman, appealing to all of the
18 members of this committee for us to try to find a way to
19 work in a bipartisan basis so that when we are through we
20 can give some certainty to the future of health care in
21 this country and people will know where we are headed.
22 The Chairman. Senator Boren, I do not know a better
23 note on which both to end our personal comments and to
24 begin the walk-through of our bill.
25 May I say just in the interest of keeping the mark-up

1 moving, could I ask the members of the committee circulate
2 their amendments as soon as possible.
3 And also, as members of the committee are aware,
4 Senate rules require that legislation brought to the floor
5 be fully paid for during fiscals 1995 to 1999 and 2000 to
6 2004. And in the interest of sending a bill to the floor
7 which complies with these requirements, I would ask
8 members to explain to the committee, to the extent
9 possible, the budget affects of their amendments.
10 Senator Baucus. Mr. Chairman?
11 The Chairman. Yes, sir.
12 Senator Baucus. On that point, because this is a
13 very difficult matter, that is knowing what the cost will
14 be of an amendment and whether an offset would be, you are
15 saying that because we do not have a sense, I guess the
16 Joint Tax Committee is going to precisely tell us, you
17 know, the precise dollar amount --
18 The Chairman. Eventually they will.
19 Senator Baucus. -- that at this point, when we offer
20 amendments, we just do the best we can.
21 The Chairman. Do the best you can and you will
22 helped by the CBO and by OMB.
23 Senator Baucus. I understand. Thank you.
24 The Chairman. And the Joint Tax Committee is always
25 available where there is a tax issue.

1 Now, we are going to go through our titles one by
2 one. We will try to keep each title to 10 minutes. So
3 insurance reform, in which Jane Horvath will speak first
4 and then followed by Mr. Podoff and Will Sollee.
5 Senator Packwood. Mr. Chairman?
6 The Chairman. Mr. Packwood.
7 Senator Packwood. I have just a quick question.
8 Senator Domenici, who is of course the Ranking Republican
9 on the Budget Committee, has raised some questions about
10 the fail safe procedure on pages 27 to 34 of the bill. He
11 thinks it is going to further complicate the already
12 complicated budget process. He has raised some legitimate
13 preliminary questions and has asked if the staff might
14 give us answers, hopefully by tomorrow. They are
15 legitimate questions about the budget process. I think we
16 are going to need the answers before we go on and I will
17 give the questions to them.
18 The Chairman. And here are his letters.
19 Senator Packwood. Here are the questions and the
20 letters, that is correct.
21 The Chairman. We most assuredly will do it. But I
22 have to express a very serious reservation to the thought
23 that anything could complicate the budget process further.
24 All right, Ms. Horvath.
25 Ms. Horvath. Thank you. I will be starting with the

1 insurance reforms.

2 The Chairman. Panel one is insurance reforms. Very

3 good.

4 Ms. Horvath. Right. I will just give the

5 highlights. We have built on a State-based regulatory

6 system for monitoring and enforcing the insurance reforms.

7 The proposal aims for two goals.

8 The first is to minimize disruption in the market by

9 phasing in the insurance reforms. I would point out under

10 that that the community rating would become effective in

11 1996 and limits on pre-existing condition limitations

12 would also become effective in 1996.

13 The second aim was to minimize any potential adverse

14 impact for the currently insured during the transition to

15 community rating and limitations on pre-existing

16 conditions. To that end, we have guaranteed renewal of

17 currently insured policies effective immediately.

18 New things that I would call the members' attention

19 to that were not listed in the Chairman's draft mark is

20 the one-time amnesty for people with pre-existing

21 conditions to enroll in insurance without any pre-existing

22 limitation exclusions. That would be effective during the

23 first open enrollment period in 1996.

24 And that insurers would be required to offer under

25 family coverage coverage of dependent adult children up to

1 age 24. This is designed to encourage the coverage of the
2 younger population.
3 In terms of community rating, the States are required
4 to establish geographic areas, geographic rating areas,
5 within the federal guidelines. The community rating
6 market includes all individuals and firms with fewer than
7 500 employees, except for certain union plans, existing
8 rural cooperative plans and multiple employer welfare
9 associations.
10 The community rating would be modified in the mark
11 for family size, geography and age.
12 Senator Durenberger. May I ask, what is the
13 proportion on the age?
14 Ms. Horvath. Two to one.
15 Senator Durenberger. Two to one.
16 Ms. Horvath. And that employer responsibilities
17 toward providing greater coverage, all employers would be
18 required to offer their employees a choice of three
19 certified standard health plans; and all employers would
20 be required to do payroll deductions for health insurance
21 for employees who request it. That is the highlights of
22 Title I.
23 Mr. Sollee. There is also a provision in the mark
24 that would repeal the immunity of health insurance
25 companies from federal antitrust laws.

1 Ms. Horvath. Right.

2 The Chairman. Thank you. I wish Senators would ask
3 questions, but not long ones.

4 Senator Baucus. Mr. Chairman, at that point, if you
5 could explain that in more detail. What is the provision?

6 Senator Hatch. You would repeal the McKerrin-
7 Ferguson with regard to health insurance companies.

8 Mr. Sollee. Right, the immunity that is there now.

9 Senator Baucus. You just outright repeal the
10 McKerrin-Ferguson?

11 Senator Hatch. I think that is a big problem. That
12 means you are deferring to the five largest insurance
13 companies.

14 Senator Packwood. What did you say, Orrin?

15 Senator Hatch. That would be a big problem because
16 that means you are deferring to the five largest insurance
17 companies and everybody else.

18 Senator Packwood. Who support the repeal.

19 Senator Hatch. That is right. Where all the other
20 literally hundreds, if not thousands, of companies do not.

21 The Chairman. I will ask that we debate these issues
22 after we --

23 Senator Hatch. I just wanted to mention it.

24 The Chairman. Very clearly.

25 Senator Daschle, did you want to ask something?

1 Senator Daschle. Mr. Chairman, could I have a better
2 explanation of this amnesty provision? I was under the
3 impression that one of the things for which there was
4 general agreement is the elimination of pre-existing
5 condition. But I took from your explanation that the
6 elimination of the pre-existing condition is only good
7 during that period for which there was an amnesty. After
8 that the pre-existing condition would be considered again
9 by companies. Is that correct?
10 Ms. Horvath. Yes. Generally, the mark limits --
11 insurers would be limited in the extent to which they
12 could apply a pre-existing condition limitation to no more
13 than six months. Beginning in 1966, insurers would be
14 permitted to do no more than look back when a person
15 applies for coverage, look back six months to see if there
16 is an indication or if they have been treated or diagnosed
17 with a condition in six months and then the maximum they
18 could exclude from coverage or limit coverage for that
19 condition is six.
20 Then in 1997 insurers would be limited in their
21 ability to look back for a condition that was treated or
22 diagnosed to three months.
23 Then under a mandate trigger, insurers would not in a
24 situation where there is a mandatory purchase, insurers
25 would not be allowed to apply pre-existing condition.

1 Senator Daschle. If a person has a disability or an
2 illness during that three-month period of time, I assume
3 that the insurance company then is still within its rights
4 to exclude coverage from that applicant.
5 Ms. Horvath. For six months.
6 Senator Daschle. Just for a six-month period of
7 time?
8 Ms. Horvath. For a six-month period of time.
9 Senator Daschle. I see. Then they have to take
10 them?
11 Ms. Horvath. Then they must cover that condition.
12 Senator Daschle. So all people regardless of
13 condition would still be insured except for that time
14 frame?
15 Ms. Horvath. Exactly.
16 Senator Daschle. I see.
17 The Chairman. Thank you. All right, we will go on.
18 Senator Roth. Mr. Chairman, could I?
19 The Chairman. Sure. Excuse me. Senator Roth and
20 then Senator Durenberger.
21 Senator Roth. Yes. On page 1 we have a civil
22 monetary penalty not to exceed 50 percent of gross
23 premiums. Who would implement and collect the 50 percent
24 premium penalty?
25 We also have, I think, on page 5 a similar penalty.

1 Fifty percent is a pretty substantial penalty. Again,
2 what recourse would employers have there, that is in the
3 self-insured plan?
4 Mr. Sollee. States would enforce the monetary
5 penalty in the case of insurers in the community-rated
6 market and single State self-insured plans. The Federal
7 Government, Department of Labor, would apply the penalty
8 in the case of multi-State and self-insured plans.
9 Senator Roth. One further question. We have had a
10 lot of discussed on unfunded mandates. Do we provide for
11 paying the cost of these administrations to the State
12 anywhere in the agreement?
13 Ms. Horvath. Senator Roth, the State Administration,
14 the State requirements to have an accreditation and
15 certification program that is approved by the Secretary is
16 all covered in Title X and the federal participation,
17 financial participation, in discussed in that title. So
18 we will be getting to that.
19 Senator Roth. We will be getting to that later?
20 Ms. Horvath. Yes.
21 Senator Roth. All right.
22 The Chairman. Senator Durenberger?
23 Senator Durenberger. Mr. Chairman, I do have several
24 questions to clarify the issue of size of community-rated
25 pools, the size of employers. I am going to need some

1 help, if you can give it to me, to understand across the
2 country how many employees and how many employers are
3 affected by the decision to stop at 500 as we cut off
4 between experience ratings.
5 The Chairman. Can we get that overnight for you in
6 writing? Or, can you give it to us now?
7 Ms. Horvath. I believe I can give it to you now.
8 The Chairman. Fine.
9 Ms. Horvath. In terms of workers, 500 -- with firms
10 of one to 500, there is 49.3 million workers in firms
11 across the country in that size. Out of a total work
12 force of 92.9 million.
13 The Chairman. So half.
14 Senator Durenberger. If your cutoff is firms with
15 500 employees or fewer are required -- well, they cannot
16 experience rate, right? That is what we are talking about
17 here.
18 Ms. Horvath. Right.
19 Senator Durenberger. You are saying half the work
20 force is employed in firms of fewer than 500?
21 Ms. Horvath. Yes.
22 Senator Durenberger. I know that is a very different
23 figure from the one we used in the Labor Committee. The
24 Labor Committee at 100 I thought we had half the
25 employees.

1 Ms. Horvath. We had asked DOL to give us this
2 information because this is DOL's run, the information
3 they gave us as of around the 20th of June, Senator.
4 Senator Durenberger. All right.
5 Ms. Horvath. Because there is so much different
6 information about who is in what size firm.
7 Dr. Podoff. Senator, we have 37 percent of the work
8 force are in firms of 100 or less. Another 14 percent are
9 in firms of 100 to 500. That adds up to a little bit more
10 than half, as Ms. Horvath suggested.
11 Senator Durenberger. All right. The second question
12 is whether or not there is in this mark a one percent
13 payroll tax on firms of certain size.
14 Mr. Sollee. That is correct.
15 The Chairman. Could we wait until we get to revenue
16 provisions?
17 Senator Durenberger. I guess so.
18 The Chairman. Yes, not far.
19 Senator Durenberger. Then is there also a
20 requirement that each firm, small or large, be required to
21 offer three plans for their employees?
22 Ms. Horvath. Yes, sir.
23 Senator Durenberger. Is there a requirement that the
24 employer --
25 The Chairman. One of which would be a choose your

own physician.

Senator Durenberger. All right. Is that a fact, that one of the requirements like in the Clinton plan is that one of those plans must be a fee-for-service?

Ms. Horvath. Fee-for-service.

Senator Durenberger. All right. Thank you very much.

The Chairman. Ms. James, will you join in any conversation where you feel is in order.

Ms. James. Thank you.

The Chairman. Senator Bradley has arrived and claims the right to make the last, last statement of the afternoon.

Senator Bradley. Thank you very much, Mr. Chairman. I will be very brief. I will not take the committee's time. I think that a lot of hard work on the part of everybody on the committee has brought us to this point and I hope that we will be able to finish a bill and move it out of this committee in rapid order.

But I think it is important that we also look at the bill thoroughly so that we know precisely what we are doing. I think that we should have a bill that achieves universal coverage. If not in the Finance Committee, I think the ultimate product should achieve universal coverage.

1 I think we should use the market mechanism as much as
2 possible to ensure quality and to ensure that coverage. I
3 think we need cost containment and I believe it is very
4 important that we preserve for individuals the right to
5 determine their own health choices.
6 I think that there are a number of provisions as I
7 have seen in this bill that has been presented to us that
8 we will want to have some time to discuss. I will save
9 some of my comments for that point in the mark.
10 But I do think I am glad we are finally in this stage
11 and I think that this will be a process that will probably
12 take several stages before it reaches the point that we
13 will actually have a bill that we can be pleased to have
14 passed out of this committee.
15 To me, again, one of the key principals is to
16 encourage efficient markets where Americans making
17 decisions about what they value serve as engines behind
18 quality and innovation and cost containment.
19 The Chairman. Thank you, Senator Bradley, very much.
20 We will now move to Title II, Coverage.
21 Senator Grassley. Mr. Chairman?
22 The Chairman. I am sorry, Senator Grassley.
23 Senator Grassley. I wanted to ask, I do not disagree
24 with what you said about rural cooperatives being able to
25 offer insurance. But is that word used in the strictest

1 sense of the word as cooperatives are defined under the
2 Cappers Act or under the tax laws or would it be rural
3 organizations that maybe do not strictly come under the
4 cooperative definition of our statute?
5 Mr. Sollee. It would be those that are defined in
6 ERISA.
7 Senator Grassley. Defined in ERISA?
8 Mr. Sollee. Right.
9 Senator Grassley. I am not sure what that means, but
10 I will check that out.
11 The other thing I would make a point to you, Mr.
12 Chairman, of a discussion we had a couple weeks ago in the
13 outer room when we were meeting, about the real necessity
14 of completely exempting health insurance or rewriting
15 McKerrin-Ferguson for health insurance.
16 Some of it I know is absolutely necessary. And,
17 obviously, the easiest way to do it is probably the way
18 you have done it in the bill. But it was my understanding
19 you were headed towards doing it where it would be just
20 necessary where we were specifically preempting State law
21 and State regulation on certain things that we had to have
22 a national pattern for. There is a difference. At least
23 I hope there is a difference.
24 The Chairman. There is a difference, yes.
25 Senator Grassley. I guess I do not want to do

1 anything more than just remind you of it. I hope we do
2 not have to go with a complete reissue.
3 The Chairman. Very well. Dr. Podoff, Title II,
4 Coverage.
5 Dr. Podoff. Thank you, Mr. Chairman. Part II on
6 Coverage starts on page 10. The legislation sets
7 universal health care coverage as a national goal.
8 Coverage is defined as being covered by a certified
9 standard or certified very high deductible health plan or
10 a public plan.
11 The National Health Care Commission will monitor
12 trends in coverage and is discussed in a later section,
13 also trends in health care costs. The Commission will
14 make a determination if goals have been met with respect
15 to three categories of firms stratified on the basis of
16 firm size -- 100 plus, 25 to 99, less than 25.
17 If the Commission determines that the goals have not
18 been met for any one of these categories, then a mandate
19 would be triggered for the particular category of firms
20 that did not meet that goal, starting in 1998 with respect
21 to the 100 plus firms, 1999 for the firms of 25 to 99, and
22 2000 for firms less than 25.
23 If the goals are met for either all or some of the
24 specific categories, the Commission will continue to
25 monitor coverage to assure that goals will continue to be

1 met.

2 There is also, as Ms. Horvath suggested, some

3 adjustments in the insurance reforms that would be needed

4 if we went to a mandate that provided 100 percent

5 coverage, rather universal coverage, because then you

6 would eliminate the waiting period for enrollment and also

7 the pre-existing conditions that were addressed earlier.

8 The Chairman. Thank you, Dr. Podoff.

9 Senator Rockefeller?

10 Senator Rockefeller. Dr. Podoff, if the goals of

11 what you have described are met, how many employees would

12 be left without an employer contribution, number one?

13 Does that number which you would then give me include

14 family members, number two? And if not, what is that

15 number? And does this prescription include an individual

16 mandate? And if not, why not?

17 Dr. Podoff. The first question is, if the goals were

18 met, then at least 97 percent of workers would be covered.

19 That is computed by taking a weighted average of the goals

20 of those three categories. So the minimum number of

21 workers that you would have covered would be 97 percent.

22 Senator Rockefeller. It was a number of people. Is

23 that people?

24 Dr. Podoff. That would be people and workers, yes,

25 sir.

1 Senator Rockefeller. People and families?
2 Dr. Podoff. In answer to your second question, if
3 you look at the distribution of families and workers, that
4 would be, if you required coverage of both the workers and
5 the families, that would represent roughly 97 percent, at
6 least 97 percent, leaving roughly 3 percent -- at most 3
7 percent not covered.
8 Senator Rockefeller. And the number of that,
9 including people and families, the number would be what?
10 Dr. Podoff. The number would be 3 percent of 200
11 million, about 6 million people.
12 Senator Rockefeller. All right.
13 Dr. Podoff. Would not be covered by this mandate,
14 but presumably they would be covered by the subsidies.
15 But they would not be -- the 6 million persons who would
16 not be covered by either the firms reaching the goals or
17 the mandate being triggered, those 6 million presumably
18 would be covered through other mechanisms in the bill,
19 mainly the subsidies.
20 Senator Rockefeller. My third question has to do
21 with individual mandates. Are they in there? And if they
22 are not, why not?
23 Dr. Podoff. No, there is not an individual mandate.
24 We thought that that would be something that the
25 Commission would need to look at later on. If you have a

1 multiple set of triggers and a multiple set of goals, we
2 thought it is not possible to impose an individual mandate
3 until you had, if the triggers got triggered, a trigger
4 for each of those three segments.
5 So you could not have a situation whereby somebody
6 was working for a firm of more than 100 persons that was
7 subject to the mandate; and then if they quit or changed
8 jobs and went to a firm with less workers, and then went
9 to a firm that was not covered by a mandate, you could not
10 have a situation where for some months they would be under
11 an individual mandate and some months not.
12 So we thought since it was not clear that (a) that
13 the mandate would have to be triggered; and (b) when it
14 would be triggered, that it would be best to let that be
15 the kind of thing that a Commission would look at later
16 on, under the assumption that either way we would get 97
17 or 98 percent of the people covered anyway.
18 Senator Rockefeller. Thank you, Dr. Podoff.
19 Senator Packwood. I have a question.
20 The Chairman. Senator Packwood.
21 Senator Packwood. On the three categories of
22 employers -- 100 or more, 25 to 99, under 25 -- I just
23 want to get my percentages right. With employers of 100
24 or more now they have 89 percent coverage.
25 Dr. Podoff. Correct.

1 Senator Packwood. If in three years they have not
2 gotten as best I can figure to about 98 percent coverage
3 or --
4 Dr. Podoff. That is exactly right, 98.35, sir.
5 Senator Packwood. Ninety-eight point what?
6 Dr. Podoff. Point three five.
7 Senator Packwood. All right. If they have not
8 gotten on a voluntary basis to 98.35 percent coverage in
9 three years then the mandate goes into effect?
10 Dr. Podoff. Correct, Senator.
11 Senator Packwood. Now, give me the percentages for
12 the others. At 25 to 99, what is the percentage?
13 Dr. Podoff. At 25 to 99 it would be 95.80.
14 Senator Packwood. 95.80. And for businesses with
15 under 25?
16 Dr. Podoff. 93.50.
17 Senator Packwood. 93.5. So small business in five
18 years has to go from 74 percent coverage to almost 94
19 percent coverage or the mandate goes into effect?
20 Dr. Podoff. Correct, Senator.
21 Senator Packwood. Thank you.
22 Senator Mitchell. Mr. Chairman?
23 The Chairman. Senator Mitchell.
24 Senator Mitchell. Doctor, I wanted to ask one
25 question. There have been several suggestions with

1 respect to the calculation of the percentages. One has
2 been that they be calculated on a national basis. The
3 other is that they be calculated on a State-by-State
4 basis. It is not clear from the document which is adopted
5 here. Can you tell us which it is?

6 Dr. Podoff. We were envisioning it doing it on the
7 national basis.

8 Senator Mitchell. I thank you.

9 Senator Bradley. Mr. Chairman?

10 The Chairman. Senator Bradley.

11 Senator Bradley. Let me ask, could a 101 person firm
12 drop 2 employees to put off the trigger for a year?

13 Dr. Podoff. Yes, Senator.

14 Senator Bradley. That would be possible?

15 Dr. Podoff. Yes.

16 The Chairman. That is the dilemma of stacking
17 organizations by size.

18 Senator Bradley. Are employer subsidies available
19 before a trigger?

20 Dr. Podoff. We are going to talk about that in the
21 next section. But the quick answer is, employer subsidies
22 are not available until the trigger kicks in for at least
23 one category. Once it kicks in, other employers who
24 voluntarily offer coverage because they are not subject to
25 the trigger would be eligible to collect subsidies.

1 Senator Bradley. So why is it structured so that you
2 do not get subsidies until there is a trigger?
3 Dr. Podoff. Until it is triggered for at least one
4 group?
5 Senator Bradley. Yes.
6 Dr. Podoff. I think the belief is that what we are
7 trying to do is see how far you get with market reforms
8 and therefore reduce the need for subsidies and the cost
9 to the Treasury. We would wait a couple of years and see
10 whether one got to your goals without the subsidies. If
11 you then needed a mandate -- if you then mandated
12 coverage, presumably that meant you did not get to the
13 goals and would also need to subsidize the firms that were
14 being required to offer coverage.
15 Senator Bradley. Now, as I understand it on the
16 mark, if you have a firm with average wages over $24,000,
17 what would be the cap of your premiums?
18 Dr. Podoff. The cap would be 12 percent of the
19 payroll of the individual worker.
20 Senator Bradley. Say the firm split into a number of
21 smaller firms with low-wage workers, what would be the cap
22 then?
23 Dr. Podoff. It could range as low as 5.5 percent.
24 The firm would still get some subsidies, but it would be a
25 lower subsidy.

1 Senator Bradley. So there would be an incentive for
2 larger firms to split up into smaller firms as I read
3 this; is that correct?
4 Dr. Podoff. Correct, Senator.
5 Senator Bradley. So that if you also had concerns
6 about your pension you might have been mandated to cover
7 for health insurance, but you would split up into smaller
8 firms and those smaller firms might not be delivering on
9 your pension. Would that not be a possibility?
10 Dr. Podoff. That certainly would be a possibility,
11 Senator.
12 Senator Bradley. That is among serious problems.
13 The Chairman. Well, thank you, Dr. Podoff.
14 Senator Durenberger. Mr. Chairman, I am sorry.
15 The Chairman. I am sorry, did I miss that?
16 Senator Durenberger. No, Mr. Chairman. I did not
17 have my hand up and I was conversing.
18 The Chairman. Senator Durenberger.
19 Senator Durenberger. I apologize to you.
20 Dr. Podoff, can you help me understand, maybe help us
21 understand, under the definition of coverage what we do
22 about the part-time workers who might be working several
23 part-time jobs for several employers or the husband/wife
24 situation where one spouse is working with one employer,
25 one with another? Do you know what I am getting at?

1 Senator Packwood. You mean and they are both
2 covered?
3 Senator Durenberger. Yes. How is this Commission
4 going to deal with the issue of what is covered since
5 covered means insured by a certified standard or very high
6 deductible plan or Medicare/Medicaid, Department of
7 Defense? What other kinds of coverage issues should we be
8 aware of in terms of the nature of the employment, the
9 number of hours, seasonal versus nonseasonal.
10 If, in fact, a family with a dependent had up to 24
11 qualifies, how are we to anticipate that they will deal
12 with those issues?
13 Dr. Podoff. I think, Senator, if I understand your
14 question, if the mandate is not triggered, then you do not
15 need to really be concerned about part-time or seasonal
16 workers from an implementation point of view.
17 All you then do is go to the Census data and see new
18 people where there is a head of household working for a
19 firm of a given size, do they have coverage from whatever
20 source. It could be from your spouse's employment or it
21 could be from a public program or your private purchase.
22 So I think the issue of part-time and seasonal does not
23 come up in a non-mandate world.
24 In a mandate world, I think you do need to begin to
25 deal with how you treat part-time workers. We were

1 envisioning that the firm would then under a mandate -- if
2 the firm were under a mandate, it would have to make some
3 pro rata contribution based on hours, assuming the person
4 worked at least 10 hours, and deal with those kind of
5 issues.
6 The third part of your question, I think, is what do
7 you do when you have a spouse and there we have not worked
8 that all through. But there are some mechanisms you can,
9 where you would have the family covered by the work of one
10 spouse and perhaps the other firm would have to send --
11 the non-enrolling firm would have to send some money over
12 to some pool. That needs to be worked out.
13 The Chairman. Could I just say, do we not anticipate
14 that a National Health Care Commission is going to address
15 those complexities beyond legislative determination at
16 this point?
17 Senator Durenberger. I am sure that is what you
18 contemplated. That they are complex means that some of
19 these questions deserve an answer before the Commission
20 gets to deal with them. If we are asked to vote for a
21 triggered mandate, the coverage issues become pretty
22 critical.
23 Let me ask you another question. This is one of the
24 things I have frankly learned from this debate over
25 coverage that I should have been aware of before. The

1 traditional way of looking at impact of a mandated cost
2 requirement is to look at it in terms of its impact on
3 firms of different sizes.
4 One of the things I have learned from this debate is
5 that in many cases the difference is not size as as much
6 the nature of the business.
7 In other words, my youngest son is a restaurant
8 manager and most of the people that he employs -- 78 of
9 them or something like that in his restaurant -- are paid
10 somewhere in the $7 to $10 an hour category or something.
11 But the contribution that they actually make to the bottom
12 line of that restaurant with all that effort is relatively
13 small.
14 In other words, the pool from which the restaurant
15 has to draw premium costs for these people is pretty small
16 for employees.
17 The Chairman. You mean what Mike Conason called
18 value added?
19 Senator Durenberger. Yes, they are not adding -- as
20 compared, let us say to the manufacturing business and so
21 forth. I am pulling these off the top of my head. The
22 average worker contributes about $8,000 to $10,000 per
23 year to the bottom line, if you will, of the company. In
24 the restaurant business, in a lot of retail businesses, in
25 wholesale businesses, in the service industry probably in

1 general, my impression is the contribution is more in the
2 neighborhood of like $1,500 or $1,800 or $2,000.
3 Obviously, this issue has been looked at before
4 because the administration also uses a number of employees
5 per employer. Am I overlooking something when I suggest
6 that different firms, depending on their business, have
7 different capacities to make contributions to insurance
8 premiums as opposed to a firm based on number of
9 employees?
10 Dr. Podoff. I think though, Senator, some of that
11 has to get reflected in the average wage of the firm,
12 which is something you hinted at, where the person is
13 making $12,000 or $13,000 or $14,000. And the subsidy
14 schedule that is in there in the next section would, I
15 think, address part of that, but not all of your concerns.
16 Senator Durenberger. I raise it because Bill Bradley
17 really reminded me of it, because he is asking the
18 questions about the degree to which there are subsidies in
19 place at the time a trigger mechanism is applied to a
20 mandate. So is the answer to the question we have to wait
21 until we get to the subsidy section?
22 The Chairman. That is next.
23 Senator Durenberger. Yes.
24 Senator Baucus. Mr. Chairman?
25 The Chairman. Senator Baucus.

1 Senator Baucus. It may be the same subject, but all
2 in all the question I think the Senator from New Jersey
3 asked, that is, are there subsidies for a mandates
4 trigger, subsidies for small business, the answer I
5 understand is no, there are none.
6 Dr. Podoff. Correct, Senator.
7 Senator Baucus. The question I next have is, what
8 estimates do we have as to what small business people will
9 be paying in health care costs on that date? I am going
10 to say five years after enactment, 75 percent of the
11 uninsured.
12 Dr. Podoff. I think, Senator, that is the kind of
13 things we hope to get when we get our estimates from CBO
14 about premium costs, and subsidy costs and coverage.
15 Senator Baucus. So we do not know the answer to that
16 question?
17 Dr. Podoff. Not at this time, Senator.
18 Senator Baucus. So we do not know how much more
19 small businessmen will be paying in the event that the
20 trigger is pulled or we would be paying in health care
21 costs if the trigger is pulled?
22 Dr. Podoff. Well, we do not know that. But we do
23 know that if the amount that they paid was more than 12 --
24 if they were a firm with more than 75 workers and the
25 amount that they paid was more than 12 percent of the wage

1 of that individual worker, I should say, if the amount in
2 premiums that they had to contribute was more than 12
3 percent of each worker, then they would be eligible for a
4 subsidy which would limit that contribution to no more
5 than 12 percent.
6 Senator Baucus. But what if it is a firm with fewer
7 than 75?
8 Dr. Podoff. I suppose I should direct you to the
9 schedule on page 16. If they were a firm of less than 75
10 and they had an average wage of less than $12,000, then
11 their contribution rate might be limited to only 5.5
12 percent.
13 So the liability of the firm may not depend so much
14 on what the premium was but on the subsidy schedule that
15 is in here. So as I said, if you were looking at a firm
16 with less than 25 workers and the average wage of that
17 firm was less than $12,000 for a $10,000 worker the only
18 thing you would have to pay was $550. The rest would be
19 subsidy, irrespective of what the premium was.
20 Senator Baucus. But what about in the interim before
21 the trigger is pulled?
22 Dr. Podoff. Well, before the trigger is pulled there
23 is no mandate, so they do not have to pay anything. That
24 is one of the trade-offs. We do not know what is going to
25 happen to coverage as we have insurance reforms and other

1 things we have put in place.

2 But in the interim, before there is a mandate, they

3 would not have to pay anything.

4 Senator Baucus. I guess what I am really get at is,

5 do we know the degree to which the rate of increase in

6 health care costs would be diminished under the mark so

7 that businessmen could afford insurance before the trigger

8 is pulled? That is the basic question.

9 Dr. Podoff. I think the answer is basically we are

10 all hoping that the insurance reforms which will allow

11 people to get into groups, that those are the kinds of

12 things that will lower the cost of health insurance.

13 Senator Baucus. Do we have anything more definite

14 than hope?

15 Dr. Podoff. Well, I think the CBO is going to give

16 us some estimates. Hope is the wrong word, sir. CBO is

17 going to give us some estimates on trends in these things.

18 Senator Baucus. Can you give us some idea as to when

19 CBO will give us those estimates?

20 Dr. Podoff. As you know, they have been working on

21 these things. They have been working on a number of

22 bills.

23 The Chairman. Not for some time.

24 Senator Baucus. But I think it would help, Mr.

25 Chairman, if we had rough ideas, at least a rough idea of

1 when we are going to get these estimates.

2 The Chairman. We can get rough ideas.

3 Dr. Podoff. We will try to get some numbers for

4 this.

5 Senator Baucus. So rough means like next week, two

6 weeks, next month, what?

7 The Chairman. Tomorrow.

8 Senator Baucus. We will have numbers tomorrow? I do

9 not think so, Mr. Chairman.

10 Senator Bradley. Now mind you, these will be very

11 rough.

12 (Laughter.)

13 Senator Baucus. Numbers so we have a sense of what

14 is going on here.

15 Dr. Podoff. You would like some estimates. We can

16 get you some numbers on what has been happening.

17 Senator Baucus. Well, I do not want some numbers. I

18 want to know what the answer is.

19 Dr. Podoff. I do not know if we can give you an

20 answer. We can get you some numbers on trends.

21 The Chairman. Can we make the point that if we knew

22 we would not have to put in the arrangement that if by

23 this time you have not done that, then this, because we do

24 not know.

25 Senator Baucus. And that is one of my concerns, we

1 do not know.

2 The Chairman. And what is more, sir, you will not.

3 Senator Baucus. Well, I am trying to get a little

4 better idea so I can decide with a little more certainty.

5 The Chairman. Right. I do not blame you.

6 Senator Bradley. Mr. Chairman?

7 The Chairman. Senator Bradley.

8 Senator Bradley. Just before we leave the issue of

9 the mandates, the employer mandate. As I understand the

10 way it is structured, if you have covered -- if you are a

11 firm of over 100 workers and you have covered 85 percent

12 of your workers you do not have a mandate; is that right?

13 Dr. Podoff. No. The mandate is stated globally.

14 Senator Packwood. The mandate is what?

15 Dr. Podoff. The mandate is stated for all firms in

16 that category. It is not stated for an individual firm.

17 Senator Bradley. So that it has to be all firms over

18 100?

19 Senator Packwood. That is correct.

20 Dr. Podoff. Correct.

21 Senator Bradley. So all firms over 100 have to cover

22 -- 85 percent of all firms. So you could have one firm

23 that does not cover anybody.

24 Senator Packwood. It pulls everybody down.

25 Senator Bradley. And another that covers and that

1 basically pulls the average down. Or you could have a
2 firm where you have an overall total would be 85 percent,
3 85 percent of all firms over 100 who have covered their
4 workers; but you then have a firm that covers nobody, and
5 they have more than 100 workers. They would not have to
6 cover because the group would have reached 85 percent and
7 therefore they would not be subject to a mandate. Is that
8 correct?

9 Dr. Podoff. Can I restate the numbers, Senator? I
10 think where we now are is for firms over 100, 89 percent
11 of workers are covered. As I went through with Senator
12 Packwood, that in order to keep the mandate from being
13 triggered, that requires that 85 percent of the remaining
14 11 percent.

15 So you already have almost 90 percent coverage in
16 these areas and you are really only dealing with the
17 increment. It is certainly true, Senator, that
18 mathematically, if you had a very large firm in the 100
19 and over they could pull the average down.

20 But I think as we look at 100 and over firms, we do
21 not have that situation. You have some firms that are not
22 providing coverage and you are really looking at the
23 increment here.

24 Senator Bradley. But could you have a firm of over
25 100 who did not provide any coverage for its worker?

1 Dr. Podoff. Correct. Yes, you could, Senator.
2 Senator Bradley. So you could have 89 percent of all
3 firms of over 100 cover their workers and then you could
4 have 11 percent covering nobody, none of their workers, as
5 I understand this.
6 Dr. Podoff. Correct, Senator.
7 Senator Packwood. I do not think that is the correct
8 answer if I understand it.
9 Dr. Podoff. Well, we were starting with the base.
10 Right now you could have 89 -- right now when we have 89
11 percent of workers covered, it is true that that is a
12 weighted average of some firms covering all their workers,
13 some firms covering only part of their workers, and some
14 firms covering none of the workers.
15 So we now have a situation in which although 89
16 percent of workers in firms with 100 or more workers
17 receive coverage, not all firms are offering coverage.
18 That is true now.
19 Then as you try to move to the goal of adding another
20 9.5 percent, it is possible that many more firms will
21 offer coverage to their workers. But if some firm dropped
22 out of there, they could pull the average down below --
23 thank you, Senator Packwood -- the 98.35 thing. So if you
24 had a very large firm that did not cover its workers, the
25 mandate would get triggered.

1 Senator Packwood. Then let me put it the other way
2 around, Bill. Let us assume that in this country there is
3 100 million workers in firms of over 100. Just for
4 purposes of assumption.
5 The Chairman. That is about right.
6 Senator Packwood. It is easy; it is divisible by 10.
7 If in three years 98,350,000 are not covered, then the
8 mandate goes into effect. You would have to have a hell
9 of a big company to pull that average down below 98.35.
10 It is not just the likelihood, it is inevitable, we are
11 going to the mandate.
12 Hawaii has been working on this for 20 years and they
13 are some place between 92 and 96 percent. Am I right, if
14 we do not get to 98,350,000 the mandate goes into effect
15 for all businesses over 100?
16 Dr. Podoff. Correct, Senator.
17 Senator Bradley. Could I ask a slightly different
18 question? That is that if you reach the coverage level
19 that would exempt firms over 100 from the mandate, but
20 that firms under 25 did not reach the 75 percent level,
21 that you could have a situation where Walmart would be
22 free of a mandate, but the corner drugstore would have a
23 mandate to cover all of their workers?
24 Dr. Podoff. Correct, you could trigger a mandate for
25 some categories and not for others.

1 Senator Bradley. So that the people who are over 100
2 would be free of a mandate and those who are under 25
3 would be required to cover everybody.
4 Dr. Podoff. But for the firms over 100 to be free,
5 they would have to cover, as Senator Packwood said, 98. --
6 almost all their workers.
7 The Chairman. Thank you, Senator Bradley.
8 Senator Baucus?
9 Senator Baucus. Mr. Chairman, just very briefly.
10 So back to the earlier question that I asked. It
11 just seems to me that probably most business people can
12 expect health care costs to continue to go up roughly over
13 the next several years, four, five, six years, at roughly
14 the same rate that they have been going up, but for the
15 degree that managed competition and the market generally,
16 we hope, retard that rate of growth; is that correct?
17 Dr. Podoff. I think, Senator, yes. I mean, the
18 reason the mark has sort of a pause in which you are going
19 to take a look in several years at what is happening is
20 that I guess we all really do not know what the effects of
21 the insurance market reforms that Ms. Horvath talked
22 about, and all the other managed competition things we are
23 trying to put in, whether premiums will continue to rise
24 at previous rates is something I think would be very hard
25 to estimate.

1 That is why we want to come back. The mark provides
2 for coming back and looking at what has happened to
3 coverage. Did more small firms come in and purchase
4 coverage because the market reforms in terms of having the
5 purchasing pools and all the other things we did, did
6 something to slow down the growth of premiums.
7 Senator Baucus. What I am really getting at is, it
8 seems to me the likelihood that the trigger is going to be
9 pulled is very high because if the past rate of increase
10 in health care costs continues roughly in the future, then
11 health insurance is going to be more and more expensive
12 for these businessmen who are now not providing health
13 insurance, which again makes it more likely that the
14 coverage is not going to be near what we like it to be,
15 which makes it more likely that the trigger is going to be
16 pulled.
17 (Continued on page 106.)

1 The Chairman. Could I just say on that, there are
2 regional variations. There are places where health care
3 premiums are going down.

Gilmour 4 Senator Baucus. There are regions.

71 pp. 5 The Chairman. Yes. They tend to be heavily
6 population.

7 Senator Baucus. And there are other regions..

8 The Chairman. And there are other regions which are
9 going up, and they tend to be lightly populated.

10 Well, now we are going to try to get through this
11 today. So, coverage. We now go to coverage. I am sorry,
12 to subsidies. And Margaret Malone and David Podoff.

13 Ms. Malone. Mr. Chairman, a description of the
14 subsidies program begins on page 13 of the document that
15 you have in front of you.

16 The Chairman's mark provides a full subsidy for the
17 purchase of health insurance premiums by individuals and
18 families with incomes below 100 percent of poverty, which,
19 in 1994, is $14,800 for a family of four.

20 The subsidy eligibility level will be phased up over
21 four years, so that by the year 2000, all those with
22 incomes up to 200 percent of poverty will be eligible for
23 either a full or a partial subsidy.

24 The Chairman. How many persons is that, Ms. Malone?

25 Ms. Malone. We do not have an estimate from CBO for

1 this particular construction. Under Senator Breaux's and
2 Durenberger's bill, the 200 percent of poverty level
3 reached 43 million insurance units, which translated into
4 slightly more than 100 million individuals.
5 The Chairman. Slightly more than 100 million persons.
6 I think an insurance unit is a very complicated thing
7 called two and a half people.
8 Ms. Malone. That is right, Senator.
9 The Chairman. Well, there you are. Thank God I'm not
10 an actuary. But we are talking about subsidies for 100
11 million people.
12 Ms. Malone. We do not, as I say, have a specific
13 estimate for this, but it would be in that neighborhood.
14 The Chairman. Yes. Yes.
15 Ms. Malone. Subsidies will be phased out for those
16 with income between 100-125 percent of poverty in 1997;
17 between 100-150 percent of poverty in 1998; between 100-175
18 percent of poverty in 1999; and between 102 percent of
19 poverty in the year 200.
20 The subsidy program will be administered by the States,
21 with the Federal Government paying 75 percent of all
22 administrative costs.
23 The Secretary of HHS is directed to develop standards
24 to assure consistency among States with respect to data
25 processing systems, application forms, and other

1 administrative procedures.

2 Individuals and families with income below the poverty
3 level will be eligible for reduced cost-sharing for out-of-
4 pocket costs, as determined by the National Health Benefits
5 Board which is created by this mark.

6 If States choose to provide subsidies for cost-sharing
7 for individuals and families between 100 percent and 200
8 percent of poverty, they will be eligible to receive 50
9 percent federal matching for this purpose, with a limit on
10 federal funding for this purpose of $2 billion a year.

11 And Dr. Podoff may want to describe further the
12 subsidies for employers.

13 The Chairman. Thank you, Ms. Malone.

14 Dr. Podoff?

15 Dr. Podoff. We have discussed some of these things, so
16 discussion of employer subsidies starts on page 16. The
17 employer subsidies are targeted to low-wage workers,
18 irrespective of where they are employed. So, if a high-
19 wage firm hires a $10,000 worker, they would still be
20 eligible for a subsidy because that firm's contribution
21 would be capped at 12 percent of that worker's wage.

22 The subsidies become available when and if a mandate
23 kicks in, and the subsidies would be available to sectors
24 of firm sizes, even if a firm was not subject to the
25 mandate.

1 So, as I described earlier, there were three segments
2 we had talked about, firms over 100, firms 25-99, and firms
3 less than 25. If the mandate kicked in for one particular
4 group, other firms would, at that point, also be available
5 for subsidies, provided they paid at least 50 percent of a
6 cost of a certified standard plan.
7 So they were trying to provide some incentives once the
8 mandate kicks in for those firms that are not subject to
9 the mandate and might not be subject in the future. That,
10 basically, is a summary of what I talked about earlier.
11 Senator Rockefeller. Mr. Chairman.
12 The Chairman. Senator Rockefeller.
13 Senator Rockefeller. Let us take your cost-sharing
14 provisions. Let us suppose that there is a family in a
15 rural area that is eligible for a subsidy, like southern
16 West Virginia, but there is not an HMO in that area. And,
17 in southern West Virginia right now, there are no HMOs.
18 Therefore, there only would remain the high-cost
19 alternative, which would be a fee-for-service plan,
20 perhaps.
21 And what I want to know is, under the plan as it is
22 before us, what would be the out-of-pocket obligation costs
23 to that family eligible for subsidies in an area in which
24 there was not an HMO?
25 Ms. Malone. Senator, that is not specified in this

1 mark. That amount would be determined by the National
2 Health Benefits Board. It would presumably be a nominal
3 amount related to the family income.
4 Senator Rockefeller. You mean, the National Health
5 Benefits Board could simply adjust that arbitrarily?
6 Ms. Malone. That is right.
7 Senator Rockefeller. Thank you.
8 The Chairman. Thank you, Senator.
9 Senator Roth?
10 Senator Roth. Perhaps this has been covered, but I was
11 out of the room for a few minutes. But has any study been
12 made of the difference between establishing a subsidy on a
13 broad range of benefits versus a more scaled down, so that
14 we have some means of judging what the costs would be for
15 different standard benefit programs?
16 Dr. Podoff. I think, Senator, we begin to get some of
17 this, and we will get more when we get our numbers from
18 CBO. But the package that we have before us which we will
19 be talking about before does have 10 percent lower benefits
20 than appear in the Clinton bill, and I think it would begin
21 to compare when you put together the estimates that CBO has
22 provided for President Clinton's bill, plus the estimates
23 they have done for several versions.
24 They had two benefit packages for Senator Breaux's and
25 Senator Durenberger's bill, and then they will get some

1 subsidy estimates from ours. I think what you do, is you
2 begin to get some indication of the sensitivity, if you
3 like, of subsidies to changing the cost of the standard
4 benefit package. So it is not that we are going to do it
5 specifically for this bill, but we are going to try to pull
6 this together when we look at all the different approaches.
7 Senator Roth. Mr. Chairman, it would seem to me very
8 important that we have this kind of information as we
9 proceed.
10 The Chairman. To the degree we can get it, sir, you
11 are absolutely right. We are going to go to the benefits
12 and the National Benefits Board next, which will help a
13 lot.
14 Senator Roth. But could I ask one additional question?
15 The Chairman. You surely may. You surely may.
16 Senator Roth. On page 17, it says "If Trust Fund
17 obligations in a year exceed Trust Fund receipts, any
18 shortfall would be automatically deposited into the Trust
19 Fund from general revenues." The potential effect on the
20 deficit would apparently be immense if the subsidy is not
21 appropriately calibrated. Does this provision remove the
22 authority of the budget fail-safe provision?
23 The Chairman. I believe not.
24 Ms. Malone. No, Senator.
25 Dr. Podoff. No, it does not. No, Senator.

1 Senator Roth. Does not.

2 Dr. Podoff. Does not.

3 Senator Roth. Thank you.

4 The Chairman. Senator Bradley.

5 Senator Bradley. Yes, Mr. Chairman.

6 Following up on my earlier concern on the cap, on what
7 payroll that you would have to pay, reducing large firms,
8 splitting up into small firms so that what they would have
9 to pay is not 12 percent, but five percent, I would like to
10 then look at the issue of subsidies. As I understand it,
11 there is a more generous subsidy for a smaller firm.
12 Right? For a smaller firm.

13 Dr. Podoff. Correct, Senator.

14 Senator Bradley. What is the difference between the
15 subsidy for a smaller firm versus the subsidy to a larger
16 firm?

17 Dr. Podoff. Well, there is a schedule on page 16. And
18 for firms with 75 or more workers, their contribution rate
19 is capped at 12 percent. If you are below 75, and if your
20 average wage is below $24,000, then your contribution rate
21 could be lower than that, and, as I indicated earlier,
22 could go down to as low as 5.5 percent.

23 Senator Bradley. Right. Now, what about the subsidy
24 level?

25 Dr. Podoff. I am sorry. I am not sure I follow you.

1 Senator Bradley. Well, let us say an employer with 25
2 employees wants to add one more worker. How much would he
3 have to pay?
4 Dr. Podoff. All right. I think this was a concern.
5 Senator Bradley. As a percent of wage.
6 Dr. Podoff. And how many workers did they have?
7 Senator Bradley. 25.
8 Dr. Podoff. If they had 25. And what is the average
9 wage?
10 Senator Bradley. Say the average wage is $24,000.
11 Dr. Podoff. All right. Then in that case they would
12 be responsible for 12 percent of that worker's wage that
13 they added.
14 Senator Bradley. No, no. What I would like you to do,
15 is give me the percent of the wage, the subsidy value, to
16 a small firm versus a large firm.
17 Dr. Podoff. All right. I am sorry. All right.
18 If you started with a premium for a single worker and
19 you had a mandate, then the firm would be responsible for
20 80 percent of $2,000, or $1,600.
21 Senator Bradley. Right.
22 Dr. Podoff. And if you had somebody who was making
23 $24,000, and 12 percent, they would not--I think my
24 calculation is right--be eligible for subsidy for that
25 particular worker.

1 Senator Bradley. But the larger the firm, the more
2 generous the subsidy, or the reverse.
3 Dr. Podoff. The reverse.
4 Senator Bradley. Right.
5 Dr. Podoff. But if the wage was $24,000 or more in
6 that particular case, even if it was a firm -- no firm
7 would get a subsidy if the average wage was $24,000 for the
8 premium of a single worker. A single worker premium is
9 roughly $2,000, and if they were required to pay 80 percent
10 of that, that's $1,600.
11 Senator Bradley. Right. So you have the effect of a
12 generous subsidy for smaller firms, low wage.
13 Dr. Podoff. Correct.
14 Senator Bradley. That subsidy decreases, basically,
15 the larger the firm. My concern is, just as now we have
16 kind of a job lock, meaning people stuck in jobs because
17 they do not want to leave because they will lose their
18 health benefits, this could lock people into small firm
19 lock. They would be stuck in a small firm because if they
20 were going to try to go to a bigger firm on the margin, the
21 bigger firm would not hire.
22 Dr. Podoff. But if the worker was making $10,000, even
23 if they worked for the larger firm, then they would get a
24 subsidy because, in that case, 12 percent of a $10,000
25 worker's wage is $1,200, and the contribution of 80 percent

1 of $2,000 was $1,600. So, even if the firm was very large
2 and had a very high average wage, the firm would still get
3 a subsidy for that particular worker of, in that example,
4 $400.

5 Senator Bradley. Yes. Mr. Chairman, you have said in
6 the past on this question of a cliff that it is
7 unavoidable, that we face this in a variety of social
8 programs.

9 Let me just try once more, because I am not sure I get
10 it. Let me try once more. I am not sure everybody gets
11 it, either.

12 If I am a $20,000 worker in a 25-person firm, it costs
13 about $1,800 to cover me. But, if I move to a 1000-person
14 firm, it costs $2,400 to cover me. And the question then
15 is, it is going to cost more to cover me in a bigger firm
16 because the subsidy is less generous for the same $20,000
17 a year person, and that locks me into a small firm.

18 Dr. Podoff. If a $20,000 worker went to a small, low-
19 wage firm, it is correct, their employer would be eligible
20 for a larger subsidy.

21 Senator Bradley. Right.

22 Dr. Podoff. That is correct.

23 Senator Bradley. Right. And a smaller subsidy at a
24 larger firm. So, that locks you into a small firm, which
25 means you have less chance for promotion, less chance for

1 more generous pension benefits, less chance for all these
2 other things that you associate with larger firms, as
3 opposed to smaller firms, beyond health care.
4 And then, if you add to that a mandate system that
5 gives the incentive to split firms from large firms to
6 small firms, you potentially have a problem.
7 The Chairman. Yes, you do.
8 Senator Mitchell. But does that not assume that the
9 employing decision by the large employer would be based
10 exclusively on the costs.
11 Senator Bradley. Right.
12 Senator Mitchell. Secondly, that employer hiring
13 another person would not reduce his costs, so it would not
14 be a factor. For the larger employer, the cost is
15 identical no matter which employee --
16 The Chairman. In that case, it is a matter of a
17 difference.
18 Senator Mitchell. It is clearly not a factor that the
19 person involved may have been receiving a larger subsidy at
20 a different employer. It cannot be a factor for the larger
21 employer because, if the subsidy for the additional
22 employee is identical to that employer, regardless of who
23 the employee is, then the fact that one potential employee
24 has been receiving a larger subsidy at another firm can be
25 of no economic consequence because it does not affect his

1 decision.

2 So, to the larger employer making the employment
3 decision under the example you cited, there is no
4 distinction. There can be no economic significance since
5 the subsidy to him, the cost, is identical, regardless of
6 who he employs. And the fact that one potential employee
7 happened to be getting a larger subsidy at a previous
8 smaller employer and two others did not does not make any
9 difference.

10 Senator Bradley. But my point is, you have to see this
11 in the context of also the mandate decision and the cap on
12 payroll. And if the effect of the mandate decision is to
13 get large firms to split up into small firms, and the
14 worker who was working for a large firm with full benefits
15 then was split off into a small firm, losing some of his
16 other benefits, then why would the large firm rehire that
17 person, taking on the responsibility for all the other
18 benefits that it had just shed, and receiving less of a
19 subsidy for the health care than he otherwise would?

20 Senator Mitchell. It is actually the reverse, because
21 I think we have got two concepts confused here. The
22 incentive to split into smaller firms is to get a larger
23 subsidy per employee. That is the very incentive for the
24 employee. Since you have a uniform set of benefits, it is
25 not a case of splitting into smaller firms to offer less in

1 the way of benefits. The benefits package is --

2 Senator Bradley. Other than health.

3 Senator Mitchell. Other than health. Well, obviously

4 those are factors that will exist outside this context in

5 any event.

6 The Chairman. We are not persuaded that the --

7 Senator Bradley. No. That is perfectly clear, Mr.

8 Chairman.

9 (Laughter)

10 The Chairman. Well, if satisfied, we will go on to the

11 subject of benefits and the National Benefits Board. We

12 welcome Dr. Karen Hein, who will lay out this subject for

13 us.

14 Dr. Hein. Thank you.

15 The subject of benefits begins on page 18. There are

16 three provisions related to benefits and the Benefits

17 Board. The first, has to do with the value and structure

18 of the benefits, the second, with covered services, and the

19 third, with the new National Health Benefits Board.

20 The value of the standard package would be based on the

21 actuarial value of Blue Cross/Blue Shield's standard option

22 under the Federal Employees' Health Benefits program.

23 The Chairman. Can I just call attention to that? We

24 have a metric here. The standard Blue Cross/Blue Shield,

25 under the Federal Employees' Health plans. Now, that is

1 what we are trying to do. We work against that standard
2 mileage post.
3 Dr. Hein. That mileage post would then be adjusted for
4 an average population. There would be several cost-sharing
5 arrangements. The higher cost-sharing arrangement would be
6 specified in statute, but the Board would work out the
7 details of a lower cost-sharing plan and the combination
8 cost-sharing plan.
9 Integrated plans could reduce cost-sharing, set at a
10 level to keep the average premiums at or below the fee-for-
11 service level. In addition, a certified, very high
12 deductible health plan consisting of the same covered
13 services with a $5,000 per person, or $10,000 per family
14 deductible would be available, but not as a certified
15 standard health plan.
16 In terms of the covered services, health plans would be
17 required to offer a standardized set of covered services.
18 Categories of covered services would be specified in
19 statute, and simple definitions of these covered services
20 would be included in statute.
21 The National Health Benefits Board would be directed to
22 refine the covered services by reference to standards of
23 medical necessity or appropriateness. This would be
24 defined, briefly, as those intended to maintain or approve
25 the biological or psychological condition of the enrollee,

1 or to prevent or mitigate against an adverse health outcome
2 of the enrollee. And there is a special provision for
3 children under the age of 22 regarding their age and health
4 status.
5 The 16 categories of covered services are summarized
6 briefly by title as being 1) hospital services; 2) health
7 professional services; 3) emergency and ambulatory medical
8 and surgical services; 4) clinical preventive services.
9 And, here, there would be no cost-sharing requirement and
10 there would be no specificity in statute. But, again, the
11 Board, in consultation with expert task forces and so
12 forth, would come up with these specifics. 5) mental
13 illness and substance abuse. And, of note, as the Chairman
14 mentioned in his introduction, is that there would be
15 parity of these services as compared to other medical
16 conditions. 6) family planning services and services for
17 pregnant women; 7) hospice care services; 8) home health
18 services; 9) extended care services; 10) ambulance
19 services; 11) out-patient laboratory, radiology, and
20 diagnostic services; 12) out-patient prescription drugs,
21 home infusion therapy, and biologicals; 13) out-patient
22 rehabilitation services; 14) durable medical equipment,
23 prosthetics, orthotics, and prosthetic devices; 15) vision
24 care, hearing aids, and dental care for individuals under
25 the age of 22 years; and, lastly, 16) investigational

1 treatments, including the routine care provided as part of
2 research trials. These policies would go into effect on or
3 after January 1st, 1996.

4 The last part of benefits then is a description of a
5 new National Health Benefits Board that would be created as
6 part of the Department of Health and Human Services. The
7 Board would consist of seven members nominated by the
8 President and confirmed by the Senate. The members would
9 serve for six-year staggered terms.

10 The Board, in consultation with expert groups, would be
11 authorized to promulgate regulations, to clarify covered
12 services and cost-sharing, to refine the statutory
13 definition of medically necessary or appropriate services,
14 to develop appropriate schedules of covered services, and
15 to refine policies regarding coverage of investigational
16 treatments.

17 The Board would also be authorize to issue regulations
18 to modify the categories of covered services and cost-
19 sharing that would go into effect, unless Congress
20 overturned the regulations by joint resolution considered
21 under fast-track procedures.

22 The Chairman. Thank you. May I make the point, and
23 tell me if you agree, that one of the purposes of this
24 Board is that medicine--and you are a medical doctor--is
25 changing at such a rapid rate that you would not want to

1 put in statute what one new pharmaceutical or one new
2 procedure might just transform in six months' time. So you
3 have a Health Benefits Board that can react quickly to
4 sudden, new conditions.
5 Dr. Hein. Indeed.
6 The Chairman. Could you go back just a moment and tell
7 us the category of which there is a very -- well, what we
8 call catastrophic insurance, with that high $5,000, and for
9 family, $10,000 deductibility.
10 Dr. Hein. Yes. This high deductible plan would, once
11 again, have the same set of covered services. It would be
12 counted for purposes of counting the insured. It would be
13 community-rated. It would not be available through
14 employers, but would be available through co-ops, insurance
15 brokers, or insurance companies.
16 The Chairman. And that is for the individual who,
17 taking account of their circumstances, feels that is all
18 they need.
19 Dr. Hein. The individual would have to demonstrate
20 that he or she has the ability to provide for that high
21 deductible amount.
22 The Chairman. Right.
23 Senator Packwood. I have a question, Mr. Chairman.
24 The Chairman. Senator Packwood, then Senator Roth.
25 Senator Packwood. The $5,000 deductible is or is not

1 available to employees?

2 Dr. Hein. It is not a standard health plan, and,
3 therefore, would not be one of the three plans that would
4 have to be offered by employers. It would be available
5 through a cooperative insurance company or an insurance
6 broker.

7 Senator Packwood. I am confused by the answer. It is
8 available to them, but who can buy it?

9 Dr. Hein. An individual can buy it, but it would not
10 be made available through an employer.

11 Senator Packwood. An employee has to take one of the
12 three options.

13 Dr. Hein. In other words, you can buy it on your own.

14 Senator Packwood. I understand that. But, at the same
15 time, you cannot drop one of the three options that you
16 have as an employee.

17 Dr. Podoff. Correct, Senator. An employer has to
18 offer three plans --

19 Senator Packwood. Right.

20 Dr. Podoff. -- one of which is not this catastrophic.
21 In fact, the employer --

22 Senator Packwood. Well, none of which are this
23 catastrophic.

24 Dr. Podoff. None of which are catastrophic.

25 Senator Packwood. Yes.

1 Dr. Podoff. And the employer cannot offer that even as
2 a fourth option. If you want to get your catastrophic
3 plan, you have to get it through the co-op. You cannot get
4 it through your employer.
5 Senator Packwood. I understand that. And can you
6 choose to get no insurance through your employer?
7 Dr. Podoff. Sure. Particularly in the non-mandate
8 world, yes.
9 Senator Packwood. Particularly, what?
10 Dr. Podoff. Certainly, in a non-mandate world you
11 would not have to get insurance through your employer.
12 Senator Packwood. Well, I am assuming we are going to
13 be at mandate very soon with the percentages that we are
14 looking at.
15 Dr. Podoff. Then that is a different situation.
16 Senator Packwood. Well, I understand that. But, on
17 the assumption we are going to get to the mandates, I still
18 muse over Bill Bradley's idea of an employer big enough to
19 pull that -- that 98.35 percent is a whale of a percent.
20 I cannot imagine any company big enough--not General
21 Motors, not MicroSoft--big enough to pull that percentage
22 down below so that they do not have to be covered, so I am
23 assuming that they are going to have an employer mandate.
24 Can the employee opt out and buy the $5,000 policy?
25 Dr. Podoff. In the mark there is no provision for an

1 individual mandate. An employee could opt out, but the
2 employer would be required to pay 80 percent of the cost of
3 the standard plan.
4 Senator Packwood. Whether the employee chooses to take
5 it or not.
6 Dr. Podoff. Well, the employee could opt out of that,
7 yes, because there is no individual mandate. Although, in
8 response to the --
9 Senator Packwood. Wait. Say that again. The employee
10 can opt out?
11 Dr. Podoff. In response to a question that Senator
12 Rockefeller asked, the mechanics have not been worked out
13 until the Board decides what should happen later on, so we
14 do not know whether there will be an individual mandate
15 underlying the employer mandate.
16 Many of the bills that have employer mandates have
17 underlying individual mandates. If there were an
18 individual mandate, that would be a different story. And
19 perhaps--I do not know--the employee could not opt out.
20 Under the mark, that is --
21 Senator Packwood. Let us assume for the moment no
22 individual mandate. We simply say the employer must insure
23 his employees if we do not hit 98.35 percent in three years
24 for employers over 100.
25 So Bethlehem Steel has to offer all of its employees

1 one of the three options. And if the employee says, no, I
2 do not want that, I want to buy this $5,000 option and I
3 can afford it, the employer still has to pay the money for
4 one of the plans, even though the employee does not use it?
5 Dr. Podoff. No. I think the employee just walks away
6 from the contribution and you have to have some rules for
7 figuring out how to give credit to the employer who was
8 willing to pay that.
9 Senator Mitchell. Well, Bob, could I just ask?
10 Senator Packwood. Yes.
11 Senator Mitchell. How is it conceivable that an
12 employee would reject a more comprehensive benefit plan on
13 which he must pay 20 percent of the cost and elect a much
14 less attractive plan on which he must pay 100 percent of
15 the cost?
16 Senator Packwood. I am not sure he would do that. I
17 am just trying to find out theoretically, first, before I
18 work down to pragmatics.
19 Senator Mitchell. Oh. All right.
20 (Laughter)
21 The Chairman. Senator Rockefeller.
22 Senator Rockefeller. Mr. Chairman, a couple of
23 questions. Number one, are there any balanced billing
24 protections in the mark?
25 Dr. Hein. Balanced billing would be possible for fee-

1 for-service providers except in rural areas, where there
2 would be a need to have a participating list of physicians,
3 in which case that would be tied to a certain amount.
4 Otherwise, balanced billing would be permitted in fee-for-
5 service.
6 Ms. King. Senator, if I might, it sets up a concept
7 similar to the Medicare participating physician. So, if
8 you accept a payment in full -- and we would require under
9 health plan standards that health plans establish standards
10 that have a certain number of physicians who accept
11 assignment. So there is no outright prohibition on
12 balanced billing, but there are limits.
13 The Chairman. I do believe that meets some of the
14 concerns you have had. If it does not, we need to know
15 that.
16 Senator Rockefeller. Well, I need to take a closer
17 look, because it is a concern.
18 The Chairman. Yes.
19 Senator Rockefeller. The second question. Is
20 catastrophic deductible to the employer?
21 Dr. Hein. No. And, again, the word catastrophic --
22 basically, this policy would have the same set of covered
23 services. That's the answer right now.
24 Senator Rockefeller. All right. And in catastrophic,
25 are individuals eligible for subsidies?

1 Dr. Hein. No.

2 Senator Rockefeller. They are not. All right.

3 One final question. Who makes the decisions on medical

4 procedures, is that done by the doctor of the patient, is

5 there Board intervention, is there a combination, what?

6 Dr. Hein. Generally speaking, it is up to a patient

7 and physician to decide what is medically necessary or

8 appropriate. However, the new National Health Benefits

9 Board would be able to refine and further define standards

10 of medically necessary or appropriate.

11 Senator Rockefeller. Thank you.

12 The Chairman. Thank you, Senator Rockefeller.

13 Senator Roth, then Senator Bradley.

14 Senator Roth. Yes. I wonder if you could tell me,

15 what would be the tax treatment of benefits beyond the

16 standard benefit package?

17 Mr. Sollee. Certified supplemental policies would

18 receive favorable tax treatment. There is no tax cap.

19 Senator Roth. There is no tax cap of any sort.

20 Mr. Sollee. No.

21 Senator Roth. Secondly, what limits are there on the

22 Board as to what services can be covered? As I understand

23 it, we have got these broad generalities, so there is very,

24 very broad discretion in the Board as to what they could

25 include. But it has to go to the Congress under a fast-

1 track proposal. Would that fast-track proposal be subject
2 to amendment?
3 Dr. Hein. To answer your first question about the
4 Board's powers, the Board could refine and clarify the
5 covered services, particularly in terms of their scope and
6 duration. It is not likely that the Board would specify a
7 particular treatment, the particular treatment for a
8 condition is left to the discretion of the physician and
9 the patient with the standard of what is medically
10 necessary or appropriate treatment. In terms of the fast-
11 track procedures, there would be no amendments possible
12 under the fast-track procedure.
13 Senator Roth. Am I correct that the categories are
14 fairly broad, so very broad discretion is, in effect, being
15 given to the Board as to what could be added, and only
16 limited, perhaps, somewhat hard political decisions to make
17 to turn down the more favorable treatment if there are not
18 the finances for it?
19 Dr. Hein. The Chairman's mark contains 16 categories
20 of covered services. The Board would be directed to
21 clarify the covered services, again, mostly in terms of
22 scope and duration with the help of expert boards and task
23 forces, and so forth.
24 For example, the schedule of preventive services, such
25 as immunizations for children or adults at different ages,

1 and the schedule for those immunizations, those sorts of
2 details would be left to the Board.
3 Senator Roth. Thank you, Mr. Chairman.
4 The Chairman. Thank you.
5 Senator Bradley?
6 Senator Bradley. Mr. Chairman, I was just curious. In
7 the mark, it sets a high cost-sharing benefit package into
8 law.
9 Dr. Hein. Yes.
10 Senator Bradley. And then it says that the Benefits
11 Commission can vary cost-sharing for the lower cost-sharing
12 plan. So, why is one in law and one is modified by the
13 commission?
14 Dr. Hein. Senator Moynihan referred to the yardstick,
15 or benchmark that we have put in statute. Another, would
16 be to specify the fee-for-service particulars, and they are
17 in statute, to have an annual out-of-pocket maximum of
18 $2,500 for individual, $3,000 per family, $400 for
19 individual, or $800 per family deductible, 25 percent co-
20 insurance, $250 per admission hospital deductible, $250
21 prescription drug deductible, and that is the only
22 specifics around cost-sharing that would be in statute.
23 Senator Bradley. Yes. But my question is, why is it
24 in statute only for the high cost-sharing plan and not the
25 low cost-sharing, or vice versa? Why do you not have the

1 commission determining low cost-sharing plan, as well as
2 high cost-sharing plan?
3 Dr. Hein. Yes. The idea was, again, to use a broad
4 outline which then could be filled in later, and that
5 integrated plans could look at this set of covered services
6 and come up with a list of cost-sharing provisions that
7 might come in and a lower premium to give that degree of
8 flexibility after this has been locked into statute.
9 Senator Bradley. So that you are saying the only way
10 that fee-for-service cost-sharing can be changed is by
11 passage of law.
12 Dr. Hein. It would be indexed to CPI, plus a certain
13 amount per year.
14 Dr. Podoff. Senator, there is also a scoring issue
15 here. In order for CBO to score this, you need to specify
16 the cost-sharing arrangements or the general plan. If you
17 assume the HMO is not going to charge more than that, they
18 can, indeed, lower their cost-sharing.
19 Senator Bradley. All right. That is the answer I was
20 wondering about. Thank you very much.
21 The Chairman. Thank you. Now, can we go, next, to the
22 all-important question of health insurance purchasing
23 cooperatives, otherwise known as HIPCs. We are going to
24 hear, first, from Jane Horvath. Thank you, Dr. Hein.
25 Now, we are going to hear from Kathy King.

1 Ms. King. I was pretending. The Chairman's mark
2 provides for the establishment of voluntary purchasing
3 cooperatives, which means that no individual and no
4 employer would be required to purchase insurance through a
5 purchasing cooperative. The people who would be eligible
6 to purchase through a cooperative include those below the
7 community-rating threshold.
8 The cooperatives would be competing. There could be
9 multiple cooperatives in an area. The cooperatives would
10 be permitted to negotiate and would not have to accept
11 every plan. However, if it did negotiate a lower price
12 with a plan, then that price would become the community
13 rate throughout the area.
14 If a cooperative were not established in every State by
15 1996, the State would either have to establish or sponsor
16 a cooperative so that every individual would have the
17 opportunity to purchase insurance through a cooperative.
18 Cooperatives would have to offer at least three health
19 plans, including a fee-for-service plan, and a plan with a
20 point-of-service option. The cooperatives would be non-
21 profit institutions. And that is a brief summary.
22 The Chairman. Would you mention the Federal Employees'
23 Health Benefits?
24 Ms. King. Yes. It builds on Senator Roth's proposal.
25 Each health plan participating in the Federal Employees'

1 Health Plan would be required to offer coverage in the
2 community-rated area, and people enrolling in those plans
3 would be community-rated in the community rating pool.
4 The Chairman. Which is the case with the federal
5 employees' plan now.
6 Ms. King. No, Mr. Chairman. I believe that federal
7 employees are in a large, experience-rated pool.
8 The Chairman. As against the community pool. That is
9 all. Yes. Fine. Well, do you want to add to that?
10 Senator Durenberger. Mr. Chairman.
11 The Chairman. Senator Durenberger.
12 Senator Durenberger. Kathy, let me ask you to explain
13 to me sort of the power, the authority of what you call the
14 State or local government units forming cooperatives. I
15 think you know my concern, that it might go beyond just the
16 ability to charter the co-op and so forth, but to, in one
17 way or another, dictate the terms of the co-op. Can you
18 help me understand what is contemplated here?
19 Ms. King. I hope so. I think that our intent is that
20 most of the cooperatives will be in the private sector and
21 they will be non-profit corporations. But, in the event
22 that one was not established, then the State could
23 establish one or sponsor one, but they would operate under
24 federal rules.
25 Senator Durenberger. Does that mean that only in the

1 absence of a cooperative in -- excuse me. What do we call
2 the areas that the States are going to designate, the
3 marketing areas?
4 Ms. King. Community rating areas.
5 Senator Durenberger. Community rating areas. And
6 within those community rating areas, the employers and
7 individuals will have opportunities to buy, either through
8 a co-op if there is one that exists, or get it at work from
9 a choice of health plans.
10 Now, I can understand if there are no co-ops at all, no
11 BEWAs, no anything else, in one of your community rating
12 areas that we would want someone to create, whether it is
13 a State or local authority, to charter a co-op with federal
14 rules. But, if there are existing co-ops and if there is
15 no impediment to membership in those co-ops, either by
16 individuals or small groups, does a State or local
17 government have authority in those kinds of circumstances
18 to go in and create -- are there any limitations on the
19 authority?
20 Ms. King. Under the mark there are no limitations.
21 The State or unit of government would not be prohibited
22 from forming a cooperative.
23 Senator Durenberger. Is there authority in the mark to
24 set rules as to membership in the co-op, where it is a
25 local government as opposed to a national government, or is

1 it all played by national rules?

2 Ms. King. It is all played by national rules.

3 Senator Durenberger. And are these member-owned and
4 operated, in effect, cooperatives?

5 Ms. King. They are not--and this is really more of a
6 tax question, in a way--cooperatives in the strict federal
7 sense of the law. They do not operate under federal
8 cooperative rules, but that is a name that we have given
9 them. They are non-profit organizations.

10 Senator Durenberger. Is there someone--and maybe we
11 should not get too far into this because we are getting
12 into legalisms here--who can explain to me why we do not
13 use the co-op law for the formation of these?

14 The Chairman. May I say that Secretary Samuels is
15 here, as is Joe Gale, our tax counsel, if you would like to
16 address them.

17 Senator Durenberger. May I do that? Yes.

18 Mr. Gale. Senator, if your question if why we did not,
19 say, take the existing rules for cooperatives in the
20 Internal Revenue Code and use them here, I will say it is
21 a decision we did not spend a long amount of time on, but
22 the initial analysis was that the cooperative rules, which
23 are essentially designed to take care of things like
24 farmers' cooperatives where they have collective purchase
25 of farming goods or collective sale, did not lend

1 themselves particularly well to what we were trying to do.
2 We are going to create a new number under the 501(c)
3 section of the Internal Revenue Code and just give non-
4 profit treatment, and that was thought to create the
5 maximum flexibility, and that you would get results under
6 the co-op rules of the Tax Code that you did not
7 particularly want, or had not anticipated.

8 Senator Durenberger. And I certainly am not familiar
9 with either. My concern goes to the fact that, in effect,
10 these are co-ops of some kind that we are setting up, and,
11 hopefully they are, to some degree, member-owned and
12 operated rather than being run by the government, or
13 something like that, and I know you can accomplish that,
14 either under a non-profit or a co-op.

15 But the traditional way, in terms of what is the
16 relationship between the members and the operating
17 authority seems to exist in the co-op law, so I thought
18 perhaps there was some --

19 Mr. Gale. I think there is essentially an opting for
20 the most flexible standard. The thing you would have to
21 watch out for in the non-profit realm is simply assuring
22 yourself that there was not private inurement occurring to
23 any private individual, and beyond that you would have a
24 great deal of flexibility in how to set it up. But it is
25 a question that we could continue to look at, if you think

1 that is advisable.

2 Senator Durenberger. All right. Thank you very much.

3 The Chairman. Fine.

4 Senator Roth?

5 Senator Roth. Just two quick questions. Who would be
6 able to participate in the local federal program,
7 individuals as well as small business and large
8 corporations? What role would the OPM play in the program,
9 if any?

10 Ms. King. Following along the lines of your proposal,
11 Senator, OPM would not have a role.

12 Senator Roth. And what about, it would be open to any
13 individual under this proposal, or just small business or
14 corporations?

15 Ms. King. Yes. Individuals would be included.

16 Senator Roth. Individuals would be eligible, including
17 those working for large corporations?

18 Ms. King. Individuals who work in firms of 500 or
19 fewer would be eligible to participate because they would
20 be entering into the community rating pool, and individuals
21 and firms above 500 would not be eligible to participate.

22 Senator Roth. Thank you.

23 Senator Durenberger. Mr. Chairman.

24 The Chairman. Sir.

25 Senator Durenberger. If someone is qualified to

1 respond to questions on the FEHBP, I want to, first, draw
2 the distinction between the government-wide FEHBP plans.
3 Is that you, Kathy?
4 Ms. King. Yes.
5 Senator Durenberger. The government-wide FEHBP plans
6 would not be required to open a non-federal employee
7 enrollment. And maybe I can get the answer to the question
8 I have in my head if you just tell me why they are not
9 open, but the other plans are.
10 Ms. King. Senator, I think our thinking on that is as
11 follows, that the national plans offer a national rate,
12 and, in some areas where there is a high-cost plan, these
13 plans could be swamped by the fact that so many people
14 would flock to them because the national rate would be so
15 much lower than the prevailing community rates.
16 Senator Durenberger. So, in other words, when we are
17 talking about the FEHBP there are certain plans available
18 to members of Congress and all other federal employees here
19 in the District of Columbia today which are community-rated
20 across America, right?
21 The Chairman. Experience rated. Is that not what you
22 said?
23 Ms. King. Yes.
24 Senator Durenberger. They are experienced rated. But,
25 in effect, it is the community of all members of those

1 plans all the way across America, right?

2 Ms. King. That is correct.

3 Senator Durenberger. And, in addition to that, in the

4 District of Columbia we also have plans that are rated on

5 the risk experience right here in the District of Columbia,

6 Northern Virginia, and Maryland, and so forth. Is that

7 right?

8 Ms. King. Yes, essentially. I mean, what it is, is

9 that there are plans who only offer to a limited market

10 area, so their plan is priced for that community.

11 The Chairman. There are some 300 plans, are there not?

12 Ms. King. Yes.

13 The Chairman. And some would just sell here. They do

14 not sell anywhere else.

15 Ms. King. And, Senator, this is the proposal that came

16 from the mainstream coalition. It is different from what

17 was in the Chairman's draft mark.

18 The Chairman. Senator Durenberger, this is your

19 proposal.

20 (Laughter)

21 Senator Durenberger. I want to claim I am not asking

22 the question out of ignorance, but just to clarify it for

23 those who were not in the room when we were coming up with

24 this recommendation. And I do not want to belabor

25 everybody in America ought to be able to get the same

1 health plan that members of Congress have, I am trying to
2 say that it requires a little bit more definition.
3 I mean, we have a choice of a plan which is experience
4 or community-rated across all members in America, and then
5 some which are specific to Minneapolis, St. Paul, if you
6 live out there, or Kansas City, or New York City, or
7 Portland, or Washington, D.C.
8 And your proposal, and our proposal, would be to make
9 it possible for an individual living in the District of
10 Columbia to buy an accountable health plan, or whatever we
11 call these, through the local plans offered by the FEHBP.
12 Ms. King. That is correct.
13 Senator Durenberger. And if I live in Minneapolis or
14 St. Paul, I would be buying a different plan and I would be
15 buying it through the FEHBP in Minneapolis, St. Paul.
16 Ms. King. Right.
17 Senator Durenberger. Now, if in Minneapolis, St. Paul
18 we are talking about a community base for the Federal
19 Employee Health Benefit Plan of, say, 500 federal
20 employees, in the future, will the accountable health plan
21 that sells through the FEHBP in Minneapolis, St. Paul be
22 community rating their plan, or will they be experience
23 rating that plan, based on the experience of the 500
24 federal employees, or their spouses and children, in
25 Minneapolis, St. Paul?

1 Ms. King. I think the answer has to parts. One, is
2 that the federal employees in the plan would be experience
3 rated with other federal employees, and the non-federal
4 enrollees would be in the community-rated pool.
5 Senator Durenberger. You mean, if I am not a federal
6 employee but I want to buy through the FEHBP in
7 Minneapolis, St. Paul, I pay a different rate from the rate
8 that would be paid for the very same plan in Minneapolis,
9 St. Paul by a federal employee?
10 Ms. King. Yes, it could be. I presume it would be.
11 It could be a different rate.
12 Senator Durenberger. Why would we do that?
13 Ms. King. I think the thinking is this, is that if you
14 allow everyone who is a non-federal enrollee to enroll in
15 FEHBP, then those people are, if you will, siphoned off out
16 of the community rating pool, and if they tend to be a
17 healthier population and a better risk, then you are
18 driving up the rate in the community rating pool.
19 So, if you split them into two, you keep those people
20 in the community rating pool and you keep the federal
21 enrollees --
22 Senator Durenberger. In other words, the federal
23 employees would not like to have the premium that they are
24 paying on their own experience diluted by people coming
25 into their pool who are higher cost.

1 The Chairman. I think it might be just the other way
2 around.
3 Ms. King. Well, the problem is, we do not really know
4 who would come into this pool.
5 Senator Durenberger. No.
6 Ms. King. And federal enrollees are older, on average.
7 So it could be better or worse. We do not --
8 Senator Durenberger. And I am only working my way to
9 the final conclusion, which is the value then of buying
10 your health plan from the FEHBP--you are not buying FEHBP,
11 you are just buying your Blue Cross plan, or your Aetna
12 plan, or whatever it is, through FEHBP--is the
13 administrative savings, if you will, that come from buying
14 through an FEHBP pool rather than a local co-op pool, or
15 something else. Is that basically the bottom line?
16 Ms. King. Yes. And I think there could be an
17 additional advantage in that they would save on FEHBP.
18 There is an FEHBP plan every place mail is delivered, so it
19 could increase access to plans in rural areas.
20 Senator Durenberger. Well, I will not belabor that.
21 But your point is, that maybe in some rural areas there are
22 not co-ops or other access mechanisms or buying mechanisms.
23 Is that is your point?
24 Ms. King. It would be an additional choice.
25 Senator Durenberger. But, in Minneapolis, St. Paul,

1 the issue is just, do I save any money at all on the
2 administrative costs by buying through the FEHBP rather
3 than buying through some other local co-op? All right.
4 Thank you.
5 The Chairman. A nice point. Everywhere the mail is
6 delivered a Blue Cross/Blue Shield health insurance plan
7 will be available. Not the worst achievement. All right.
8 Thank you, Kathy.
9 Now, to the always interesting subject of cost
10 containment. We will ask Dr. Podoff back, with our
11 committee attorney, Chuck Konigsburg. Dr. Bill Braithwaite
12 will join us, along with Dr. Peter Rudetti, who, as I
13 remarked in one of our earlier hearings, is both a
14 physician and a lawyer. Dr. Rudetti is over there.
15 David, you are listed first, so we will start out with
16 you.
17 Dr. Podoff. Thank you, Mr. Chairman.
18 The section on cost containment starts on page 26. The
19 first issue we were going to deal with were our premium
20 targets. We will have a commission, the same one that is
21 going to be tracking changes in coverage, monitor changes
22 in per-capita premiums and other indicators of health
23 inflation.
24 Targets would be set for these premiums, and they are
25 targets, at CPI, plus an increment, starting at four

1 percent in 1996, and then winding down to two percent by
2 2000, and staying there.
3 This increment or adjustment factor is designed to
4 account for increases in real per-capita income, changes in
5 demographics and health status, and changes in medical
6 technology. The commission would make recommendations if
7 it finds that the targets, adjusted for the actual rate of
8 inflation, have been exceeded. The recommendations of the
9 commission would then be considered under expedited
10 procedures, which Mr. Konigsburg will explain.
11 The Chairman. Could I add just one point here? It can
12 easily confuse any one of us. As real income rises, it is
13 not required that we just keep to the CPI, which is
14 basically a measure of inflation. If we held to CPI, the
15 Consumer Price Index, while real income was growing, as it
16 does, you would see the proportion of medical costs as
17 dropping in the household budget; would you not?
18 Dr. Podoff. That is exactly correct, Mr. Chairman.
19 That is why it is CPI, plus something.
20 The Chairman. That is why we have that.
21 Dr. Podoff. That is why we have CPI, to exactly
22 account for increases in real per-capita income. Exactly
23 right, Senator.
24 The Chairman. And a choice that a household with more
25 disposable income might make, is to spend more on medicine.

1 Dr. Podoff. Exactly, Mr. Chairman. And the fact that,
2 as incomes rise, we would expect the incomes of everybody
3 to rise, including medical providers. They are people
4 also. So, if everybody's income is rising, theirs would
5 rise and the premiums would reflect that.
6 The Chairman. Thank you.
7 Mr. Konigsburg?
8 Mr. Konigsburg. Mr. Chairman, the commission's
9 proposals would be drafted as a joint resolution by the
10 House and Senate legislative councils. It would then be
11 introduced by the Majority and Minority Leaders by March
12 15th. Committees would have 45 session days to report the
13 cost containment resolution, or be discharged, and
14 amendments would be permitted, but only if relevant to cost
15 containment.
16 Motions to proceed would be non-debatable, and if
17 motion to proceed was agreed to, there would be a 50-hour
18 time limit on consideration, and, following conference, a
19 20-hour time limit on consideration.
20 With regard to the deficit control mechanism, under
21 current law we have two sets of budget rules. The first,
22 is the Budget Enforcement Act of 1990, which established
23 the pay-as-you-go process requiring that all entitlement
24 spending and revenue legislation be fully paid for at the
25 time of enactment.

1 We also now have the 10-year pay-as-you-go requirement
2 in the Senate, which was adopted as part of the 1994-1995
3 concurrent resolutions on the budget. That requires that
4 all legislation be fully paid for in the first year, the
5 first five years, and over the second five years.
6 Together, those two processes operate to require that
7 new entitlement legislation such as health care reform be
8 estimated at the time of enactment as being fully paid for
9 in fiscal year 1995, fiscal year 1995-1999, and fiscal year
10 2000-2004.
11 However, as we all know, projections of costs can be
12 wrong. As the Chairman has often reminded us, Medicare now
13 costs more than envisioned at its creation, and that is the
14 reason for this fail-safe mechanism in the mark.
15 The mechanism would operate as follows: OMB would be
16 required in January to determine whether health care reform
17 had caused a deficit in the prior fiscal year. If OMB
18 determines, through a comparison of baselines, that health
19 care reform had, in fact, caused a deficit in the prior
20 year, then it would be required to determine the amount of
21 proportional reductions in subsidies and in new tax credits
22 required to offset the health-related deficit in the
23 upcoming fiscal year.
24 The automatic reductions would be implemented by OMB
25 and the Secretary of Treasury on September 20th unless, in

1 the interim, Congress enacts alternative deficit reduction
2 legislation.
3 The alternative deficit reduction legislation would be
4 developed under a fast-track process similar to the trade
5 fast-track, which this committee is quite familiar with.
6 Under that process, Congressional committees would consult
7 with each other and with the administration in developing
8 the deficit reduction legislation.
9 The President would then transmit the product by June
10 1st, and it would be considered under expedited procedures,
11 which would culminate in a final vote in August. And your
12 mark-up books lay out the day-by-day process.
13 The Chairman. Yes.
14 Mr. Konigsburg. The expedited procedures would operate
15 only if the chairmen of the budget committees, using CBO
16 estimates, certify that the alternative legislation would
17 fully offset the deficit.
18 If Congress does not enact alternative deficit
19 reduction legislation, the automatic reductions calculated
20 by OMB back in January would then go into effect in
21 September. It would be applied according to a progressive
22 schedule so that the lowest income beneficiaries of the
23 subsidies and tax credits would receive the smallest
24 reductions. The deficit fail-safe mechanism would be
25 suspended in the event of two consecutive quarters of no

1 real economic growth.

2 The Chairman. Thank you.

3 Dr. Rudetti, I think you are next. No, Dr. Braithwaite
4 is next. Doctor.

5 Dr. Braithwaite. Mr. Chairman, thank you. The mark's
6 administrative simplification and paperwork reduction
7 proposal is a refinement of the work that has been done in
8 the past by Senator Riegle and Senator Breaux, and
9 introduced last year as the Health Care Information
10 Modernization Act of 1993. The proposal would implement a
11 national health information network to reduce the burden of
12 administration complication, paperwork, and cost on the
13 health care system.

14 To provide the information on cost and quality
15 necessary for competition to exist in the health care
16 market, and to provide information tools that would allow
17 improved fraud detection, outcomes research, and improve
18 quality of care.

19 The Chairman. Outcomes research. That is a new thing.

20 Dr. Braithwaite. With the help of an advisory
21 committee of experts, the Secretary of HHS would adopt
22 standards for the content and format of the information
23 used in common administrative transactions of health care
24 for both paper and electronic forms.

25 The Secretary would also establish standards for

1 electronic transactions and for certification of network
2 service organizations which would enable private sector
3 implementation of the network. Health care providers and
4 plans would be required to participate in the network, at
5 least for claims processing. Implementation would enable
6 a total paperless claims processing and payment mechanism
7 in the health care system.

8 The Chairman. A paperless claims process. Wow. That
9 may be the most important thing we do today.

10 Dr. Braithwaite. The proposal would also preempt State
11 laws which require that health records be written on paper.
12 The Secretary would establish standards for a health
13 security card, so that a card issued anywhere in the
14 country would function in all other locations.

15 The card would carry a unique identifier, based on the
16 Social Security number, and would be protected by law from
17 being used or required for any purpose other than obtaining
18 or paying for health care.

19 The Chairman. It is our purpose in this draft that
20 your health security card number should be your Social
21 Security number. That is a common identification. Now it
22 has been adopted. I believe children receive Social
23 Security numbers in their bassinets.

24 Dr. Braithwaite. Further, the requirement on all plans
25 to make eligibility information on their enrollees

1 available electronically allows the functionality of this
2 network to replace the function of the Medicare and
3 Medicaid coverage data bank required by OBRA-93, but not
4 yet implemented.
5 The Chairman. Devoutly to be desired. Thank you very
6 much, Dr. Braithwaite.
7 Dr. Rudetti, you take on the more disagreeable matters,
8 such as malpractice and fraud.
9 Dr. Rudetti. Thank you, Mr. Chairman. The malpractice
10 reforms in the Chairman's mark would require plans to
11 establish processes that would be designed to try to settle
12 disputes without going to court, processes such as
13 alternative dispute resolution procedures, such as
14 arbitration and mediation.
15 But, if persons were dissatisfied with the results of
16 these, they could then go to State court for resolution of
17 their claim. There would be a sliding scale of contingency
18 fee limits on attorneys' fees that would require the
19 reduction in the percent of payment as the size of the
20 award rose.
21 There would be a required reduction in the awards by
22 the amounts that were paid in from any other source, such
23 as Worker's Compensation, or sickness or disability
24 programs, and from private insurance.
25 Large payments would be paid over time under the

1 court's discretion, and could be paid on a schedule that
2 would be established by the court.
3 Then there are two provisions for demonstration
4 projects to test alternative ways of resolving disputes.
5 One, would be enterprise liability, which would be a system
6 under which States would opt to hold health plans liable
7 for malpractice claims rather than the physicians and the
8 health plans together, and another demonstration project to
9 test the use of medical practice guidelines as setting the
10 standard of care.
11 In the fraud arena, there would be a program
12 established to combat fraud in the health care arena, and
13 the trigger would be fraud that could affect any federal
14 outlays. There would be provisions that would draw largely
15 upon current procedures in the Social Security Act that
16 would try to combat measures that would be fraudulent that
17 would involve matters such as filing false claims, bribery,
18 and other kinds of overt fraudulent activities against the
19 health plans.
20 There would also be a new fund set up to try to provide
21 a steady stream of money for the Inspector General, the
22 Department of Justice, and the Attorney General to conduct
23 investigations to try to protect against fraud and abuse
24 against federal outlays.
25 The Chairman. That funding stream will come from

1 where?

2 Dr. Rudetti. The funding stream would come from any

3 recoveries of monies that were fraudulently obtained.

4 The Chairman. Yes.

5 Dr. Rudetti. So that some of that money recovered

6 would go into this fund, and the remainder would go back to

7 the Treasury.

8 The Chairman. Senator Bradley.

9 Senator Bradley. Mr. Chairman, I would like to ask a

10 general question on the cost containment section. And that

11 is, is there a premium cap in this section?

12 Dr. Podoff. No, Senator.

13 Senator Bradley. Is there a tax cap in this section?

14 Dr. Podoff. No.

15 Senator Bradley. Is there a tax on high-cost premiums

16 in this section?

17 Dr. Podoff. No, Senator.

18 Senator Bradley. Will CBO score this as achieving the

19 targets?

20 Dr. Podoff. The targets -- we will have to see what

21 CBO does. I do not know what they will do on targets.

22 Senator Bradley. So we do not know.

23 Senator Packwood. Let me ask a question. We are

24 planning to vote this out without any knowledge from CBO

25 anyway, are we not?

1 The Chairman. Yes.

2 Senator Packwood. So it does not really matter.

3 The Chairman. We do not know the answer to your
4 question.

5 Senator Bradley. All right. What happens if the
6 targets are not met?

7 Dr. Podoff. What happens is, the commission is
8 required to make some recommendations on how to deal with
9 that. They could recommend changing the targets.

10 Senator Bradley. Right.

11 Dr. Podoff. They could recommend several things.

12 Senator Bradley. And what happens if Congress does not
13 act?

14 The Chairman. There is the right for the Executive
15 Branch to implement provisions.

16 Mr. Konigsburg, answer the Senator.

17 Mr. Konigsburg. Congress would have to act in order
18 for any of these cost containment measures to be adopted.

19 Senator Bradley. Right. So if Congress does not act,
20 there is no cost containment.

21 Mr. Konigsburg. Not under these procedures.

22 Senator Bradley. Thank you.

23 The Chairman. I would make the point that Congress
24 makes the laws.

25 Well, we thank you very much. We now go on to the

1 always cheerful subject which the Finance Committee sees,
2 called Revenue Provisions, and which Joe Gale, our Chief
3 Tax Counsel, will be here. Will Sollee, and someone from
4 the Joint Committee on Taxation. I do not have a name
5 here.

6 While we are here, a quorum has been present today. We
7 have previously heard testimony from Valerie Lau, who has
8 been nominated by the President to be Inspector General of
9 the Department of the Treasury, and Ronald Noble, who is
10 currently an Assistant Secretary--I believe that is right--
11 for Enforcement to be promoted to the new position of Under
12 Secretary for Enforcement, Department of the Treasury.

13 I propose these nominations be reported out, if there
14 is a second.

15 Senator Packwood. Second.

16 The Chairman. There is a second. All in favor will
17 say aye.

18 (A chorus of ayes)

19 The Chairman. Those opposed?

20 (No response)

21 The Chairman. None are opposed. We congratulate Ms.
22 Lau and Mr. Noble. Someone might notify them.

23 Mr. Gale, good morning. No, not yet. For the
24 Minority, we now have Mark Prater. Mr. Prater, good
25 morning. It is not yet good morning.

1 (Laughter)

2 The Chairman. Good evening.

3 And Mary Schmitt. There you are, for the Joint
4 Committee. And we have the distinct high honor and
5 distinct privilege of having Secretary Samuels with us as
6 well.

7 Secretary Samuels. Mr. Chairman.

8 The Chairman. Good evening, sir.

9 Mr. Gale, you begin.

10 Mr. Gale. Thank you, Mr. Chairman. We will do a brief
11 walk-through of the provisions in Title 7, the revenue
12 provisions in the proposal. I will take you through in the
13 order they are in in the mark.

14 Starting on page 41, the increase in excise taxes on
15 tobacco products. The excise tax rate on cigarettes would
16 be increased under the proposal by $1.76 per pack from the
17 current 24 cents per pack, which would mean a total $2.00
18 per pack tax.

19 A comparable increase, generally based on tobacco
20 content, would be imposed on other tobacco products:
21 cigars, snuff, chewing tobacco, pipe tobacco, cigarette
22 papers, etc. The increase would take place on January 1,
23 1995.

24 Item B. Additional Medicare Part B premiums for high-
25 income individuals. Starting on page 44. The higher

1 income individuals will pay premiums for Medicare Part B
2 equal to 75 percent of the estimated program costs rather
3 than the current 25 percent.
4 The Chairman. The current 25 percent. Right.
5 Mr. Gale. Item C. Modification to self-employment tax
6 treatment of certain S corporation shareholders and
7 partners. That discussion begins on page 45. Under this
8 proposal, a shareholder owning more than two percent of the
9 S corporation stock and providing significant services
10 would pay payroll taxes on 80 percent of his or her share
11 of the earnings from service businesses of the S
12 corporation. Limited partners in a partnership would be
13 subject to similar rules. The limited partner rule,
14 however, would not be limited to two percent owners.
15 Finally, a portion of the income from inventory earned
16 by sole proprietors and partners and S corporation
17 shareholders would be exempted from employment taxes.
18 The gist of this provision, Mr. Chairman, is to ensure
19 that a proper amount of wages is accounted for in the
20 situation of an S corporation where two percent greater
21 shareholders are both owners and suppliers of services to
22 the corporation.
23 In the case of corporation that are intensely service-
24 related, the net income of that corporation that is
25 distributed to an owner is arguably service income and

1 should be treated, for payroll tax purposes, as income from
2 wages.
3 The Chairman. Could I ask Ms. Schmitt, what we are
4 dealing with in this latter point is basically a tax
5 loophole at the present time, is it not?
6 Ms. Schmitt. Yes, Mr. Chairman. I think that there
7 clearly is a problem with present law to the extent that
8 two percent shareholders of S corporations are basically
9 not being required to pay SECA taxes with respect to an
10 imputed wage, or earnings from the --
11 The Chairman. Could I ask Secretary Samuels--you may
12 not wish to comment--would that be your view, the Treasury
13 view?
14 Secretary Samuels. Mr. Chairman, yes. This type of
15 provision was included in the administration's proposal and
16 it was included because we recognized --
17 The Chairman. Because of this. Yes. Fine.
18 Mr. Gale. I would note that the proposal in the mark
19 is a narrower proposal, though, than in the administration
20 bill, which is a smaller class of corporations.
21 The Chairman. All right.
22 Mr. Gale. Item D. Extending Medicare coverage and the
23 HI wage tax to all State and local government employees.
24 That is on page 48.
25 The Chairman. So we finally get to that. How long has

1 it taken us? Almost 30 years, just about.

2 Mr. Gale. Yes. Under current law, State and local
3 employees hired prior to April 1, 1986, it is an optional
4 rule as to whether you are covered under Medicare, and
5 whether the employer has to pay the employer's share, and
6 employee the employee's share of the HI tax. This proposal
7 would extend it to all outstanding employees.

8 E. A credit for health insurance costs of individuals
9 not eligible for subsidized employer-provided health care.

10 The Chairman. Now, here we are spending money.

11 Mr. Gale. Yes. This is a new tax credit. It is
12 basically designed to provide parity under the Tax Code for
13 individuals who do not have health insurance coverage
14 through their employer. This allows the individual, self-
15 employed or otherwise, to take a tax credit that is equal
16 to 15 percent of the cost of a certified standard health
17 plan.

18 Now, that 15 percent tax credit is the equivalent of a
19 100 percent deduction for taxpayers who are in the 15
20 percent bracket, and then up in the 28 percent brackets are
21 greater than 50 percent, and so forth. It is, in other
22 words, progressive, and delivers the tax expenditure in a
23 greater amount to lower income individuals.

24 The Chairman. Mr. Prater, you will not hesitate just
25 to volunteer.

1 Mr. Prater. Thank you, Mr. Chairman.

2 Mr. Gale. Item F. Limitation on prepayment of medical
3 insurance premiums. For purpose of the new credit I have
4 just mentioned, as well as the current law, itemized
5 deduction for medical expenses, this proposal would limit
6 the deductibility of amounts paid for health insurance
7 coverage to be delivered greater than 12 months in the
8 future.

9 It basically is designed to prevent the so called
10 front-loading of health care expenses to obtain a higher
11 tax credit or a higher deduction, say, in a current year
12 for purchases of insurance over periods far into the
13 future. Without it, you would be able to manipulate your
14 tax liability in a given year.

15 Item G. Definition of employee. This provision would
16 authorize the Treasury Department to issue regulation
17 related to the classification of workers as employees or
18 independent contractors under the common law test.

19 These regulations would apply only on a perspective
20 basis, and the further limiting factors that the
21 regulations could not have the effect of repealing the
22 ability of any business to utilize a present law safe
23 harbor to treat a worker as an independent contractor.

24 Senator Pryor. Mr. Chairman, may I ask Joe a question?

25 The Chairman. Yes, sir. Senator Pryor.

1 Senator Pryor. Does this change the definition of
2 independent contractors all over the IRS code, or just a
3 certain class of independent contractors.
4 Mr. Gale. This does not address any particular class
5 of independent contractor. Most of the relevant law here
6 is based upon Section 530 of the Revenue Act of 1978, which
7 sets up a series of safe harbors that, if you meet them,
8 the employer cannot be challenged as treating someone as an
9 independent contractor for employment purposes.
10 This provision would not change any of those current
11 law protections, but there will be situations under current
12 law where, for one reason or another, you cannot qualify
13 for a safe harbor. In that case, the Treasury would be
14 able to issue regulation that would clarify or give a set
15 of clarifying rules about where the line is between
16 independent contractors --
17 Senator Pryor. Well, the independent contractor issue
18 is one that is very much alive out there in the real
19 marketplace today, and I am just wondering about whether we
20 should have it in this health care legislation or not.
21 This is not a question, Mr. Chairman, and I will
22 conclude with this. I am concerned that what I think is
23 also being explained to us equals the fact that, under our
24 proposal, or this proposal, that the self-employed are not
25 going to get the 100 percent deduction that all other plans

1 have basically encompassed.

2 The self-employed individual, under this plan, will not
3 receive but a 25 percent deductible for the first two
4 years, and then there is some formula that they find
5 themselves under an umbrella after the two years. Is that
6 correct?

7 Mr. Gale. Well, what the proposal does, the new 25
8 percent tax credit does not come into play until January 1,
9 1997, to allow time for the new community-rated health
10 plans to be in effect. During that interim, we reinstate
11 the present law, 25 percent reduction for self-employed,
12 which, as you probably know, expired at the end of 1993.

13 So we pick it up for 1994, 1995, 1996, and then self-
14 employed individuals would claim the new credit that all
15 individuals not covered at work are entitled to. And that
16 credit, I should note, is more generous than the treatment
17 of self-employed under the deduction that was available
18 through --

19 Senator Pryor. But it is not as generous as a 100
20 percent deduction.

21 Mr. Gale. It would depend on the income level. At a
22 15 percent rate bracket, yes, but at a 39 or so, less than
23 100.

24 Senator Pryor. Mr. Chairman, tomorrow I will ask some
25 questions, probably, of the proper authorities as to what

1 the difference would be in just a straight 100 percent
2 deduction for the self-employed versus the plan that is in
3 your mark.
4 The Chairman. All right. Anticipating the Senator's
5 question --
6 Senator Pryor. I will not take the committee's time to
7 go through that tonight.
8 The Chairman. Fine. But, anticipating the Senator's
9 question, would we have some work on that?
10 Mr. Gale. Certainly.
11 The Chairman. Thank you, Senator.
12 Senator Pryor. Thank you.
13 Mr. Gale. Let me see. I will pick up with Item H, the
14 increase in penalties for failure to file correct
15 information returns. That is on page 53. The proposal
16 would increase the penalty for the failure by business to
17 file a correct information return with respect to services
18 performed by non-employees, i.e., independent contractors,
19 from $50 for each return, to the greater of $50 or five
20 percent of the amount required to be reported correctly.
21 This would apply to information returns, the due date for
22 which is more than 30 days after the date of enactment.
23 Now, this provision is important in the context of
24 health care reform because there will be an incentive for
25 an independent contractor to, say, understate income in

1 order to qualify for the individual subsidies.

2 The Chairman. Yes.

3 Mr. Gale. And this provision would help to ensure that
4 the amount of income being paid to an independent
5 contractor is reported and can be recorded for purposes of
6 monitoring eligibility for subsidies.

7 The Chairman. Fine.

8 Mr. Gale. Item I, tax treatment of accelerated death
9 benefits under life insurance contracts, page 54. This is
10 a proposal that would provide tax-free treatment for
11 payments received under a life insurance contract if the
12 insured is terminally ill.

13 In other words, the benefits that might otherwise be
14 paid under a life insurance policy can be accelerated
15 during the lifetime of the insured upon certification by a
16 doctor that they are terminally ill.

17 The Chairman. Certification by a doctor that they are
18 terminally ill.

19 Mr. Gale. Right.

20 Item J. Tax credit for the cost of personal assistance
21 services required by individuals. This is page 56. Under
22 this proposal, physically impaired taxpayers who are
23 employed would be entitled to a new non-refundable income
24 tax credit equal to half of the first $15,000 of personal
25 assistance expenses. The credit would phase out between

1 incomes of $50,000-70,000. Basically, it is a credit to
2 help offset the cost of personal assistance for the
3 physically impaired who are employed and need such services
4 in order to pursue their gainful employment.
5 Item K. Tax treatment of organizations providing
6 health care services and related organizations. That is
7 page 58. This is a set of proposals that strengthen rules
8 for the tax-exempt status of non-profit health care
9 organizations.
10 It consists of a set of standards that will, for the
11 first time, be set out in statute to basically require non-
12 profit health care organizations to provide community
13 benefits. We want to be sure that the tax exemption is
14 extended only in situations where a health care
15 organization is, indeed, contributing to the public good,
16 or, more specifically defined community benefit.
17 There would also be the introduction of a new set of so
18 called intermediate sanctions that would increase the
19 ability of the IRS to ensure that tax-exempt health care
20 organizations are meeting their obligations for their tax-
21 exempt status and ensure that no private inurement is
22 occurring for the managers or other insiders associated
23 with the tax-exempt.
24 Senator Packwood. Can we ask the Secretary --
25 The Chairman. I think we want to get to Section K. We

1 are just getting there.

2 Senator Packwood. All right.

3 Mr. Gale. All right. I was on intermediate sanctions.
4 Under current law, the only real sanction the IRS has for
5 purposes of monitoring the activities of a tax-exempt is
6 revocation of the tax-exempt status of the organization.
7 Commissioner Richardson, and I believe others, have
8 testified that that is such a draconian penalty that it is
9 seldom used. I do not think it has been used, certainly,
10 in recent times. It also is often disproportionate to the
11 infraction involved.

12 So the proposal here would be to impose a 25 percent
13 tax on the excess benefit that is obtained by an insider in
14 a non-fair market value transaction with a tax-exempt, or
15 other arrangements where private inurement can be said to
16 have occurred.

17 The proposal further provides for a repeal of the
18 special tax deduction now available to Blue Cross/Blue
19 Shield organizations. That is a proposal that was in the
20 administration plan. This does make certain adjustments to
21 the transition period under which the repeal would occur.

22 Section L is starting on page --

23 The Chairman. May I ask, Mr. Gale, on Section K, the
24 tax treatment of 501(c)(3).

25 Mr. Gale. Right.

1 The Chairman. I guess Senator Packwood wanted to ask
2 Mr. Samuels whether the Treasury supports this measure.
3 Senator Packwood. Let me make sure I understand, Joe.
4 I did not realize we were removing the bond cap. And, if
5 we are, does Treasury agree with it?
6 Secretary Samuels. Senator Packwood, we have testified
7 on this issue last year, and we would not oppose that
8 provision.
9 Senator Packwood. That surprises me. I did not
10 realize that was Treasury's position. I appreciate it.
11 The Chairman. I do believe we have heard so much
12 testimony that, with the new medicine, the freestanding
13 hospital just does not exist anymore. They have to start
14 investing in out-patient clinics, and this and that, and
15 just need to be able to raise capital. I see, Shirley, you
16 are nodding.
17 Ms. O'Doughery. Yes.
18 Mr. Gale. That is correct. The current cap, the $150
19 million cap, does not apply to a non-hospital strictly
20 defined. That is, an acute care, primarily in-patient
21 facility, but under the landscape envisioned under this
22 proposal, there will be mergers, there will be other cost
23 containment arrangements that hospitals enter into with
24 clinics and managed care delivery systems.
25 The Chairman. Which requires a lot of capital.

1 Mr. Gale. Right. And any health care facility that is
2 not a hospital, as narrowly defined, would be under the
3 stricture of the bond cap, and this proposal would remove
4 that limitation for those health care organizations.
5 The Chairman. Hospitals do not now have a cap, but
6 these other not quite hospital things do.
7 Mr. Prater, you indicated that you agreed with this
8 measure.
9 Mr. Prater. Well, we were aware of the problem, Mr.
10 Chairman.
11 The Chairman. Yes. All right. Fine. Thank you.
12 Mr. Sollee. Section M would eliminate the present law
13 employee exclusion for accident or health benefits provided
14 through a flexible spending arrangement. Flexible spending
15 arrangements are discretionary accounts, typically funded
16 with employee money. It can be used to pay out-of-pocket,
17 uninsured medical expenses with pre-tax dollars.
18 Section N. Premium assessment. And this proposal
19 would impose a 1.75 percent assessment on health care
20 premiums and on health care expenditures and administrative
21 expenses of self-insured plans. In other words, premium
22 equivalents for self-insured plans.
23 And a portion of this assessment will be used to fund
24 the academic health centers trust fund, graduate medical
25 and nursing education trust fund, and the health research

1 trust funds. That will be discussed later.

2 Section O. Tax treatment of --

3 The Chairman. What page are you on, Mr. Sollee?

4 Mr. Sollee. I am on page -- I do not have it.

5 Senator Packwood. 71.

6 Mr. Sollee. 71.

7 The Chairman. Thank you.

8 Mr. Sollee. Section O would require that retiree

9 health benefits be funded over a minimum of 10 years.

10 Right now, the rule requires that retiree health benefits

11 be funded over the working life of a participant, and it is

12 possible to wait until the year before someone is about to

13 retire and say, that is the working life, and fund the

14 benefit over one year. This would require a more even

15 funding of retiree health benefits, and more secure.

16 Section P is one of two provisions in the proposal that

17 are designed to provide tax incentives to increase the

18 medical personnel serving in medically underserved areas.

19 Under the provision, physicians who provide full-time

20 primary health care services in either a rural or an urban

21 area with a shortage of health professionals, a HPS, or

22 Health Professional Shortage area, would be eligible for an

23 income tax credit equal to $1,000 per month, or up to 36

24 months; $500 a month in the case of a primary care

25 physician who is already in the shortage area at the date

1 of the enactment. Similarly, a credit equal to $500 would
2 be provided to physician assistants, nurse practitioners,
3 and certified nurse midwives who locate in medically
4 underserved areas.

5 The Chairman. Now, this is a very important provision.
6 We think so, and it speaks to the whole question of
7 underserved areas.

8 Mr. Gale. Right. A second and related provision also
9 applicable in the same medically underserved areas is a
10 proposal that would permit an additional amount of
11 expensing for medical equipment used in primary health care
12 services. Credit would be equal to an additional $15,000,
13 for a total of up to $32,500 in expensed equipment in the
14 year of purchase.

15 Section R, coordination with COBRA health care
16 continuation provisions. That is at page 77 in the
17 document.

18 The Chairman. Right.

19 Mr. Gale. Under present law, there are so called COBRA
20 continuation provisions that require that health plan
21 participants to be afforded the opportunity to continue
22 their health care coverage at an adjusted price for a
23 period of generally up to 18 months after an event that
24 would otherwise terminate the coverage. Say you divorce,
25 or termination of employment, death, et cetera.

1 This proposal would retain the present law rule, but
2 shorten the period to the greater of six months, or year-
3 end. The idea basically is that a COBRA continuation rule,
4 as under present law, is not necessary when an individual
5 has the option of buying coverage in a community-rated
6 plan, but we leave six months in there basically to avoid
7 disruption where an individual might just have a short
8 period of unemployment.
9 The Chairman. Fine.
10 Mr. Sollee. Section S. Disclosure of taxpayer return
11 information for administration of health subsidy programs.
12 That is on page 78. The proposal would permit disclosure
13 by the IRS of certain taxpayer return information to the
14 State agencies that are responsible for verifying
15 eligibility for the new individual subsidies under the
16 bill.
17 The Chairman. Yes.
18 Mr. Sollee. It is basically a tax information sharing
19 proposal.
20 Section T. The tax treatment of voluntary employer
21 health care contributions. Under this provision, employers
22 that voluntarily contribute towards the cost of health
23 coverage for their employees would be required to satisfy
24 certain voluntary contribution rules if they want to
25 continue to receive tax-favored treatment for those

1 benefits. Employers that violate any of these rules would
2 be subject to an excise tax designed to approximate the
3 effect of denying the tax deduction for health expenses
4 during the year.

5 Under the first rule, the deductibility of employer
6 health care contributions would be limited to contributions
7 for permitted coverage. That would include any certified
8 plan, a certified standard health plan, a certified
9 supplemental health plan, a certified long-term care plan,
10 as well as certain other types of coverage.

11 This is not a tax cap because it includes supplemental
12 plans, but the plan must be certified. This really is a
13 way to steer employers into purchasing certified standard
14 plans, which we need to do for managed competition. It is
15 a way to enforce that provision.

16 The second rule would prohibit employers from
17 discriminating against employees based on their health
18 status. The third rule would require that any employer
19 that voluntarily contributes towards the cost of health
20 care coverage for a full-time employee would have to make
21 an equal contribution to all full-time employees, and the
22 same rule would apply separately to part-time employees.
23 So any employer that makes a contribution to any part-time
24 employee must provide an equal contribution to all part-
25 time employees.

1 This is an important rule because it keeps employers
2 from manipulating the individual subsidies because there
3 would be an incentive for an employer to drop their low-
4 wage workers, who would then become available for
5 individual subsidies.
6 The Chairman. Fine. Section U.
7 Mr. Sollee. Section U. Assessment on large employers.
8 This proposal would impose an annual assessment of one
9 percent of payroll on employers who are not in the
10 community-rated market.
11 The idea of this provision is really that employers who
12 are not in the community-rated market may be able to have
13 lower premiums than those in the community-rated market
14 because they can experience rate. So this is to level the
15 playing field.
16 The Chairman. Right.
17 Mr. Sollee. Section V. Increase excise tax on handgun
18 ammunition. This proposal would increase the excise tax on
19 handgun ammunition from 11 percent to 50 percent generally,
20 and it is just handgun ammunition. It would exclude .22
21 caliber and other types of ammunition. Shotguns and rifles
22 would not be affected. It would be a 10,000 percent rate
23 on cop-killer type bullets and large .50 caliber bullets.
24 The Chairman. Those .50 caliber bullets are just a
25 devastating street weapon. Yes. There are now hand-held

1 .50 calibers, if you can imagine.

2 Mr. Sollee. It is a hand-held elephant gun.

3 The Chairman. A hand-held elephant gun. Exactly.

4 Senator Rockefeller. Mr. Chairman.

5 The Chairman. Sir.

6 Senator Rockefeller. I expect, on certain parts of

7 Section V there might be vigorous discussion tomorrow.

8 The Chairman. On Section V? Oh, I expect there will.

9 As long as it is not extensive. Vigorous, but not

10 extensive. And there will be a vote. There will be a

11 vote.

12 Mr. Sollee. And the final provision in this section

13 would require the Postal Service to prefund their health

14 benefits for retirees and increase security for retiree

15 health benefits.

16 The Chairman. Is that something that we are doing sort

17 of arbitrarily to the Postal Service? This is a new idea

18 to me.

19 Mr. Sollee. It was in the mainstream coalition's

20 proposal.

21 The Chairman. This is the mainstream coalition. Could

22 I just hear for just a moment--we are going to close after

23 this point, if you all will just endure and have patience

24 with us for a little bit--what will this cost the Postal

25 Service?

1 Mr. Sollee. It is not clear. They have said that it
2 would probably require them to increase stamp rates, but we
3 do not know.
4 The Chairman. I am sorry I asked.
5 (Laughter)
6 The Chairman. Well, I think we need to know something
7 about that, do we not?
8 Mr. Sollee. Right.
9 The Chairman. And a little more. I think this is from
10 the mainstream proposal, but it is not very extensively
11 analyzed here. It has two lines.
12 Mr. Sollee. It has been carried in the CBO options
13 sheets for a number of years as well.
14 The Chairman. Oh. He says stamp tax. I see. Got
15 you. All right. So says Mr. Packwood.
16 (Laughter)
17 The Chairman. Well, that gets us through a good deal
18 of this. We want to thank you all. We want to
19 particularly thank Secretary Samuels, who has been here all
20 afternoon, and now is going to go back and work on the
21 decline -- is the dollar up or down today?
22 Secretary Samuels. I do not have any comment on that.
23 The Chairman. No comment.
24 (Laughter)
25 Secretary Samuels. But I would say, Mr. Chairman, that

1 we very much appreciate your leadership on this, to get
2 through all this this afternoon.
3 The Chairman. You are very kind. We will call it a
4 day. Thanks to everybody here. Just about everybody left
5 has been slogging away. Thanks to Sheila and her cohorts.
6 There is Mr. O'Donnell. Thanks to Senator Rockefeller, who
7 stayed with us till the end. We will resume at 10:00
8 o'clock in the morning. Thank you, Senator Packwood.
9 (Whereupon, at 6:30 p.m., the meeting was recessed, to
10 reconvene on Thursday, June 30, 1994, at 10:00 a.m.)
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 CERTIFICATE

2 This is to certify that the foregoing proceedings of an
3 Executive Committee Meeting of the Committee on Finance,
4 United States Senate, held on June 29, 1994, were
5 transcribed as herein appears and that this is the original
6 transcript thereof.

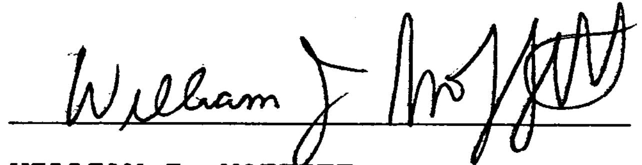
7

8

9

10

11

12 

13 WILLIAM J. MOFFITT

14 Official Court Reporter

15

16

17

18 My Commission Expires April 14, 1998

19

20

21

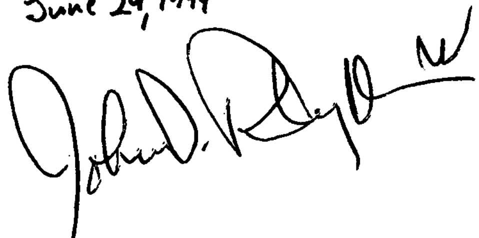
22

23

24

25

for Record
June 29, 1994



Statement
Finance Committee Health Mark-Up
June 29, 1994

Mr. Chairman, I start by commending you for your hard work and [illegible] in bringing us to this point. The Chai[illegible] represents compromises. It represents progress. And, most importantly, it represents your own commitment to the idea that all Americans should be able to count on health care.

Sev[illegible] this Committee all sat down together [illegible] g to get a better understanding o[illegible] and proposals for health care reform. Ev[illegible] st and the commitment to mo[illegible] and to finally -- [illegible] - - ena[illegible].

Our moderator at that bipartisan meeting[illegible] n, [illegible] n, the [illegible] and once served on the [illegible] H[illegible] C[illegible] wh[illegible] th[illegible] nd this Congress still have to [illegible] through deeds, and not just words. [illegible] an [illegible] n expressed the cha[illegible]

"during the pull and tug of congressional action, the moral compass to guide us through the health insurance debate and lead to a successful conclusion must not be lost or set aside. That moral compass is the attainment, by a date certain, of universal coverage...

In the quest to gain broad bipartisan support ... there is the danger that the goals of avoiding taxes and mandates will again take precendence over the goal of achieving universal coverage -- and we will again fail to meet the major moral test of this debate...

You can negotiate on the types and mix of taxes and mandates, but a guaranteed date for universal coverage must be nonnegotiable if we are to avoid the mistakes of the past and seize this historic opportunity. [illegible]"

[illegible] And I also would li[illegible] received [illegible] h[illegible] b[illegible] lo[illegible]

[illegible] t. [illegible] ."

I believe [illegible] an [illegible] that eliminates the fear of being uninsured and unprotected. I co[illegible] hope that [illegible] ght. [illegible]

Rt. 3 Box 84
Bridgeport, WV 26330
June 11, 1994

Senator John Rockefeller
109 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Rockefeller:

I urge you to support health care reform that provides for coverage of every one regardless of pre-existing conditions. I am a fifty-year-old widow who must raise my eight-year-old. I recently lost my health insurance and have been unable to buy other coverage.

I have a small business of my own. I pay my taxes and try to live responsibly, but the thought of the devastations caused by a major illness is overwhelming. While I am presently independent, a major illness could make me a burden to the taxpayers of my state. If I were to die for lack of medical attention, my daughter would then become the taxpayer's problem.

According to a study recently released by the League of Women Voters, it is a fact that women without insurance get attention for breast cancer later than women who have insurance and that they die sooner as a result of this later intervention.

Not for one minute do I expect that my health care will be free. I expect to pay a premium or a tax or whatever you choose to call it, but I believe that this expense to the government and the individual is well worth the cost. It is ultimately cheaper, I believe, to keep people like me healthy rather than to create more homeless persons or welfare recipients.

My present experience is that it is diffucult to get an appointment without a medical insurance card. I had difficulty paying for a mammogram with a personal check beacuase I am self-employed. By the way, my credit rating is impeccable!

It is for these reasons that I urge you support health care reform that provides coverage for all. What we have is a system that rations health care by denying middle class persons coverage or preventive medical treatment. I don't believe that we can afford this lack of care as a nation.

Sincerely,

Carol E. Clevenger

James J. Mongan

Health Care: Why We Failed the Last Time

I am the doctor who was at the bedside when the last national health proposal, put forth by the Carter administration, died. The time was May 1980 and the place the Senate Finance Committee. I was the White House representative for the Carter administration during the committee's bill-drafting session. The proposal died quietly, with little attention from the media, after a two-year "wasting illness" during which it shrank from a large, relatively robust proposal to a small, anemic shadow of its former self.

The Carter plan began, under principles released in July of 1978, as a proposal for a phase-in of universal coverage. But the administration was never certain of support for the increased taxes of employer mandates necessary to make universal coverage a reality. So the plan began to diminish even before it was released in "draft form" in January of 1979—to a proposal for a phase-in of coverage, with each expansion conditional on certain economic circumstances. This conditional phase-in was then diluted further, during congressional consultations, to one conditioned on further congressional votes for implementation at each phase.

Finally, universality was left behind in March of 1979 when the Carter administration fell back to an attempt to pass a phase-one-only bill that would have achieved some modest expansion of low-income coverage, along with a diluted employer mandate of much less expensive coverage, against only catastrophically high health costs. The proposal finally expired in May 1980 when the Finance Committee failed to reach agreement even on this anemic remnant of the original proposal.

I write now in the hope that we can learn some lessons from an autopsy of this case that might lead to a different outcome for the Clinton proposal.

There are important similarities between the Carter and Clinton plans and their political context. Both proposals, at least at the outset, have been quite broad in scope, calling for a phase-in of universal coverage, and a broad set of benefits, financed in good part through an employer mandate, with appropriate subsidies. There are also some similarities in the political setting with, in both instances, a Democratic president working with a Congress controlled by Democrats.

There are also, of course, important differences. Substantively, the Clinton proposal has a somewhat different administrative structure, relying on state-based health alliances that foster managed competition. There is a relatively large role for state flexibility. The Carter plan had a larger federal role, with employers having a choice of obtaining private coverage, or obtaining coverage through a federally sponsored public backup program modeled after Medicare.

As for the political setting, there are at least two important differences. First, President Clinton has placed health insurance high on his agenda from the earliest months of his administration. In the Carter administration, health insurance took a back seat to energy issues and welfare reform, to name but two competing issues. Secondly, there appears to be somewhat more cohesion among Democrats than there was in 1979 and 1980, when health insurance became an important battleground in the struggle between President Carter and Sen. Edward M. Kennedy prior to the primary election fights in 1980.

What lessons can be learned, then, from the story of the ill-fated Carter proposal? First we must establish the cause of death. The Carter proposal wasted away a little at a time, gradually growing smaller and smaller. Why? Undoubtedly, division among the Democrats was a major factor; it gave the administration little choice but to attempt to build a more conservative coalition around a much smaller proposal in the Finance Committee. Equally important was the subordination of the goal of universal coverage to other goals—among them avoiding tax increases and employer mandates, which aroused the anger of the small-business community.

The first lesson, then, is to remember the importance of party cohesion. A health insurance bill cannot be passed by Democrats alone. It surely cannot be passed with a badly fractured majority party. Democrats who want health insurance to pass must not allow the best to become the enemy of the good and bog down the debate in repeated tests of ideological purity.

Having said that, the second lesson is that during the pull and tug of congressional action, the moral compass to guide us through the health insurance debate and lead to a successful conclusion must not be lost or set aside. That moral compass is the attainment, by a date certain, of universal coverage. Once this debate begins to slide down the slippery slope away from universal coverage, through contingent universal coverage, on down to incremental expansions of coverage, it will suffer the same death by degrees as the Carter proposal.

Although just about everyone in Congress, of both parties, is ostensibly in favor of the concept of universal coverage, there is still a notable queasiness about the employer mandates and taxes necessary to make universal coverage real.

In the quest to gain the broad bipartisan support that will be necessary to pass legislation, there is the danger that the goals of avoiding taxes and mandates will again take precedence over the goal of achieving universal coverage—and we will again fail to meet the major moral test of this debate.

There is a message here for members of Congress. You can negotiate on the types and mix of taxes and mandates, but a guaranteed date for universal coverage must be nonnegotiable if we are to avoid the mistakes of the past and seize this historic opportunity. The test of history will be simple: Is everybody covered?

The writer was associate director of the White House domestic policy staff in the Carter administration. He is now dean of the medical school at the University of Missouri-Kansas City.

THE WASHINGTON POST

Tuesday, November 9, 1993