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EXECUTIVE COMMITTEE MEETING

THURSDAY, JUNE 30, 1994

U.S. Senate,

Committee on Finance,

Washington, DC.

The meeting was convened, pursuant to recess, at 10:12 a.m., in Room SD-215, Dirksen Senate Office Building, Daniel Patrick Moynihan, Chairman of the Committee, presiding.

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

Also present: Lawrence O'Donnell, Jr., Staff Director; Lindy Paull, Chief of Staff, Minority.

Also present: Les Samuels, Assistant Secretary for Tax Policy, Department of the Treasury; John L. Buckley, Chief of Staff of the Joint Committee on Taxation; Mr. David Podoff, Economist; Peter B. Budetti, Dr. Karen Hein, and Dr. Bill Braithwaite, Congressional Fellows, Majority; Chuck Konigsburg, Chief Counsel; Joseph Gale, Chief Tax Counsel; Will Sollee, Tax Counsel; Fay Drummon, Senior Health Analyst; Jane Horvath, Kathy King, and Sheila O'Dougherty, Professional Staff Members; and Sue Nester and Roy Ramthun, Professional Staff Members, Minority.

The Chairman. A most welcome good morning to our guests and the staff that has been up all night, but seems bright as ever this morning.

First, let me announce our schedule for today. We will work now until 1:00. We will break until 2:30 and then we will resume and continue as long as we seem to be getting some productive work done, which I think will be into the early evening at the very least. We expect to be working Saturday.

May I ask turning to the core group, may I ask with some fervor that we will need to see amendments as soon as we can so the staff can look at them and be able to tell the committee what this involves. Of course, you will want to do that.

And now as we indicated last night we will resume our walk-through. We have a fair amount of titles to cover, but nothing we cannot get done within the hour. On Title VIII now we will begin with Medicaid. Jane Horvath will be the lead. We have Ms. King, Ms. O'Dougherty, Dr. Budetti will no doubt arrive and Mr. Ramthun. We begin with you, Ms. Horvath.

Ms. Horvath. Thank you. Senator, I will be working off of the marked document, pages 86 through 88. Our proposal is to mainstream the portion of Medicaid, the population that is on Aid to Families with Dependent

Children.

The Chairman. Now, when you use a word like mainstream, that is a word that you understand but not everyone does. There, for example, is the mainstream coalition. Now you do not want to --

(Laughter.)

The Chairman. What do you mean by mainstream?

Ms. Horvath. Sir, I mean that these people would move into the reformed health care system and be treated like other low-income people in terms of subsidy and enrollment in standardized -- or certified standard health plans.

The Chairman. You mean you wish to move the Medicaid recipients away from the fee-for-service, which is what most entered in the 1960s when Medicaid began?

Ms. Horvath. Yes.

The Chairman. And when fee-for-service was the normal arrangement, into the HMOs which are becoming the normal.

Ms. Horvath. Yes.

The Chairman. Good.

Ms. Horvath. And move them into the service delivery system that everyone else is in.

The Chairman. But everyone else is -- increasingly most people are in.

Senator Packwood. May I ask a question?

The Chairman. Of course you may.

Senator Packwood. How far has the country moved now in capitating and moving Medicaid into some kind of managed care? Is it vary widely State-by-State?

Ms. Horvath. Yes, it does vary widely State-by-State. I imagine, sir, that about half the States have Medicaid waivers for some portion of their population or some part of their State. There are very few States that have State wide waivers to integrate this population into managed care. New York is one though.

Senator Packwood. Is the tendency in that direction?

Ms. Horvath. Yes, it is.

Senator Packwood. And if we were to do nothing, would that trend continue in your judgment?

Ms. Horvath. Yes, sir; it would.

Senator Packwood. Thank you.

The Chairman. I could make the point that on the front page of the New York Times it reports that the new York City hospitals, that public hospitals, are finding that Medicaid patients are leaving them, finding alternate arrangements that are preferable.

Senator Packwood. You mean under the capitation they are getting better service in their mind and in the recipient's mind than they were from the public hospitals?

The Chairman. Yes.

Senator Packwood. That is probably a good trend.

Mr. Sollee. The population that would not be integrated into the community-rated pool that is currently under Medicaid and would remain under Medicaid is the population receiving supplementary security income, ESSI population. Our proposal would call for maintaining current Medicaid law with respect to those duly eligible for both Medicaid and Medicare.

In terms of supplemental services for the low-income population the proposal calls for maintaining current Medicaid, which under this new system would act as a wraparound and a secondary payer, covering those services that would not otherwise be covered in the standard benefit package for this population.

Disproportionate share hospital payments would be gradually phased out and replaced in 2001 with a new more targeted program for facilities serving low-income people, similar to the administration's vulnerable population adjustment in the Clinton bill.

We would make some changes in the Medicaid long-term care program, including enhancing the match for Medicaid home and community-based services, expanding eligibility for single individuals for home and community-based long-term care services and making some changes to the waiver

program rules -- home and community-based waiver program rules -- and expanding the on-lock demonstration programs. The on-lock demonstrations are this -- they are called the PACE, Program for All-Inclusive Care for the Elderly. They integrate acute and long-term care services under a capitation arrangement and integrate Medicare and Medicaid payments for that purpose.

That is the highlights.

Senator Durenberger. Mr. Chairman?

The Chairman. I am sorry, Senator Durenberger.

Senator Durenberger. Mr. Chairman, thank you.

Jane, I wonder if I could ask you to rather than describing the Chairman's mark if you could give us a sense of what Medicaid is designed to accomplish now and what you think it will accomplish in the future.

My understanding of what we are trying to do in health care reform is first the President's guarantee, as I understand it, is that every American will be guaranteed access to a private health plan that cannot be taken away from them. That is what I understand to be his present commitment to Americans.

At the present time a lot of people -- I mean, everyone gets some kind of coverage but not everyone has a private plan. There is just a large number of Americans -- the elderly, disabled people, and a lot of low-income

people -- who are in some kind of a government-sponsored, largely government-sponsored program.

If I understand Medicaid, probably what I understand of it, it is the most complicated part of this because we are trying to use a public-sponsored system to pay for a variety of services for quite a wide variety of people. We are talking about pregnant moms and all the way up to the seriously ill, the chronically ill, the profound and severely disabled members of our community.

I wonder if you could not, since we are talking about a long-term sense of direction here and so forth, can you give us a sense of how close this proposal will get us to assuring every American, whether they are elderly, they are disabled, they are low-income or whatever, that they will have a private health plan that will guarantee them access to whatever service they need regardless of what their health status or medical need may be.

Ms. Horvath. Well, I am not sure that I can predict the future in that way. But I can tell you what we hope would come out of this. I mean, it is our hope that we would no longer have for the majority of the population under Medicaid, and we figure it is about roughly 60 percent of the eligibles -- about 30 percent of the dollars; but about 60 percent of the current Medicaid population -- would have access to private health care

plans and that there would be, you know, a decrease in these Medicaid managed care entities that the States are contracting with now.

So that is a mainstream and we hope it is an improvement in their access to care. We also hope that what this would do over time is help to break the link between welfare and the health care system. Those are generally the two basic goals here.

Senator Durenberger. Well, first let me ask you this question. What happens in this proposal to people with either chronic illnesses or disabilities or the people that John has been championing, the ICFMR eligibles and so forth? Does the situation change for them at all in this particular proposal?

Ms. Horvath. No. Senator, institutional care, long-term care, really remains the same under this proposal and people receiving SSI, which is the aged and the disabled, would remain in Medicaid.

What we have done, however, what we will be doing according to the mark is changing the rules a little bit around Medicaid managed care so that no plan that is contracting with Medicaid for care of these people can have more than 50 percent of its enrollment coming from SSI population. As a technical matter, the current rule is 75/25 which tends to lead to these, you know, mostly

Medicaid plans. We hope to improve the quality through that as well.

But we also feel through this proposal we are not really jeopardizing the care that people with chronic disabilities and long-term care needs. We are not jeopardizing their access to those services and their coverage.

Senator Durenberger. No, I understand that. But in effect we are guaranteeing them that unless the government changes its mind they are going to get institutional care. I have on occasion referred to, you know, what happens if my mom dies and my 87-year-old dad has no resource other than a nursing home. We are not offering people alternatives to the current institutional care.

Ms. Horvath. All right. I see your point now. We have made I think small changes in that direction in terms of eliminating this cold bed rule which is a waiver rule in order to set up a waiver program for home and community based care to divert from institutions. States have to prove that they actually have an institutional bed sitting there which generates its own costs in order to have a slot in a waiver program.

We would eliminate that so that there would hopefully be more home and community-based care slots. We are raising the eligibility threshold for individuals, the

asset limit for individuals, to get into home and community-based care, to allow more people in. So there are some improvements in that area, Senator.

The Chairman. I think that is about the sum of it. I know you would wish more, but it is a beginning. Well, we have that. The same team, can we go on to long-term care and supplemental insurance standards? Again, we will begin with Ms. Horvath.

Ms. Horvath. Mr. Chairman, I will be brief here. Basically, our proposal is like the standard insurance, health care insurance. Our proposal is built around a State-based regulatory system with federal oversight. Standardization and certification of these policies would begin in 1997. I think the most important point is that the proposal tracks the work of the National Association of Insurance Commissioners and their long-term care insurance models and regulations which about 40 States have adopted in some form or another so far.

In terms of the highlights of this proposal, it would guarantee renewal for current long-term care insurance. It would standardize reporting forms that we would have a better sense of who is receiving or who is purchasing these policies and their costs. It would equalize treatment under long-term care policies for all conditions requiring long-term care coverage.

It would limit the extent to which insurers can impose pre-existing conditions or limitations. It would provide inflation protection, in that inflation protection must be offered to everyone. It is not mandatorily included in the policy. And that nonforfeiture benefits, the amount that a policyholder would be entitled to after they cancelled their policy had they paid in for a number of years, would be standardized and required in all policies.

The Chairman. This is basically insurance reform?

Ms. Horvath. I am sorry?

The Chairman. This is insurance reform.

Ms. Horvath. Yes, it is.

The Chairman. It has to do with policies issued for long-term care.

Ms. Horvath. Absolutely.

Senator Rockefeller. Mr. Chairman?

The Chairman. Senator Rockefeller?

Senator Rockefeller. I apologize for being late. I know that there are some small improvements that are made in the frail and elderly part of the Medicaid program which some of us introduced a number of years ago. But I just wanted to put the committee on notice that I, and perhaps others, will be doing a more substantial long-term care generally amendment when we come to that point.

The Chairman. And you do not mind a gentle reminder that the sooner amendments are presented to us --

Senator Rockefeller. That we get to them, the better. Right.

Senator Grassley. Mr. Chairman?

The Chairman. Yes, Senator Grassley.

Senator Grassley. Is the purpose of this section to just bring uniformity to the present market for this type of insurance or is it to encourage and expand the market so that we have greater private?

The Chairman. I think it may be fairly described as both. It makes these more attractive policies, more dependable.

Senator Grassley. Is there anything in it that --

The Chairman. A few less surprises.

Senator Grassley. -- would have a tendency because of uniformity to make the product cheaper and more saleable to a larger number of people?

The Chairman. Well, we hope so and we expect so. The point being that the sort of unwelcome surprises that you will find in many of these policies will no longer be there and it is a more reliable product for people who are not going to have read every word of the 120 pages.

Senator Durenberger. Mr. Chairman, may I ask a question then in that regard?

The Chairman. Of course you may, sir.

Senator Durenberger. Jane, I am told and maybe you can confirm this, that the Chairman's mark allows States to develop stricter standards than the federal standards. Would you describe in what case or just explain for us exactly what that means since the Chairman has assured us we are going to have uniform standards. It appears that some States can alter the standards. Which one or is it all standards that can be stricter or am I wrong in my interpretation?

Ms. Horvath. No, you are not wrong, Senator. I think States would possibly pursue that flexibility, for instance, on pre-existing limitations. You know, they may shorten the period of exclusion, as one example. In here the proposal says that, you know, an insurer or an agent must offer to a potential policyholder inflation protection. The State could conceivably require that as a mandatory offer.

Senator Durenberger. Wy would we want in a national system in which we have a fairly substantial subsidy, why would we want States to alter the conditions of that subsidy?

Ms. Horvath. Subsidy? A fairly substantial subsidy?

Senator Durenberger. We are talking about tax subsidies and so forth under all of these plans, are we

not?

Ms. Horvath. Actually, the Chairman's mark does not propose to change the tax treatment of long-term care.

The Chairman. Mr. Ramthun agrees with Ms. Horvath. Speak, sir.

Mr. Ramthun. There is no tax clarification, if that is what you are looking for, of long-term care insurance.

Senator Durenberger. I guess I am trying to understand, if we are going to federal standards, then explain to me why we are permitting the States to have different standards, even though they may be in your terminology stricter.

Ms. Horvath. Right.

Senator Durenberger. If it is essential to have uniformity, then why do we not have uniformity?

Ms. Horvath. I guess, Senator, that this is an evolving market. You know, there are not that many policies being sold. I think with the changing demographics, you know, hopefully we will see more of these policies being sold and allowing kind of State flexibility for regulation may point up other areas where the Federal Government -- I mean, the feds are not always ahead of the States in terms of finding problems and getting on top of them.

Senator Durenberger. No, but we are talking about

people live in States and things like insurance plans and so forth, and in terms of where they live and get their care, particularly if you are talking long-term care, you are going to find people with domicile in one State who may be ill or incapacitated in another State and so forth.

I am really trying to understand what is the value that is added, other than the one of novelty or experimentation that you are suggesting. What value are we adding either to the consumer or to stabilizing the insurance market by permitting us to continue to have State-by-State standards? Maybe you can give me an example of some other area in which -- I suppose it is in all areas right now that the States are regulating insurance. This is one area in which we are going to try to federalize some part of it.

Ms. Horvath. Right. I am not sure that I can tell you that there is more value to it, other than we designed these to be the minimum standards, Senator.

Senator Durenberger. All right. Thank you.

The Chairman. Thank you.

All right. Then let us go on to Medicare. Ms. King will lead this discussion, along with Ms. O'Dougherty. I guess Ms. O'Dougherty will lead our discussion.

Ms. O'Dougherty. I guess I will start off here, Mr. Chairman.

The Chairman. Welcome.

Ms. O'Dougherty. Mr. Chairman, beginning on page 96 of your mark there are nine proposals in the Medicare Part A section which I will briefly describe.

First, the payment increase for all hospitals would be reduced by 2 percent for 1997 through 2000.

The second proposal reduces payments for capital by adjustments to reflect more accurate base year data and a 15 percent reduction in payments for hospitals, excluded from the perspective payment system.

The third proposal reduces disproportionate share payments by 25 percent.

The fourth proposal would change the payment methodology for rehabilitation and long-term care hospitals.

The fifth proposal reduces payment to skilled nursing facilities.

The sixth proposal concerns sole community hospitals. Sole community hospitals who merge currently receive one rate for all facilities, if it is a multi-campus hospital. Under this proposal, if one of the hospitals who merge is a teaching hospital, they would continue to receive their hospital's specific rate.

The seventh proposal extends the current payment provisions for Medicare dependent hospitals.

The eighth proposal authorizes appropriations for rural health transition grants.

The last proposal under Medicare Part A would establish a new rural hospital program to coordinate different payment methods for rural hospitals. It includes new rural emergency medical services, makes a demonstration in Montana permanent and available to all States, and amends and extends to all States payment flexibility for rural primary care hospitals.

The Chairman. Could you hold just a moment while we locate Senator Baucus? Senator Baucus, where are you? The Montana demonstration project is made permanent.

Ms. O'Dougherty. That is correct, Senator.

The Chairman. Repeat that. Do I take it that the essence of these proposals is that -- here is your opportunity. What was that last proposal?

Ms. O'Dougherty. If I could repeat the last proposal under Medicare Part A, it would establish a new rural hospital program to coordinate different payment methods for rural hospitals. It would include new rural emergency medical services, make a demonstration in Montana permanent and available to all States, and amend and extend to all States payment flexibility for rural primary care hospitals.

The Chairman. Give some indication of approval.

Senator Baucus. This reduces Medicare costs?

Ms. O'Dougherty. No. It should. We have yet to get CBO costing of this, but we expect it to be budget neutral overall, although there is appropriations for State grants to coordinate these programs.

Senator Baucus. Because I was led to believe earlier that it would reduce Medicare costs to hospitals. That was my understanding at an earlier date.

Ms. O'Dougherty. That could well be true, but we have not received CBO costing on this yet.

Senator Baucus. That would be important, Mr. Chairman. Thank you.

The Chairman. The general thrust here is, there will be reductions in Medicare costs as there have been in every major program from the President forward. But in our case what we have, the title we will get to next, the academic health centers, which establishes a specific trust fund for some of the purposes that Medicare has been serving.

Senator Grassley. Mr. Chairman?

Ms. O'Dougherty. That is correct, Senator.

The Chairman. Senator Grassley?

Senator Grassley. Mr. Chairman, the first question is in regard to the Medicare dependent hospital program. It sounds to me like, reading this paragraph here, that

you are maintaining the program pretty much as is, extending it pretty much as is, right?

Ms. O'Dougherty. That is correct, Senator.

Senator Grassley. My second question would be in regard to the 2 percent across the board reduction, but it might be also applicable to some of these other programs in this section. I do not know for sure in regard to the latter.

But is it simply uniform across the country so that the very most expensive hospitals have more lead way in reduction or those States like Minnesota and Iowa where we have been very careful on our expenditure of Medicare dollars and we would be I am sure in the lowest 10, maybe even the lowest 5 States, as far as our costs of the delivery of medical care. That still is even considering the fact that we have the highest percentages of Medicare people in our State.

Is it going to be across the board or is there some consideration given to States that have less lead way because we are most cost effective than States who have not been as careful with the dollars?

Ms. O'Dougherty. The payment reduction would be uniform across all hospitals in all areas.

Senator Durenberger. All right. Do you understand that that gives New York much more lead way than it gives

Iowa in the reduction of Medicare costs?

The Chairman. Well, no, I do not understand, but we will not get into it.

Senator Rockefeller. Mr. Chairman?

The Chairman. Senator Rockefeller.

Senator Rockefeller. I do not mean to delay this, but I think this is a very major question about the mark and I really need to get clarification from Ms. O'Dougherty.

In your Medicare savings numbers in the Chairman's mark you come up with, I think, $33 billion over five years; is that correct?

Ms. O'Dougherty. That is correct. Our latest estimate is $34 billion over five years.

Senator Rockefeller. Now, when the Health Security Act was measured by CBO they not only did through 1999 but they did through the year -- they did Fiscal 1996 to 2000. I had my staff do some careful work on this because I am interested in prescription drugs and long-term care.

I have two questions. One is, we come up -- well, have you done an analysis of Fiscal 1996 through 2000?

Ms. O'Dougherty. Yes, we have.

Senator Rockefeller. What are the savings numbers that come from that?

Ms. O'Dougherty. I do not know exactly what the year

2000 is. But it is my memory, and we would have to get back to you on this, that it is about $32 billion. In other words, the magnitude of just the year 2000 approximate the magnitude of the preceding four years.

Senator Rockefeller. Well, that, see, is the very basic point. We come up with, and we do not have the ability that you have to analyze this, we come up with a $54 billion saving, with the result that between the Chairman's mark 1996 to 2000, and the Chairman's mark 1995 to 1999, although the logic does not seem to follow, that there is, in fact -- it is $33 billion plus $54 billion, which if that is correct -- and I do not want to drag it out now -- but if that is correct, if I am correct, and that is what I am hoping you will find out, that we have a total of $48 billion of unused Medicare money in the Chairman's mark which would, therefore, be available for long-term care and prescription drugs.

This is an enormous point. I do not want to press it now. I just want to get you all to confirm it or whatever.

Ms. O'Dougherty. I cannot respond to its availability for other purposes. But I do know in the year 2000, although we need to get back with you to the precise number, some of these changes in proposals have not been phased in until 1998, or approximately 1998,

combined with the fact that the CBO base line is increasing very rapidly. That, yes, in the year 2000 the savings come to a substantial amount of money.

Ms. King. Senator, I think we would be happy to go over the numbers with your staff.

The Chairman. Yes. We will do that.

Senator Rockefeller. That is all I was asking for.

The Chairman. May I welcome, Ms. Nestor.

Ms. Nestor. Thank you.

The Chairman. May I make a point, and it is intended in no way to be contentious, but that the requests of the rural States are very much we feel reflected in this Chairman's mark, even as the rural States are very much represented on this committee.

I think it would be difficult to deny that urban America is much less represented on the Finance Committee than the demography would indicate if we represented demography. But we do not, the Senate represents States, and that is what the Constitution set out to do. And in the normal course of things, this legislation represents the interest of those States.

Senator Baucus. Mr. Chairman?

The Chairman. Yes.

Senator Baucus. I appreciate that comment. I think it is fair to say though that the provisions in this bill,

or Medicare provisions, particularly with respect to, say, medical assistance facilities, as the Senator from Iowa pointed out, result in lower Medicare costs.

I think CBO last year scored --

The Chairman. Medicare outlays.

Senator Baucus. Outlays. But it is costs. Because of efficiencies in medical assistance facilities and other similar facilities, there are fewer Medicare dollars being spent. So we in the rural part of the country are working hard to be efficient and to save dollars. That is what has happened.

I think the Senator was pointing out that some other parts of the country may be receiving more Medicare dollars. That is, there are not the same efficiencies in savings. We in the rural part of the country are just trying to be sure that we are not taken advantage of and we are showing that by finding new ways -- medical assistance facilities is the best example -- to achieve savings and achieve efficiencies to save taxpayers' dollars.

The Chairman. Right. And do it very well indeed.

Ms. O'Dougherty, would you like to continue now with Part B?

Ms. O'Dougherty. Kathy is going to handle the Part B, Senator.

Ms. King. Senator, I will be very brief about this. There are some provisions in the Chairman's mark that allow Medicare beneficiaries when they become eligible for Medicare to remain in private health insurance plans. This was a proposal that was made in the President's budget and it just allows them --

The Chairman. And this is a theme that we have been trying to develop in this legislation.

Ms. King. Yes. The mark also includes some provisions designed to improve Medicare risk contracts or HMO situations. We hope to do some more work on that.

With regard to Part B proposals, most of those proposals are those that were in the President's budget. There are a few provisions which were omitted, which have to do with imposition of a co-payment for home health services. That proposal is not included and there are a couple of proposals designed to increase primary care services.

There is a provision that would implement a new payment methodology for physician practice expenses and there is a provision that would increase bonus payments in rural areas.

The Chairman. Another, bonus payments in rural areas. It has been observed, if I may say to my friend from Rhode Island, that a New Yorker is Chairman of the

Committee on Finance for the first time since 1849. It is no accident.

Senator Chafee?

Senator Chafee. Mr. Chairman, on this Part B, is it income adjusted?

Ms. King. Yes. Senator, that was discussed yesterday because it is a revenue rather than an outlay reduction.

Senator Chafee. Oh, I am sorry. Thank you.

The Chairman. All right. We welcome the Majority Leader.

Senator Hatch. Mr. Chairman?

Senator Hatch?

Senator Hatch. Have we passed over -- I missed part of this because of Judiciary. But have we talked in terms of lab services yet or clinical labs? I know you are on Part B.

Ms. King. There are a couple of proposals relating to Part B in particular to lab services. One would be the imposition of co-insurance on laboratory services and the other one has to do with authorizing the Secretary to engage in competitive acquisition of laboratory services.

Senator Hatch. Is it all right, Mr. Chairman, if I ask a question about co-insurance? Is it okay with you?

The Chairman. Yes.

Senator Hatch. As I understand it, if this proposal is enacted, labs would have to produce two claims -- one to Medicare and one to the patient; is that right?

Ms. King. Yes.

Senator Hatch. Then I understand the estimates of these forms will cost between $3 and $5 extra. In many cases, those costs would exceed the amount of the new co-insurance.

Ms. King. Senator, I have not seen the estimates on the costs for the forms.

Senator Hatch. Let me give you an illustration. If those costs are accurate as I have stated them, and I think they are, for a complete blood count once the OBRA-93 reductions are fully phased in, the coupon payments would be $10.36 and the co-insurance would be $2.02. You do not disagree with those figures?

Ms. King. No, Senator; I do not.

Senator Hatch. Well, if they are correct, does this proposal really make any sense?

Ms. King. Senator, I do not know how to respond to that except by saying that previously Medicare had a co-insurance requirement for laboratory services that was repealed. This proposal would reinstate that provision.

But your point is well taken that some of the co-insurance payments that would be made would be rather

small and that the cost of collecting on them could be substantial.

Senator Hatch. Yes.

The Chairman. Senator, would you want more data on that?

Senator Hatch. Well, I think we ought to verify those figures because I think that $3 to $5 is accurate. If that is so, then this is crazy to do it this way and we ought to find a better way of doing it.

Ms. King. I will follow up on that.

Senator Hatch. Thank you.

The Chairman. Fine. Thank you.

Senator Durenberger. Mr. Chairman?

The Chairman. Yes.

Senator Durenberger. Has Kathy finished the presentation on Medicare?

The Chairman. Well, I think if there are questions on the matter. Kathy, you have finished?

Ms. King. Yes, I have, Senator.

Senator Durenberger. I would like to ask some questions on risk contracting.

The Chairman. Please do.

Senator Durenberger. Thank you.

Hopefully so we all start from the same basis, this is the experimental effort that John Heinz got us started

on 10 or 12 years ago on helping elderly and people with disabilities in some cases a more comprehensive plan than the fee-for-service system.

The first question I would like to ask is relative to if there is any change from current risk contracting policy in the Chairman's mark. In other words, what kind of plans are eligible for the risk contracting provisions under the Chairman's mark.

Ms. King. Well, Senator, this picks upon two things -- one part that was in the President's proposal and one part that was in your bill. Under the Chairman's mark, organizations that have risk contracts or are eligible to have risk contracts now could keep their beneficiaries when they turn 65.

So it expands substantially the number of private health organizations that could enroll or keep Medicare beneficiaries when they turn 65.

Senator Durenberger. Can an employer sponsor a plan for its current and former employees who are Medicare eligible?

Ms. King. Yes, I believe they can. Senator, if I might, there is another proposal that was in your bill that would require risk contracts to follow health plan standards. So that proposal is in there too.

Senator Durenberger. All right. Let me ask you then

a couple questions that relate to the -- I know this is so darn arcane I even hate to ask these questions, except that they are important because they relate to the way in which the plans are designed and priced and so forth.

But try to help me understand the relationship between AAPCC which is a current way to determine how much money is going to be paid to a health plan -- and there is some geographic identity there -- and the proposals we have in this bill for these health care areas -- the geographic areas in which we are going to have certified health plans or accountable health plans, whatever we call them.

Ms. King. Well, Senator, right now the risk contracts, the AAPCC is made on a county-by-county basis. And as you have pointed out before, there are a number of problems with that payment methodology. The Chairman's mark -- your proposal recommended moving that to market areas. I think we were not exactly sure what the best definition of market areas was. So in this bill we put the community rating area.

Now I understand that there may be some concerns with that and that is something that we can continue to work on.

Senator Durenberger. All right. If you do not mind, I am going to share with you Rochester, New York and a few

other things that we may have before, just to demonstrate the problems that are created when you enlarge certain of these areas, the problems that are created for everybody, and particularly for the plan. But we will use, if we may use, some relevant areas that will be very helpful.

Let me ask you then about the issue of uniform benefits. I think the Chairman's mark requires uniform marketing materials be provided to Medicare beneficiaries so they get some idea of what their choice is in each of the areas. Will fee-for-service be included in that presentation?

I would assume that it would, Senator. The Chairman's mark does not address that directly, but I assume that it would.

Senator Durenberger. But you would be open to some language that would permit all of the plans, including fee-for-service, to be incorporated into that presentation?

Ms. King. Yes.

Senator Durenberger. Do you include an era of open enrollment period and do you include the requirement we had in our bill that Medigap and Medicare supplementals all be included in the annual presentation?

Ms. King. Under insurance reform, all plans have to have an annual open enrollment period. But your proposal

for all of the open enrollment periods to occur at the same time is not included because of some concerns that have been expressed about the difficulty of making all plans do open enrollment at the same time every year. That insurance plans would have a lot of difficulty mechanically complying with that.

But that is something I think that we can work on.

The Chairman. And we will. Is that is all right?

Senator Durenberger. Yes. Let me ask you, before when we were on Medicaid we were talking about -- I think Jane responded with the 50/50 rule. This is kind of that quality question.

Traditionally we have thought about quality in terms of let us have an appropriate mix of private pay or commercial patients and some others. When the Chairman and I did the -- whatever we called it last year, the managed care/Medicaid bill, I think we at least provided for waivers if we did not provide for some potential elimination of the 50/50 rule.

But I heard your response earlier with regard to Medicaid to be that you preserve the 50/50 rule. Both with regard to Medicare and Medicaid, is there a reason to have to keep the 50/50 rule in place? Could we not make some provision that once there were adequate quality standards adopted and approved within a health plan that

you can break down that 50/50 barrier?

The Chairman. I do not know why not.

Ms. King. All right.

The Chairman. All right?

Senator Durenberger. All right.

The Chairman. Thank you.

And now could we go to a new section in our lexicon, if you will, the Academic Health Centers, Graduate Medical and Nursing Education and Research, the Academic Health Centers Trust Fund. Dr. Budetti, are you going to walk us through this?

Dr. Budetti. Yes, sir.

The Chairman. If I could just note while Dr. Budetti is getting himself settled that one of the subjects that emerged from our long series of hearings was the concerns of the academic health centers, their related institutions such as medical school hospitals for the affects of the rationalization in pricing in the health care system on their own practices, which are not market oriented, but are educational and research institutions.

We thought -- it has occurred to some of us, not all of us, that it will no longer do just to provide for these centers by indirect subsidies from Medicare, Medicaid, but really do it open, up front by a trust fund.

Dr. Budetti?

Dr. Budetti. Good morning, Mr. Chairman and members of the committee. The provisions dealing with academic health centers, graduate medical education and nursing education and biomedical and behavioral research begin on page 116.

The proposal would establish three different trust funds. One trust fund would be established to make payments to teaching hospitals and to academic health centers that operate teaching hospitals, to a group of high intensity, non-teaching rural hospitals and to dental schools for dental education.

A second trust fund would be established to provide supplemental payments for biomedical and behavioral research conducted by the National Institutes of Health.

The third trust fund that would be established would be set up to make payments for graduate medical education, for advance practice, and for advance practice nursing education.

An additional sum of money would be paid to medical schools to assist them with the transition to a more competitive health care system. In each case the funding for the trust funds would come from a combination of Medicare payments that otherwise would have been made under current law going into the academic health centers trust fund from the payments that would have been made for

the indirect medical education adjustment under current Medicare law and for the graduate medical education trust fund from the payments that otherwise would have been made for direct medical education payments under Medicare law, supplemented by portions of the 1.75 percent assessment on premiums in insured and self-insured plans.

Thank you, Mr. Chairman.

Senator Daschle. Mr. Chairman?

The Chairman. Yes, Senator Daschle.

Senator Daschle. One of the things that we have talked a lot about over the last several months as we have considered the goals for education in the future is to put a greater degree of emphasis on primary care.

Dr. Budetti, could you describe for us what we do in this bill that would give us some assurance that we are going to be moving more towards primary care emphasis as we look to education in the future?

Dr. Budetti. Senator, the bill contains a number of provisions that would assist somewhat in advancing primary care. There are some bonus payments in other provisions, in other sections. There are some bonus payments that would be made for primary care physicians. You heard yesterday about the tax credit that would be established for primary care practitioners.

Also the payments for graduate medical education and

the payments to the medical schools are designed to encourage the schools to move in the direction somewhat of primary care. There are no specific proposals other than those.

Senator Daschle. How does that differ from the proposals that are out there that the Breaux-Durenberger and Clinton and Chafee proposals? Do they not have more of a delineated requirement that academic centers move more directly to primary care emphasis?

Dr. Budetti. Yes, Senator, there are a variety of proposals, including some that have come from members of this committee, as well as the administration's proposal, that would make the payments to the medical centers for graduate medical education contingent upon their meeting certain specific national goals and that would establish their national policy and a national process for reaching those goals. Other bills contain demonstration projects along the same lines.

Senator Daschle. I am concerned, and this may be an area we will have to revisit at some point, either during the mark or on the floor. I am concerned that as good as it is, it may not go far enough in getting the kind of direction that we need to give as a function of national policy on the emphasis on primary care.

I think it may fall short of what may be necessary.

But I thank you for the explanation.

Thank you, Mr. Chairman.

Senator Chafee. Mr. Chairman?

The Chairman. Senator Chafee?

Senator Chafee. Mr. Chairman, you had a briefing on this the other day and I was unable to attend. That was my fault because of a conflict. So I will not profess to know a great deal about this section here.

But the questions I have are, this is a big amount of money that we are dealing with. Do I understand that it is $40 billion over 5 years?

Dr. Budetti. $30 billion.

Senator Chafee. $30 billion?

Dr. Budetti. Yes.

Senator Chafee. I am not sure what that compares with based on what we have previously given to the medical schools or the academic health centers and the other entities. That is my first question.

My second question is, how is this divided up? Who does the dividing? As you know, we have had bad experiences around here with Congress getting into specific allocations in connection with universities all too often and rather than some peer review or situation like that.

Like everybody else, just as the Chairman has

graduate medical education entities in his State, I have one in my State with Brown University and our major hospitals. They have spoken to me about this and they are very anxious that the situation be taken care of to the greatest extent possible.

But I must say that I -- could you answer those two questions? One, the size compared to whatever we were doing before or currently. And second, who makes the decisions on how this money is divided.

Dr. Budetti. Yes, Senator. The proposal does represent an increase in payments that would be made in an identified direct fashion. The current law -- and I will give you the numbers in one second -- hospitals, teaching hospitals, do receive payments directly from Medicare that are identifiable under the indirect medical education and the direct medical education.

They would also argue that they are able to cross-subsidize additional costs from the private sector from their insured patients as well; and that under the new health care delivery system they would be involved in a much more competitive marketplace and, therefore, unable to add to what the designated federal funds would be from Medicare and, therefore, need an identifiable stream of funds as well to help them be able to sustain their research and education functions. That is what this

proposal attempts to address.

Under current law our estimate from the CBO is that Medicare, indirect medical education payments over the next -- between 1996 and 1999 would total just under $19 billion. New funds in the Chairman's mark would add $12.5 billion to that for a total of $31.2 billion, as Senator Moynihan reflected a minute ago.

The payments for graduate medical education, the separate payments, under the current direct Medicare GME during that same time period, 1996 through 1999, we would anticipate Medicare payments of about $7 billion, to which the Chairman's mark would add $11.7 billion up to $18.7 billion.

The other payments are new payments that are not in current law. The biomedical research payments would total about $5 billion during that period; the direct payments to medical schools, $1.4 billion; and the new program of payments for advanced nursing education would total $800 million.

Your second question in terms of the allocation, the allocation would be done by a formula and not by individual decision making on a school-by-school basis. The payments for the academic health centers would be made on a formula that would be patterned after the current Medicare, indirect medical education payment formula.

But, of course, it could not exactly parallel that since Medicare pays on DRGs and not everybody pays on DRGs. That is what that formula is based on.

So it has to be modified somewhat to take that into account and also to take into account the payments to the rural hospitals that are listed as well as the dental schools.

The payments on the graduate medical and nursing education trust fund would be made also on a formula, again patterned after, but by necessity not identical to the current graduate medical education allocation formula, based on current hospital costs.

Senator Chafee. Well, Mr. Chairman, I share your enthusiasm for the support of graduate medical education. I read the paper, the article, by Dr. DeBachie that you sent around. But I must say that I am a little ill at ease here because of the massive size of these amounts of money.

The Chairman. It is our understanding that we do not add a very great deal to what we now spend, but we provide a settled flow of funds to those objects. The addition is the biomedical and behavioral research trust fund which Senators Hatfield and Harkin have proposed.

I would like, if I may, since we will be getting to this further on down, we will get you as precise a set of

tables as we can do.

Senator Chafee. Well, I certainly cannot claim to be any expert. I just wanted to voice my nervousness here.

The Chairman. Yes, perfectly understandable.

Senator Chafee. Like all of us, I am besieged by the folks at home who obviously want as much as possible.

The Chairman. And as I said, it did emerge from our hearings that this is an area of concern.

Senator Danforth?

Senator Danforth. Yes. It was not clear to me, Dr. Budetti, when you were rating the numbers how it all nets out. My understanding of the reason for this is that if we are going to reform health care the cross-subsidy that is going to flow from Medicare to the teaching medical centers is going to be squeezed. And, therefore, what we were attempting to do is to make up for that, to compensate for it.

But is it my understanding that in addition to compensating for it this is a very substantial increase in what we are spending?

Dr. Budetti. Senator, the Medicare payments that are reflected in the Chairman's mark would continue current law levels under Medicare. There have been a number of proposals that would have otherwise reduced the Medicare level of contribution and then tried to offset both those

reductions as well as trying to compensate for funds that would be lost from the private sector.

The Chairman's mark continues Medicare payments in both cases at current law levels and then imposes the assessment on premiums to make up for the funds that would otherwise be available under the current private sector reimbursements to hospitals that would no longer be available under the more competitive managed competition system.

Senator Danforth. Let me make sure that I understand what we are talking about.

Dr. Budetti. Sure.

Senator Danforth. Is it our objective in the plan that you just outlined to maintain the current level of support or is it our intention in the plan that you have outlined to have a substantial increase in the level of support?

Dr. Budetti. The intention is, at a minimum, to maintain the current level. The problem, Senator, is that it depends on who you ask to try to figure out exactly how much money is now available to the academic health centers and teaching hospitals.

The Medicare dollars we do identify as a separate funding stream. So we know how much they are getting under Medicare, IMEND and direct GME right now. But there

are very different estimates as to how much additional private sector revenue they are currently able to cross-subsidize themselves with from all their other patients.

Senator Danforth. I am sorry for interrupting you.

Dr. Budetti. That is all right.

Senator Danforth. Is not the purpose of the program that you outlined to compensate for what the concerns are? In other words, the concern is that as a result of whatever we are going to pass, these academic centers are going to lose money.

Dr. Budetti. Yes, Senator.

Senator Danforth. That would be a very bad thing to happen. And, therefore, what we are going to try to do is create a fund through this additional tax to make up for that.

Dr. Budetti. Yes, that is a very good description of what this proposal is intending to do.

Senator Danforth. Does this proposal in addition to that provide more money? Is the idea to increase the level of funding for these various areas?

Dr. Budetti. There are certainly identifiable additional monies here for the research, for the payments to medical schools, and for advanced nursing education. Within the other two pots, as I said, Senator, it would depend upon whose estimates you went by.

Our assumption is that these are either sufficient to sustain the current levels of money that the academic health centers and teaching hospitals get from all sources or to provide an increase, depending upon the estimates that one accepts.

We certainly do not anticipate that this falls below what their current level of payments are.

Senator Danforth. Nobody has ever suggested that. All I want to know is, is the theory to provide more or is the theory to maintain a level?

The Chairman. Can I say, sir, that the theory is to provide what is now provided and may be in jeopardy with the addition of the biomedical and behavioral research trust fund. We would like to get you a balance sheet on this.

Senator Danforth. All right. I think that would be helpful. Let me ask you this. Is this program going to last forever or is this insofar as it is our objective to compensate for consequences of changing the health care system, is this going to be a perpetual system or is this going to be something that we will have a chance to review after a few years?

Dr. Budetti. The Chairman's mark would establish this as an ongoing program, taking into consideration the fact that the major teaching hospitals and academic health

centers, one would expect would always have sicker patients and more complicated delivery of care that they would have to deliver -- higher technology care, more advanced types of care -- and also would have costs that could not be compensated for if they were trying to compete with community hospitals.

So the anticipation is that this will be an ongoing need and a continuing program, Senator.

Senator Danforth. Well, obviously, there are going to be ongoing needs of teaching hospitals. But the question is, how much damage are we causing by whatever legislation we are going to pass and will that ever settle out over a period of time.

If we are going to have some sort of commission to try to analyze what we are doing, I wonder if that commission or some other commission might not report back in a few years.

The Chairman. Might I say, I think that is a very thoughtful proposition and we should draft language to that affect.

Senator Mitchell?

Senator Mitchell. Mr. Chairman, thank you. I know that you want to move this process along, as we all do, and, therefore, I do not have any questions.

I would merely like to reiterate an earlier comment I

made, not in these public meetings but in our private discussions. First, I commend you for your leadership in this area. The vitality of the academic health centers and the continued research is important for our nation.

Many of us, as you know, are vitally concerned with the problems in rural areas and in other parts of the country, particularly the devastating and growing shortage of primary care physicians and other providers. I merely renew my request for consideration by the Chairman and other members of the committee for a work force target of entering residents in primary care by a date certain, of the establishment of a national council on graduate medical education which would promptly report recommendations on work force policy and some provision for direct payments, undergraduate medical education to the applicant programs as opposed to going through the institutions.

That was discussed at great length at least one and I believe more of the hearings that were held here. There are a number of family residency programs that I believe -- well, their advocates, of course, were here to express their views, a view which I share, that they would be enhanced and be encouraged in the provision of more primary and family care physicians by such.

The Chairman. Let us try to draft that. Dr.

Budetti, I know you can; and let us try to do.

Dr. Budetti. Yes, Senator.

Senator Mitchell. I thank you, Mr. Chairman, for your consideration of these matters.

Senator Durenberger. Mr. Chairman?

The Chairman. Senator Durenberger?

Senator Durenberger. I appreciate what you have said about the Commission and so forth. But I think we are still dealing with the difficult issue that we are going to have to relate to which is the two-and-a-half or whatever it is, some percent.

Dr. Budetti. I.175 percent, Senator, of which 1.5 --

Senator Durenberger. Please, why do you not just go into the details of that so we can all understand it.

Dr. Budetti. The assessment on premiums is set at 1.75 percent of premiums and the equivalent sum of money from self-insured plans. Of that 1.5 percent would go into the academic health centers and the graduate medical education and nursing trust funds; and 2.5 percent of the 1.75 percent would go for the biomedical and behavioral research trust funds.

Senator Durenberger. So there will be a tax or an assessment on all premiums of 1.75 percent?

Dr. Budetti. Yes, Senator.

Senator Durenberger. Then all self-insured plans

will be similarly taxed?

Dr. Budetti. That is correct.

Senator Durenberger. And how will that be levied?

Dr. Budetti. That would be calculated based on their premium -- essentially based on their premium equivalents, the amount of money that they spend that would be comparable to what premium would be calculated for them.

Senator Durenberger. What is the estimated bottom line for that trust fund over the next five years or whatever period of time?

The Chairman. You mean the income?

Senator Durenberger. Yes.

The Chairman. $30 billion.

Senator Durenberger. And what the breakdown is between commercial plans and self-insured.

The Chairman. Yes, we will get you that by end of day.

Senator Durenberger. He may have it.

Dr. Budetti. Yes, Senator. Our tax people have estimated that approximately $31 billion over the first five-year period. We do not have a breakdown between self-insured and insured at this point.

Senator Durenberger. All right. Mr. Chairman, I just want to -- I mean, I have to qualify what I say by reminding some of my colleagues that back in 1983 when we

designed the DRG system I struggled with this issue at that time and we came up with the graduate medical education and direct teaching formula.

The Chairman. We did indeed.

Senator Durenberger. What it has done is largely compensate hospitals, academic medical centers, as opposed to compensating the interns and the residents and so forth. It has given us, at least in part, contributed to the problem which we have today, which is an alleged excess of specialists and so forth.

So my concern is not with compensating the educational institutions for the cost of medical education. I feel much more strongly about that than I do research, because I think research has a traditional variety of public sources. But I think this is a critical problem, this issue of education, and we feel it desperately in our State of Minnesota.

The problem I have, and I do not have a problem with the all payer approach. In other words, everyone who benefits ought to make a contribution of some kind. But the only alternative to an all payer approach with which we have been presented is this notion of the tax or the assessment.

I do not know if there are others out there in academia or some place that we ought to look at. But I

think my deeper problem, and the reason I am so interested in exploring some kind of a commission alternative or modification to this is, how do we make the decisions about how that money is going to be spent out there.

Do we continue the process of spending it on hospitals or do we find some way to track with the market demand or anticipate the market demand for work force changes by following the students, by following the program?

The Chairman. As a structure of hospital changes. I think we should do that.

Senator Durenberger. I think if you do not mind there are several of us in this committee who have talked about this, Mr. Chairman. If we might be able to offer a modification at some point.

The Chairman. I will look forward to it. With that free-standing hospital that was the standard in 1983, it is not there anymore.

Senator Rockefeller. Mr. Chairman?

Senator Baucus. Mr. Chairman?

The Chairman. Let us see, Mr. Rockefeller -- I am sorry, Senator Baucus has bene very patient.

Senator Baucus. Go ahead.

Senator Rockefeller. Mr. Chairman, I know the last thing we need is more discussion at this point if we want

to get through the mark. But I just want to make two quick points echoed by some others.

I think this is an incredibly important section for the future of health care, service to the nation in health care and cost containment. My reading is that this may be a doubling, in fact, of funds guaranteed to academic health centers which is fine.

But this is funded by an all payer system. If we have an all payer system that is paid by everybody throughout the country, then the country has to benefit from public health policy.

Dr. Budetti, public health policy clearly indicates parity as fast as we can get there between primary care and the specialists. You know, sir, that if we started on this day, this year, at 50/50 in our medical schools, it would be the year 2040 when we would get to parity between specialists and generalists.

An all payer system paid by all the people deserves a public health policy, health care policy, that serves all the people, both in the inner cities, the big cities and the rural areas.

The second point, in conclusion, is this is absolutely fundamental cost containment policy -- work force reform, academic health centers. If it is true, as I believe that we have between 80,000 and 100,000

specialists that we do not now need in this country, each costing $1 million a piece, therefore, $80 million to $1 billion a piece per year, we will never seriously approach cost containment until we do work force reform along the lines that Senator Mitchell included.

I wanted to make that point simply because I cannot not make that point and be serious about this subject. I thank the Chairman.

The Chairman. Thank you, Senator Rockefeller.

Senator Baucus?

Senator Baucus. Dr. Budetti, I am curious as to what the Medicare payments are currently to the academic health centers compared with Medicare payments to non-academic health centers. You said the current law be maintained.

Dr. Budetti. Yes, sir.

Senator Baucus. How much more do these teaching hospitals now get under current law compared with others?

Dr. Budetti. Under the Medicare indirect payments, which is a multiplier on their DRGs, their payments are increased to offset their increased costs. On average that approaches an increase of about 25 to 30 percent, Senator.

Senator Baucus. In some hospitals maybe twice as much?

Dr. Budetti. That is correct. It depends very much

on how many residents are in training in the hospital compared to the number of hospital beds they have.

Senator Baucus. And that would be maintained?

Dr. Budetti. That formula would be the basis for the new formula, but it would be modified somewhat to take into account different payment methods.

Senator Baucus. Now you mentioned that the private payments to these hospitals might be reduced, and you said there are lots of different estimates. What is your best evidence and what estimates are you using to determine by how much private payments to these hospitals, academic health centers, are being squeezed and cut back? What figures do you have and what is your best evidence?

Dr. Budetti. I can ask Ms. O'Dougherty to also address this, Senator. But we have looked at a variety of different sources of numbers, including numbers from the academic health centers themselves, which would suggest that these numbers are actually somewhat below what their long-term projections are.

These numbers that we have presented do represent our best estimate of what --

Senator Baucus. My question is: By what percent over the last two years have private payments to academic health centers change, been reduced, say? What is the figure? And not only what they give you, but after you

looked at it objectively to determine what you think the honest answer is.

Ms. O'Dougherty. We have been trying to determine what that figure is and have been unable to do so. We have worked with the administration to try and get that number. What that number is is the increase in their charges that are due to the special services they provide, including the education, research, severely ill patients and specialized services.

Their estimate at one point that it was a 25 to 30 percent increase in charges. But again, we are unable to verify that because no one is able to break down the charges into their component pieces.

Senator Baucus. Do we have any ideas when we might get the color, objective, best, pretty solid estimate?

Ms. O'Dougherty. To my understanding, people have been working on this for five or six months and there have been external contractors involved and they do not believe that they will get any further than they have now.

We do know, but we cannot quantify the amount that those 25 to 30 percent is the part that is being kind of torn down in the negotiation of contracts with managed care. So that level is decreasing, but we do not know precisely by what amount.

The Chairman. Could I make the point that we are

using the same numbers that Senator Kennedy's committee has.

Senator Baucus. That may be, Mr. Chairman. I was curious as to what those numbers are. We have an obligation to try to read what they are.

The Chairman. We will try to find out.

Senator Baucus. Thank you.

The Chairman. Very well.

Senator Chafee. Mr. Chairman, could I just ask one final question. The premium tax, again, Dr. Budetti, is 1.75 percent?

Dr. Budetti. That is correct, Senator.

Senator Chafee. And that will yield how much in your judgment?

Dr. Budetti. We believe over the first phase, between the first five years, that that would yield about $31.5 billion.

Senator Chafee. So this is not any little modest program?

The Chairman. No.

Senator Chafee. $31.5 billion.

Dr. Budetti. Yes, Senator.

Ms. O'Dougherty. The intent of that $31.5 billion is to replace the current increase in charges of 25 to 30 percent that teaching hospitals have been able to charge

and the past indemnity insurance bill will not be able to do in the future in negotiating managed care contracts.

Senator Durenberger. Where is the evidence of that?

Ms. O'Dougherty. As I just stated that there have been a lot of people working on this and they do not have a precise figure, but the estimate at this point is 25 to 30 percent and has been historically.

Senator Durenberger. Are we going to compensate those that lost 50 percent with 50 percent money and those who lost only 10 percent with 10 percent money? Is that the notion?

Dr. Budetti. No, Senator. It is intended that the automatic formula that is being developed would reflect the hospital's teaching costs and related expenses. But there is no attempt to adjust it on an individual basis in that sense.

Senator Durenberger. So we are going to use the measure of the total loss if we can ever find it or whatever it may be as a justification for the tax, but we are going to use a different formula than individual impact for the educational compensation component?

Dr. Budetti. We have not had any such adjustment under consideration, Senator. I have not seen any proposals quite like that. It is an interesting concept.

The Chairman. I am going to ask that we move on

because we will get back to this. This is a subject to be debated. But I do not think anyone here will question the shift away from indemnity insurance to managed care. That puts academic hospitals and academic centers in a very different situation.

Senator Durenberger. Mr. Chairman, and I do not want to be misinterpreted in my questions either, because I think my Center is probably the one that everybody in the country is looking at as being most severely impacted. But if we learn anything from the last 10 years, it is that it is in many of these centers that have given us the kind of work force that we now decry as being inappropriate for our needs.

The Chairman. Yes.

Senator Durenberger. We have had Dr. Koop in here, all kinds of people, tell us that. That it is what happens to these young people when they get to these centers that is giving us the overabundance of specialties. So I am not arguing against medical education. I am arguing that it really is a serious proposition to be treated in some way other than just raising money to compensate people for their losses because some of these people deserve these losses.

The Chairman. There you are. Now, thank you very much, Dr. Budetti, Ms. O'Doughtery.

Our next subject is one of great interest to this committee -- the Access to Health Care in Designated Urban and Rural Areas. Fay Drummond, you are on.

Ms. Drummond. The Chairman's mark would create an infrastructure development account within the Health Security Trust Fund to support the development of community health networks and certified community health plans, and to provide operating and capital assistance to such networks and plans.

The Secretary of HHS would be required to deposit $1.3 billion in the account annually and to administer all programs funded through the account. Community health networks are organizations that provide some sort of assistance, including the standardized benefit package, either directly through their members or through affiliations with other entities.

A network must ensure that services are available and accessible to each enrollee with reasonable promptness and that clients have a primary care provider. The certified community health plan is a public or non-profit private health plan that provides a significant volume of services to medically underserved populations and individuals residing in health professional shortage areas.

They would include at least one of the providers, either institutions, physicians, providers or qualified

migrant health in community health centers, qualified homeless programs, family planning providers, HIV providers, maternal and child health block grant recipients, rural providers and federally qualified health centers.

The Secretary of HHS would be required to develop standards for identifying designated rural and urban areas. They would take into account financial and geographic access to certified health plans, the availability, adequacy, quality of providers and health care facilities, as well as health status.

States would have the authority to identify designated urban and rural areas subject to the approval of the Secretary.

We have here at B. we have the network and planned development grant program. This program would aware grants to public and private health care organizations, to assist them in becoming community health networks and certified health plans.

Grant funds could be used to assist in recruitment and retention of health care professionals to develop information, building and reporting systems, to link providers together including through information systems, to meet reserve requirements and to support other activities related to developing certified community

health plans and community health networks.

There would be a priority given to networks and plans that include the largest number of entities listed under the definition of community health networks and are serving populations with the highest degree of unmet needs.

The next section, part of the trust fund of the account would be operating assistance. Here the Secretary would be required to use funds from the infrastructure development account to provide operating assistance, to certify community health plans, community health networks, to address geographic, financial and other barriers to health care services in designated urban and rural areas.

Grant funds could be used to provide consumer information and related services that will increase access to care. Related services could include rural and frontier emergency transportation systems and translation services.

Capital investment, which is the third portion of the account, the Secretary would be directed to use funds from the infrastructured account to provide capital assistance to community health plans, community health networks and isolated rule facilities in the designated urban and rural areas.

The assistance would be provided in the form of

loans, loan guarantees and direct grants. Funds could be used for the acquisition, modernization, conversion and expansion of facilities, and for the purchase of major equipment, including hardware for information systems. And at least 10 percent of the funds available for capital assistance could be reserved for applicants seeking to serve designated rural areas, provided that a sufficient number of such qualified applications were approved.

The Secretary would be required to give preference to applicants who need capital assistance to prevent or eliminate safety hazards and essential facilities, to avoid noncompliance with licensure accreditation standards and to improve the provision of essential services.

We also have in this section additional funds for telemedicine demonstration projects of $20 million. There would be four projects funded under this section which could be used to develop a Medicare reimbursement methodology for telemedicine services.

Health care providers located in rural areas would be eligible to receive funding under this section if they establish partnerships with other community institutions to identify and implement telemedicine projects. They would be required to match federal grants at at least 20 percent.

The grants here could be used to support the

establishment and operation of telemedicine systems that provide specialty consultation to rural communities, to demonstrate the application of telemedicine for preceptorships of medical and other health profession students, to pay for transmission costs, salaries, measures of equipment and compensation of specialists and referring practitioners.

The Secretary would also establish in inter-Agency task force for rural telemedicine. There are several other provisions here that are not in the trust fund but are included in Title XII, two dealing with Indian health.

The Chairman. Indian health, right.

Ms. Drummond. That would remain basically -- it states that it would remain -- Indian health service would remain as a provided health care for Indian population.

The Chairman. Right.

Ms. Drummond. And Indian tribes would be eligible to apply for appropriated funds.

The Chairman. And the Office of the Assistant Secretary for Rural Health will continue.

Ms. Drummond. Right.

The Chairman. Good.

Ms. Drummond. All right.

The Chairman. Thank you very much. Now, can we get to -- thank you, Fay Drummond, as always.

Will Sollee, will you take us up on Title XIII?

Senator Rockefeller. Mr. Chairman, could I just have one quick question?

The Chairman. Of course you can.

Senator Rockefeller. I apologize. As I see it in this rural public health question, so to speak, that the funding for public health clinics and the rest depends a lot upon the cigarette tax.

Ms. Drummond. Not anymore. All the funds have been placed into the general trust fund and is not targeted specifically to the cigarette tax.

Senator Rockefeller. So that you see that I have no reason to worry about what would happen in terms of rural public health clinics and physicians in underserved areas, et cetera, in rural areas?

Ms. Drummond. In reference to the funding, no you would not.

Senator Rockefeller. All right.

Senator Durenberger. Mr. Chairman, may I follow Jay's question?

The Chairman. Yes.

Senator Durenberger. What is the origin of the trust fund in which this is drawn?

Ms. Drummond. There is an overall health security trust fund in general where the subsidies and all monies

are placed. This is simply an account within that overall trust fund.

Senator Durenberger. Somebody asked me last night, is the one that where if we spend up all the dedicated monies in the fund then we can draw down general revenue?

Ms. Drummond. I am not aware of that.

Senator Durenberger. Would someone who understands it clarify that? Because I do not know where else to raise the issue.

Ms. Drummond. The answer is yes from the tax staff.

The Chairman. Mr. Gale says yes.

Senator Durenberger. In other words, we have a trust fund with an unlimited draw on the general revenue fund; is that it?

Ms. Drummond. Yes.

Senator Durenberger. Very interesting.

The Chairman. But we have had this for some time.

Senator Durenberger. Maybe you could explain the nature of the trust fund.

The Chairman. Mr. Gale, would you like to explain?

Senator Durenberger. Is this a new trust fund?

The Chairman. Mr. Sollee? Who wishes to speak here?

Mr. Sollee. Chuck, Mr. Konigsburg.

The Chairman. Oh, Chuck. Mr. Konigsburg, would be happy to have kindness as counsel to approach the

counsel's bench?

Mr. Konigsburg. Senator, the trust fund can draw on general revenues.

The Chairman. We knew that.

(Laughter.)

Senator Durenberger. I am asking, is that a naivete. But is this an existing fund?

Mr. Konigsburg. This would be a new trust fund.

Senator Durenberger. A new trust fund?

Mr. Konigsburg. Into which the revenues raised by this bill would be deposited.

Senator Rockefeller. And the description of this trust fund, I believe, has changed, Senator Durenberger, since the staff briefing. Am I right about that or wrong about that, on the staff briefing on the trust fund?

Mr. Konigsburg. It has not changed since the staff briefing, no.

Senator Durenberger. I am wondering, Mr. Chairman, I am sure maybe somebody -- not now -- but we could get just a little description of this trust fund, what is going into it, what the draw down is inside the bill.

The Chairman. Exactly.

Senator Durenberger. Then we can make our own estimate.

The Chairman. We will get to each of these matters

in the course of discussion. We are just laying it out.

Senator Durenberger. Thank you.

The Chairman. Thank you, counselor. Do not wander too far.

We now get to State flexibility and Mr. Sollee.

Mr. Sollee. It is Part XIII of the mark. I would clarify present law relating to federal preemption of State laws affecting employer health plans and give States new flexibility to establish their own health care programs.

Section A on page 125 of the mark would clarify that certain State laws that are intended to increase health care coverage, fund uncompensated care, or control health care costs, but which by their nature do not affect the structure, administration or type of benefits provided by an employee benefit plan are not preempted by the Employee Retirement Income Security Act, ERISA.

These laws would include all payer provider reimbursement systems, rate surcharges and premium or other health care assessments used to fund uncompensated care or other State health care programs. And community rating standards -- do not permit variation by age, apply to a larger share of the market, or apply by January 1, 1996 which is the effective date of the community rated standards in the Chairman's mark.

And as a clarification of present law, this provision would be effective before and after the date of enactment of the proposal.

Section B on page 125 would grant new authority to States to permit them to continue to experiment alternative health care systems that may help increase coverage and control health care spending.

Under the mark a State could apply to the Secretary of HHS for a federal waiver to establish a comprehensive State program for the management of all health care benefits provided in the State.

This is similar to a provision in the Ways and Means Chairman's mark and similar to a provision in the administration's bill.

The Chairman. Thank you, Mr. Sollee.

Senator Baucus. Mr. Chairman?

The Chairman. Senator Baucus?

Senator Baucus. Thank you, Mr. Chairman. The State of Montana passed legislation which provides that the State at a future date may decide to select a single payer system. Would this allow that?

Mr. Sollee. Yes, it would.

Senator Baucus. Thank you.

The Chairman. Senator Durenberger?

Senator Durenberger. We are going on the arcane here

again. But I tell you, this is probably the most critical change that I see in this whole area. If we are going to adopt the principle of national rules and local markets, we cannot have a little bit of this and a little bit of that.

We are going to have a big debate here in the next day or so with our colleague from Utah or some place else about the so-called repeal of McKerrin-Ferguson because we are trying to establish just for the changes in the health system of this country some national rules where State legislatures cannot impede pro-competitive, pro-choice market activities.

That is going to be a big enough debate, because there is a lot of the interest out there that like the access they have to State Legislatures and the way in which benefit mandates and so forth are putting a crimp in competition in economies.

Here we have the other side of that. The ERISA preemption is the only thing that has saved a lot of employers from having to live with all of these anti-competitive pro-fee-for-service, pro-provider, pro-indemnity insurance kind of mandates at the local level, which add to the cost -- unnecessarily add to the cost -- of providing access for their employees.

So the ERISA preemption of state activity that

affects self-insured plans is the only thing that has given a lot of these employers and employer coalitions the opportunity to go into these community marketplaces and force them to change.

Now, help me understand the Chairman's mark here. Because the way I understand the Chairman's mark it says we are going to undo some part of this ERISA preemption and we are going to permit State laws on all payer provider reimbursement systems, premium taxes, uniform rate schedules, price caps potentially, pure community rating standards, a variety of this kind of activity on the part of individual States, it seems, could be permitted under the mark's definition of -- here it is called the -- permits all ERISA plans -- permits State laws intended to increase health coverage, fund uncompensated care or control health care costs.

Mr. Sollee. Well, the list, there was an attempt to balance the interests of federal uniformity and the State's ability to try to improve the lot of their residents.

Those provisions that you just read in Part A are really intended -- it is intended to be a list of acts by the State which would not really affect the structural administration of plans in different States. It would not require new claims forms, data, recordkeeping, a different

package. It would really only be those laws which have an indirect economic affect on the price, for example, which a plan would pay in different States which really could happen anyway. It really would not allow a State to add benefits to the benefits package, for example.

The Chairman. Can we not agree that this is something we will have a rather vigorous debate on when we get to the actual mark-up?

Senator Durenberger. Yes. And, Mr. Chairman, if you prefer, I will not initiate the debate on the ERISA preemption now. But I am really going to need some access to the staff to deal with this.

The Chairman. Take as much time as you will require.

Senator Durenberger. Yes, I would appreciate that.

The Chairman. No, I mean, your point about national standards and local management is essential to your thinking. It will be heard.

Thank you, Mr. Sollee.

Welcome back, Dr. Braithwaite. You are going to deal with Title XIV on privacy and confidentiality, doctors' particular concerns.

Dr. Braithwaite. Thank you, Mr. Chairman. The privacy and confidentiality proposal starts on page 127 of the mark and is a refinement of a proposal introduced by Senator Leahy as the Health Care Privacy Protection Act

earlier this year.

This proposal would require that all health information that could reasonably be related to a specific individual would be protected from disclosure, regardless of the form in which the information was kept. Unauthorized disclosures would be subject to civil actions and penalties which would apply to those who knowingly obtain, as well as those who disclose, the information.

Patients would have the right to inspect and amend their health information through their providers. They would also have the right to prohibit disclosure of information, which otherwise might be shared under exceptions to the rule of nondisclosure. The exceptions are found on page 128.

The exceptions include the use of protected health information for treatment, payment, oversight, public health purposes, medical emergencies, health research and law enforcement.

The amount of health information disclosed under these exceptions would be limited to that necessary for the purpose of the disclosure. The information could not be redisclosed or used against the patient. Upon enactment, these provisions would preempt inconsistent State laws.

The Chairman. Thank you, sir.

Dr. Hein, Dr. Burdetti, as professional practitioners, these meet your standards and very much have your support. We thank you very much. I cannot tell you how much it has helped us to have three professional doctors with us who had their hands on this subject.

Senator Durenberger. Mr. Chairman, coincidentally, I got one of those calls yesterday from Everett Koop on something that was, as usual with him, way beyond mortal man. But he was pointing out to me, in the information infrastructure issues, the telecommunicatable information infrastructure that we are contemplating here, and then in this safeguards area, two critical problems we need to be aware of.

One is that the average American have access without special financial penalty to this communication system we are building, and it not just be institutional access.

The second one, that we build these privacy safeguards into the communications infrastructure as well as into the law.

I cannot elaborate on it. I suggested to Bob Packwood, who is on the Commerce Committee, that it is an issue they ought to take a look at. But he seemed to have a deep concern about the fact that we need to be sensitive to this as we promulgate the appropriate rules in this area.

The Chairman. Thank you. I hope we have been. If anyone thinks we have not, we have three doctors there to help us.

There is this conflict. Patient/doctor relationship is sacral and yet science requires data. We do a pretty good job, I think.

Thank you, Dr. Braithwaite.

Sheila O'Dougherty, where are you? There you are. Health Plan Standards. And, Dr. Burdetti, we will require your presence once again.

Ms. O'Dougherty. Mr. Chairman, the health plan standards section begins on page 130 of your mark. There are two main components of the health plan standards section -- the standards themselves and the health plan certification process.

Standards which would apply to all health plans would be requirements to establish alternative dispute resolution procedures, participate in the health information network and report the data required for consumers to compare health plans and met capital insolvency standards.

Additional standards which would apply to integrated health plans are in the area of quality, patient protection and access. States would be required to establish accreditation, certification and enforcement or

ACE programs, meeting federal guidelines.

Health security trust funds would be available to the States for their ACE programs. Health plans not certified as meeting federal standards would be subject to a civil penalty, not to exceed 50 percent of gross premiums. And they also could not receive federal subsidies.

As a final point, I might note to address Senator Durenberger's concern, is that State laws would be preempted to the extent that they constrain the development of managed care plans.

Senator Durenberger. Mr. Chairman?

The Chairman. Please.

Senator Durenberger. Two questions. I have been on this committee long enough to remember Jay Constantine and the California HMO rip-offs and things like that. So when I hear you say there is one set of standards for fee-for-service, indemnity and whatnot plans, and then as I am told five pages of additional requirements for what are called integrated health plans, I get worried.

In other words, for some reason or another we seem to be writing into law potentially a lot of so-called quality standards for something called integrated health plans that we do not have for the others. Tell me why. Because I thought we were sort of beyond the old days of worrying.

Ms. O'Dougherty. It was not our intent to have

standards that applied to integrated health plans that did not apply to insurance products. We handled the standards in the same manner, except for we felt that the standards for insurance product needed further development in that field. So they will be designated by the Secretary.

The Secretary will be responsible to develop quality and patient protection standards for insurance products. But we felt that there was enough agreement on standards for the integrated health plans at this point to go ahead and specify them in the law.

Senator Durenberger. Then my second question relates to the guarantee fund. I do not know that you mentioned that specifically. I may have missed it. But I understand the mark permits States to assess up to 2 percent of premium annually to cover outstanding claims against failed health plans.

On the surface that looks like folks that are good at what they do and mind their Ps and Qs and so forth are going to be funding folks that are not. Is there some reason why? Let me phrase it more positively then. Can we not have solvency and capital requirements, some of that sort of thing that will accomplish the same end rather than having this premium tax? Someone.

Ms. O'Dougherty. Go ahead.

The Chairman. Ms. Horvath.

Ms. Horvath. The guarantee fund is just patterned after what States do now, Senator, in terms of the 2 percent. Again, it is the NAIC model.

The Chairman. Wait.

Ms. Horvath. The National Association of Insurance Commissioners. Excuse me.

The Chairman. Good.

Ms. Horvath. And that all plans are treated the same. They are all in the same guarantee fund. I guess it is felt that the world is changing out there and that we need both for a period of time at least. There are different incentives that are being created in this new system of competition that a guarantee fund may not suffice.

The Chairman. Again, we will get to this in our general debate.

Senator Durenberger. Thank you, Mr. Chairman.

The Chairman. And thank you, sir. This is a matter of very special concern to you, as we know.

And finally Title XVI, Quality Consumer Information and Health Services Research. Ms. O'Dougherty, you are once again our lead. Your backup associate is Dr. Braithwaite, if Dr. Braithwaite would come forward.

Ms. O'Dougherty. Mr. Chairman, the quality consumer information and health services research section begins on

page 139. The three sections I will briefly outline are health services and quality improvement research, quality improvement foundations and consumer information.d

Health services and quality improvement research would include expansion of research on medical effectiveness, research on methods of measuring population health status, and research on national quality performance measures to allow consumers to compare health plans.

The second component is establishing quality improvement foundations to implement research findings into actual medical practice by providing technical assistance to health care professionals in cooperative ventures. Health security trust funds would be available to quality improvement foundations.

State level consumer information centers would allow consumers to participate in the marketplace by producing comparative value information, educating consumers concerning this information, and resolving complaints. Again, health security trust funds would be available to consumer information centers.

Senator Mitchell. Mr. Chairman?

The Chairman. Senator Mitchell, the Majority Leader.

Senator Mitchell. May I merely make again just a comment on this subject and ask that it be considered by

you, Mr. Chairman, and by the members of the committee.

I appreciate the increase in the authorization for the Agency for Health Care Policy and Research, Mr. Chairman. This is an agency created by legislation which I authored some years ago.

The Chairman. Yes, indeed. But you never found a way to pronounce it as an acronym, AHCPR. We have HCFA.

(Laughter.)

Senator Mitchell. I just call it the Health Care Research Agency.

The Chairman. Good thinking.

Senator Mitchell. It is easier to pronounce.

The Chairman. Good thinking.

Senator Mitchell. Given the current discretionary caps on appropriations, I think it likely that the level of funding appropriated will be substantially less than authorized. We have had an annual struggle, understandably, in competition with other demands for discretionary funding.

I would hope that you and the staff could give consideration to alternate and more assured sources of funding, such as some of the trust funds that are created in other parts of the bill.

The Chairman. All right. Not the worse idea at all.

Senator Mitchell. Right. The other concern I would

raise is that the quality improvement foundation proposed under this legislation are run by Boards appointed entirely by Governors.

While I think they have a very important role to play, I would hope that you would consider giving at least some role in the appointment and to the Secretary of Health of Human Services, so that there is perhaps some balance in the area and a competitive grant making process for you to select one foundation in each State.

This would permit such foundations to exist outside of the regulatory arena and I believe would help to accomplish what I believe is our common factor.

The Chairman. Could we hope for some language from you in this?

Senator Mitchell. Yes, Mr. Chairman, I will do that.

The Chairman. Good.

Senator Mitchell. I thank you for your consideration.

The Chairman. Thank you.

Senator Durenberger. Mr. Chairman?

The Chairman. Senator Durenberger?

Senator Durenberger. May I ask a --

The Chairman. The last word, until we begin the mark-up which commences immediately.

Senator Durenberger. First, I would like to fortify

the comment that George made about the funding. I think the appropriate place might be the research trust fund.

The Chairman. Yes, that is obvious.

Senator Durenberger. Then to add a dimension to that. These quality improvement foundations and consumer information centers, I understand we are going to have at least 50 of those in the 50 States. I understand further that their total cost over 10 years is something, what, $3.-some billion or something like that. So it is not insignificant. $3.7 billion is what I see here.

But it is not an insignificant amount of money. I think it is $2 billion for the quality improvement foundation and that is billions; and $1.7 billion for the consumer information center. Maybe at another time and setting I will ask why we need these things. A lot of this is the kind of work we expect the health plans to do. But I will not raise that now.

I wanted to give a dimension to George's comment about the need to find a place, if we are going to do this, find a place other than appropriated funds.

The Chairman. That is a very thoughtful comment.

Senator Durenberger. Thank you.

The Chairman. With that, we thank our resident authorities. We have concluded our walk-through and the bill is now open for amendment.

Senator Baucus. Mr. Chairman?

The Chairman. We have reached a certain comedy here as we try continuous to try to do. Mr. Baucus will have the first amendment. Mr. Packwood will have the second amendment. Mr. Breaux will have the third amendment. Then there will be no more amendments.

(Laughter.)

Senator Riegle. No more amendments today or ever.

The Chairman. I think of which I meant probably no more amendments before lunch.

Senator Riegle. All right.

Senator Packwood. Could I ask just a couple of questions?

The Chairman. Yes.

Senator Packwood. Not offering an amendment. One, have we got an answer yet from the staff to the budget questions that Senator Domenici raised that I gave them answers to which are quite critical to the whole process?

The Chairman. They surely are. Let us ask --

Senator Packwood. Who has it? If they could take the table, I would appreciate it.

The Chairman. Jeff, were you going to do that? The responses, Senator Packwood, will be ready after lunch.

Senator Packwood. All right.

The Chairman. Then if you recall, we will resume at

2:30. But let us get on with our work.

Senator Packwood. I have a second question is all. Do we have any cost estimates on the Chairman's mark or on any of the amendments that we know of from CBO or from Joint Tax?

The Chairman. No, sir. We have individual estimates about this particular item, that particular item, that Joint Tax knows and feels they know something about. CBO has been visited before. But a comprehensive report is not available. We still do not have a report on Senator Chafee's bill.

Senator Packwood. And I assume obviously, as the amendments have not been circulated, and there are numerous ones, we have no estimates, other than what the members might tell us, on any of the members' amendments.

The Chairman. That is correct, sir. That is what prevails.

Senator Packwood. I am ready.

The Chairman. All right. sir.

Senator Baucus, you are recognized for the purpose of offering an amendment.

Senator Baucus. Thank you, Mr. Chairman. Mr. Chairman, I would hope -- actually the Majority Leader just made this point to me -- that Senators who are not here, are on notice that there will be amendments and

votes on the amendments fairly soon, so we have an opportunity to vote on the amendments.

The Chairman. They surely have.

Senator Baucus. Mr. Chairman, I understand that there will be an amendment soon with respect to the so-called hard trigger provision in the Chairman's mark. I have an amendment which goes to that provision.

Essentially, the amendment which I have circulated -- I think all members have a copy of the amendment -- the amendment would carve out the obligation that low-wage, small firms would be required to buy health insurance in the event the trigger is pulled.

Essentially, the amendment provides that firms of 26 to 50 employees in the event the trigger is pulled, they are low-wage firms, that is their average wage is $24,000 per employee, would not be obligated by health insurance, but it would contribute 2 percent of their payroll to the trust fund. That would amount to $10 per week per employee.

If it was a minimum wage firm, again the number of employees 26 to 50, it would amount to about $4 per week per employee.

The contribution to the fund would be even less if it was a firm of one to 25 employees. In that case it would be a one percent contribution. So if the average wage was

$24,000 or less the contribution would amount to $5 per week per employee; and for a minimum wage firm, again with one to 25 employees, the contribution would be $2 per week.

I believe, Mr. Chairman, that smaller firms are paying much more for health insurance to the degree they are covering their employees than is big business. You hear all kinds of figures, but the average figure I have heard is that small business pays about 30 to 40 percent more for health insurance than does big business for the same benefits.

It is clear that small business with all the burdens upon them -- the red tape, the regulations, whether it is IRS or OSHA or what it is -- do bare a greater proportion of burden than big business. This is an attempt to achieve, work toward universal coverage.

I think we all want universal coverage. I think that we will get there more easily and are more likely to get there the more that small firms are also brought into the process is an attempt to bring small firms in a reasonable way into the ultimate goal that we are all seeking.

It will affect about roughly 30 million employees. There are about 30 million people who work with firms of 50 or fewer employees. That represents about 30 percent of the work force. It is significant. But I do believe

that if this amendment passes, then it would be easier for small firms if the trigger is pulled to be part of the process because they will be contributing to the trust fund which would be funds available for subsidies for individuals to buy insurance.

I strongly urge us to think favorably upon this amendment because I think it will help us advance the ball to help us reach our goal and in a common sense way toward the universal coverage. I urge us to adopt the amendment.

Senator Packwood. Can I ask a question just to see if my math is right?

The Chairman. Senator Packwood, yes.

Senator Packwood. Max, if I understand it, let us assume you have 50 employees at $24,000, I think that is a $1,200,000, you would pay a 2 percent tax on the $1,200,000 if that is your payroll.

Senator Baucus. You pay 2 percent tax on your payroll.

Senator Packwood. So it would be about, if I am correct, about a $60,000 tax.

Senator Baucus. Say if you are a $24,000 employee --

Senator Packwood. Times 50 employees.

Senator Baucus. Well, I was talking about on a per employee basis. It comes out to $10 per week per employee.

Senator Packwood. But on my assumption of $24,000 and 50, does it come out to $60,000 a year?

Senator Baucus. Whatever the math is. I just worked on a per employee basis.

Senator Packwood. Well, it is simpler on a per employee basis. For somebody that has a business with 40 or 50 employees --

Senator Baucus. If you multiply by 50, yes.

Senator Packwood. Yes, I understand that. I just wonder, I think my math is right, and the poor devils may be making $75,000 a year and now we are going to say here is a $60,000 tax.

Senator Baucus. No, no. It is on an average. The tax would be per employee, that is what it would be.

Senator Packwood. But it is on this total payroll. You just take your total payroll and multiple it by 2 percent, do you not?

Senator Baucus. Correct. If your average is 24 -- there is a cliff effect here which has to be worked out. Let us say you are a 30-employee firm, and let us say that your average wage is $25,000. Then under the bill you would be paying a lot more.

Now, I did not have time to work out the transition because we just got the mark last night or the day before, whenever it was. So this amendment is really more in

effect a placeholder, so we can work out the cliff problems which do exist as it is now formulated.

Senator Mitchell. Mr. Chairman?

The Chairman. Senator Mitchell?

Senator Mitchell. Well, Mr. Chairman, Senator Packwood has, of course, taken the employer with the largest number of employees and the highest payroll or the average payroll subject to Senator Baucus' amendment and it calculates to a $60,000 tax per year.

I am sure Senator Packwood would agree that the other end of that would be an employee with one employee, an average wage of $12,000, would be $240 per year by the same calculation. Therefore, I think it is fair to say that the range would be, depending upon the size of the employer and the average wage, between about $200 a year under Senator Baucus' amendment up to an absolute maximum of $60,000.

No one should be under the impression that the figure of $60,000 is in any way average. It affects only those right at the absolute maximum under --

Senator Packwood. That is all right. Let us take a much smaller one. Let us take 30 employees, with an average $15,000 wage. That is not a very high wage. As I look at it, that is a $22,500 tax.

Senator Mitchell. That is right. I support Senator

Baucus' amendment. I think it is a good suggestion, a good attempt to deal with the problem that is faced by small business in terms of the legislation. I just did not want the impression to exist that as the figures are thrown out that they apply to everyone. That is the absolute maximum and it would range downward from there to $100 or $200 a year, depending upon the size of the employer and the average wage.

The Chairman. Fine.

Senator Rockefeller. Mr. Chairman?

The Chairman. Senator Rockefeller?

Senator Rockefeller. May I ask Senator Baucus a question?

The Chairman. Would you, please, sir?

Senator Rockefeller. The 2 percent payroll and the one percent payroll, would that money by definition go to do what?

Senator Baucus. It would go in the trust fund from which funds are available to provide subsidies for --

Senator Rockefeller. Would that be locked in or would that be up to the discretion of some people at the trust fund?

Senator Baucus. It goes to the trust fund. It is one of the additional sources of revenue to the trust fund.

Senator Rockefeller. But I am trying to make a direct connection between that money and the ability of these employees to get subsidies or whatever.

Senator Baucus. Well, that really depends upon the amount of subsidies that this legislation provides, you know, for lower income employees. There is a formula already in the bill in the Chairman's mark and payments would be made according to that formula.

The Chairman. I see no other Senator seeking --

Senator Chafee. The problem I have with this if I understand it correctly is that it would appear to me -- and Senator Baucus can correct me if I am wrong here -- that there is a tremendous discouragement from a firm expanding. In other words, if you are at 25 and you go to 26 --

Senator Baucus. That is right.

Senator Chafee. -- you go up, your taxes double.

Senator Baucus. They could be even more than double. That is the cliff effect. That is right.

Senator Chafee. My State, like many of our States, is a small business State -- 72 percent of our people are employed in small businesses.

Senator Baucus. Right.

Senator Chafee. The last thing we want to do is to discourage that firm from going from 25 to 30 or whatever

it might be.

Senator Baucus. Yes. I appreciate that. That is why I said the amendment as crafted does have that effect, the so-called cliff effect. I did not have the time to work out a transition to address that very problem.

My point is, if the amendment is adopted, then we can work out at the staff level before we get to the floor a transition provision to deal with that problem.

Senator Chafee. Well, I do appreciate that you would do something to try to avoid this cliff. But there is no question but at some point under your proposal to soften the cliff that the tax goes up as you get bigger.

Senator Baucus. That is true. But it is also my hope that at some point we can adopt reasonable cost containment so that the insurance costs that a small business would pay would not be as high as they otherwise would be.

So there would be less of a differential between insurance costs they would pay if they were buying insurance on one hand and this contribution assessment they would be paying on the other. That really depends on the degree to which we can address cost containment in this legislation.

The Chairman. Senator Danforth?

Senator Danforth. Well, Mr. Chairman, I think that

the inherent defect of a program that attempts to differentiate by size of firms is exactly as pointed out by Senator Chafee. I really do not think it can be cured.

In other words, the idea of Senator Baucus' proposal, indeed, the idea of the Chairman's mark is that businesses be treated increasingly worse as the size of the business goes up. If that is the case, what it says to businesses is, do not grow. It is really not to your advantage. In fact, we have designed a disincentive for you if you are going to hire more people and if you are going to expand.

On the other hand, I take it that if we are going to have the number of employees being the test, we would create an artificial incentive for larger businesses to spin off component parts in order to create clusters of small businesses. I do not see that that is in the best interests of anyone.

Furthermore, if we are going to have any kind of an employer mandate, why should we treat a small business any better than a large business. Let us take, for example, a large business that has been hanging on by its fingernails, say, for example, an airline, which has numerous employees, but is on the verge of bankruptcy really creating havoc in communities and creating havoc in the lives of a lot of people.

Why should they be treated in a disadvantageous way?

So for all of those reasons, I think that this is a bad amendment.

The Chairman. I see. Thank you, Senator Danforth.

Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, in response to Senator Danforth I think what we have to recognize is what Senator Baucus is doing here is something that I thought my friends and colleagues on the other side were themselves earlier trying to accomplish. That is, to take the burden off of small business more than through a regular mandatory system.

What Senator Baucus is doing is saying, I want to carve out, I want to exempt small business from a triggered employer mandate. Now that is the purpose of the amendment. Yes, he is saying that there is a one or two percent. But the whole argument that if I reduce my business by one or increase it by two I therefore go over the cliff goes right back to what our Chairman has said many times. That is that virtually every -- many, many social programs in this country, you know, you cannot make public policy without naming the size of firms at some point. I mean, there are numbers of employees.

So it seems to me that what the Senator from Montana is trying to do here is to help small business. I thought that was part of the point of what we were trying to do.

Senator Baucus. Mr. Chairman?

The Chairman. Senator Baucus?

Senator Baucus. Very briefly here. Following up on the Senator from West Virginia's point, it is true, we make all kinds of determinations here, categories, in order to implement public policy. I might ask the Senator from Missouri if he therefore believes that we should repeal all small business programs, SBA programs, say the set-aside programs.

I mean, it is public policy here to recognize that small business often works at a disadvantage to very big business and is in many ways to be helped. That is why we have the SBA. That is why we have the SBA set-aside program.

But if we follow the Senator from Missouri's logic, we should abolish the set-aside program of the SBA. I do not think we want to do that.

And similarly here, this is an attempt to bring small business into a program, a structure, working toward universal coverage. That is what this is. There are various ways to work out some difficulties that the Senator from Missouri mentions. But I do think it is important to adopt this because it will help bring small business into the program.

The Chairman. May I say --

Senator Danforth. If I could just respond.

The Chairman. Of course, Senator Danforth.

Senator Danforth. No, it is my position that the employer mandate is a flawed concept and that it does amount to a tax and it does amount to a tax to be triggered at some future date when the economy may or may not be able to sustain or to accommodate yet another tax on business. So I am against the employer mandate.

But I do not think it solves the problem of the employer mandate to have a carve out for businesses which carve out changes if a business adds a single employee. And I also do not think that it is a good idea to have a program which provides incentives for businesses to spin off their various parts.

The Chairman. Thank you. May I just make a remark. We are about to vote here. We are going to have several votes in the next 20 minutes.

Two points. I say with some tentativeness that it has never seemed to me that the size of a firm was a stable indicator of its profitability. I think to the contrary we have seen vast firms collapse and small firms prosper. The capital ratios, things such as that, are much more indicative. Just size is a very primitive notion of what is profitable and what is not.

But second, I am in favor of an employer mandate.

This mark has an employer mandate, as the President has proposed. With the greatest respect, I cannot support an amendment which would absolve 30 percent of the American work force from the requirement of an employer mandate.

We will have a motion on the matter of a mandate itself. That will come very shortly now. But if there is to be a mandate, it is by definition, it makes sense as a universal mandate. To leave 30 percent of the population out does not make sense to me.

I hear the Republican Leader who comes to us in some stress, having spent the morning at the dentist, has asked for a vote. I think there comes a time when comedy indicates that your wishes ought to be --

Senator Baucus. I request a recorded vote, please.

The Chairman. Of course, there will be a recorded vote. The Clerk will call the roll.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Boren?

Senator Boren. No.

The Clerk. Mr. Bradley?

Senator Bradley. No.

The Clerk. Mr. Mitchell?

Senator Mitchell. Aye.

The Clerk. Mr. Pryor?

The Chairman. Aye by proxy.
The Clerk. Mr. Riegle?
Senator Riegle. No.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. Aye.
The Clerk. Mr. Daschle?
Senator Daschle. Aye.
The Clerk. Mr. Breaux?
Senator Breaux. No.
The Clerk. Mr. Conrad?
Senator Conrad. Aye.
The Clerk. Mr. Packwood?
Senator Packwood. No.
The Clerk. Mr. Dole?
Senator Dole. No.
The Clerk. Mr. Roth?
Senator Roth. No.
The Clerk. Mr. Danforth?
Senator Danforth. No.
The Clerk. Mr. Chafee?
Senator Chafee. No.
The Clerk. Mr. Durenberger?
Senator Durenberger. No.
The Clerk. Mr. Grassley?
Senator Grassley. No.

The Clerk. Mr. Hatch?

Senator Packwood. No, by proxy.

The Clerk. Mr. Wallop?

Senator Packwood. No, by proxy.

The Clerk. Mr. Chairman?

The Chairman. No.

The nays are 14 and the yeas are 6; and the amendment is not agreed to.

The bill is open to amendment and I believe we have agreed that Senator Packwood would offer the next amendment.

Senator Packwood. Mr. Chairman, we now have the mandate full fledged still in the bill. I would like to strike the Chairman's employer mandate, hard trigger in its totality. It is described on pages 10 to 12 of the mark and it is Title II.

The Chairman. That is an admirably concise, if distressingly direct proposal.

(Laughter.)

The Chairman. I do not how we can better proceed. We know what we are talking about. I see no Senator wishing recognition. Senator Bradley?

Senator Bradley. Mr. Chairman, is anyone else going to speak on this?

Senator Dole. There is no mandate.

The Chairman. Senator Bradley, Senator Mitchell would like to.

Senator Packwood. Senator Dole says there is no mandate.

The Chairman. There is no mandate to speak.

Senator Bradley. Mr. Chairman, I support universal coverage. I think that that is an important thing to achieve when we do national health care legislation. I think that it will be achieved best if we have shared responsibility on the part of the employer and the employee.

Some say that we should achieve universal coverage only with an employer mandate. Others say that we should have an individual mandate. And still others say that what we need is an assessment on firms of any size that after a certain period of time do not cover their workers.

I think in the end that we are going to have one variation of these three. I will not support this mandate and will vote to strike, but it should not be construed that at some point in the future I will not support some form of the three roots that I have just described to achieve universal coverage.

I think that this mandate does encourage companies splitting into high wage and low wage firms. I still have a serious concern about those workers who will be moved

into low wage firms, losing other benefits that this legislation does not anticipate dealing with, such as pensions and other benefits, that are much less frequently offered in smaller firms than in larger firms.

I also believe that the more complexity in a system, whether it is a tax system or a health care system, the easier it is to game that system. This mandate, with its many different levels of employees and many different levels of requirements I think would encourage that kind of gaming.

The Chairman. Thank you, Senator Bradley.

Senator Mitchell?

Senator Mitchell. Mr. Chairman, I commend you for the proposal contained in your mark. I will vote against the motion to strike. I believe that the current system of employer participation has been successful in providing health insurance for approximately 85 percent of all Americans. That is, a success only when viewed in isolation.

Every other developed nation in the world has achieved a much higher level of insurance either fully universal or nearly universal, depending upon their particular circumstances. And it is a continuing regret that the United States alone among developed nations, although clearly the wealthiest and leader of the free

world and the entire world now has been unable to achieve that level.

The concept of employer participation has been in existence for a half century. It is the means by which almost all Americans who are insured obtain their insurance. It is strongly favored by the American people. The most recent public opinion poll published just a few days ago by the Washington Post shows that 72 percent of the American people favor such a system.

Therefore, Mr. Chairman, I believe that your proposal is a sensible, responsible approach to a very serious problem. I know that the outcome of this vote is clear in advance. But I wanted to make a statement in support of what I believe has been your effort in this area.

The Chairman. Thank you very much, Senator Mitchell.

Senator Rockefeller. Mr. Chairman?

The Chairman. Senator Rockefeller?

Senator Rockefeller. I do not mean to prolong this. But I think there is a case to be made that the question of shared participation which is reflected in Senator Baucus' amendment is the heart and the soul of not only health care reform but what we are and how we see ourselves as a democracy, as a free people.

We have been blessed by unbelievable good fortune,

but have failed to live up to our responsibilities on something as Senator Mitchell said that every other industrial country in the world has and has for many years.

The concept of a hard trigger amendment in your mark, Mr. Chairman, is solid, is strong. A retreat from it I think comes to the point where we begin to make a mockery of the concept of comprehensive health care reform. I do not want to be a part of that.

The American people do not want us to be a part of that. Their feelings have been reflected constantly over the many years on this subject, the many recent years on this subject. On just about every ground I can think of, thinking about people in my State and all over this country, I would certainly not want to strike.

The Chairman. Thank you.

Senator Daschle?

Senator Daschle. Mr. Chairman, I want to be very brief. Let me just make three points quickly. First of all, I would like to reiterate what the leader said about the strength of feeling the American people have on this issue. I think that it is close to 70 percent according to the most recent poll. The American people have indicated they believe that shared responsibility is important.

In part because so many Americans, 85 percent of all Americans, generate most of their insurance in a shared responsibility today. I think that ought not be lost on anybody.

Second, there are those on this committee that advocate that we take a voluntary approach and there are those of us who believe that we need to start with a mandatory approach. But what the Chairman has done is to say, look, let us give the voluntary approach an opportunity to work. Let us see if the voluntary approach works. That is really the essence of what the Chairman has included in his mark.

We ought to remember that there is no mandate if there is participation to the degree that those who favor a voluntary approach would believe it will work. So obviously if it works as well as those who advocate it, then there is absolutely no need for a mandate. Second point.

The third point is, no one should be mislead about the alternative. The alternative to shared responsibility is more and more responsibility on the family by themselves. If it is difficult for small business, it is difficult for a family. If we do not have shared responsibility, we have individual requirements that those people out there today struggling are not going to be able

to afford the insurance that we tell them they must have.

So from that perspective, recognizing that we are going to adopt a voluntary approach first, and a mandate only if that voluntary system does not work, the trigger would kick in. And third, the American people emphasizing over and over in the polling data that we have seen want it. I cannot think of a better reason than to keep the Chairman's mark as it is.

The Chairman. I thank Senator Daschle most particularly for that second point you have made.

Senator Conrad?

Senator Conrad. Mr. Chairman, I, too, favor universal coverage. As I said in my opening remarks I believe there are two key challenges. One is the coverage challenge, the other is the cost challenge. In my constituency the cost challenge is the thing that most concerns the people that I represent.

I think it is also important to explain what this vote is about. Wee are talking here about a mandate to be imposed if goals for reducing the number of uninsured are not met. I, myself, have proposed a hard trigger. It was clear that no such proposal would command a majority vote on this committee. In fact, we all know this committee faced good luck, that no proposal commanded a majority vote.

And so a group of us on a bipartisan basis worked in good faith to fashion a compromise that would provide substantial health care reform and that would expand coverage in this country, help control costs, preserve quality, maintain choice for American consumers. And we have produced a result. I think it is a substantial result.

The members of that group have made a commitment to each other that we would support the package that we have proposed. And in keeping with that commitment, I will vote to strike. I want my vote to be seen in that light.

I thank the Chairman.

The Chairman. I think that is a very clear statement. That is an understood fact, Senator Conrad, and we appreciate your putting it that way.

Senator Riegle?

Senator Riegle. Thank you, Mr. Chairman. I think the members that worry about a mandate that say that voluntary measures are going to solve the problem, that that is inherently inconsistent. If the voluntary measures are going to solve the problem, then what is the worry about the mandate.

I should think you would want the mandate in there because that in a sense is proof of the belief that you have that it will never be triggered because the other

incentives will work to get the job done.

So I think there is an inherent inconsistency there. I think we need the mandates. I think clearly it is a shared responsibility. I do not see any other way to get to universal coverage.

I guess the other point I want to make is this. There are a lot of people in the country who work every day who cannot afford health insurance and they need it now. They are waiting for us to act to see if they have it.

This move causes us to stop far short of seeing that that is done. We are asking people, themselves and their family members, to wait indefinitely for health care coverage that they need to have now. That is not a condition that any of us want to live in or we want to have our family members living in.

I just think that we default on our responsibility here. I think there is a moral imperative involved in this area. Senator Rockefeller touched on that yesterday. So I will be voting against this amendment.

The Chairman. Thank you, Senator Riegle.

Senator Chafee. Mr. Chairman?

The Chairman. Senator Chafee?

Senator Chafee. Mr. Chairman, I find this trigger somewhat complicated because three different categories

again based upon firm sizes and different years.

The Chairman. It does.

Senator Chafee. Mr. Chairman, the problem I have with employer mandates and a trigger such as this kicking in in the out years is we just do not know what the situation is going to be in the out years. We do not know whether forcing employers in at that time is a good thing to do or a bad thing to do.

We do not know whether there is going to be a recession or just what the situation is. But, Mr. Chairman, I want to say that I for one want to see health care reform enacted this year. I think it is clear that with the employer mandate, even as a part of a trigger, as part of this legislation that we are not going to have health care reform enacted this year.

So for those reasons I will vote to strike.

The Chairman. Thank you, Senator Mitchell.

Senator Dole. Chafee. That is Mitchell over there.

The Chairman. Oh, Chafee.

Senator Mitchell. I am flattered. I do not know how Chafee feels, but I am flattered.

The Chairman. Health care gets to you.

Thank you, Senator Chafee.

Senator Durenberger?

Senator Chafee. I missed that.

(Laughter.)

Senator Durenberger. Just take it as a compliment, John.

The Chairman. We have been at this too long.

Senator Chafee. If it is a compliment, I will take it.

The Chairman. Senator Durenberger?

Senator Durenberger. Mr. Chairman, each day that I come in this room and I hear a friend Justin Dart here, I am reminded of how many versions there are of what we mean by coverage when we are talking about universal coverage.

We have not even resolved as the debate so far has indicated just exactly what it is we are going to require to be covered. That is my first concern.

Second, is this issue of shared responsibility, because I certainly agree with the term. I think it is a critical term. My opposition to the employer mandate and my support for Bob Packwood's amendment is premised on my belief in shared responsibility.

I trust we will have an opportunity here in a few minutes or whenever to look at the description of the proposal from the mainstream, which talks about the possibility of an employer mandate. But what we tried to do in a relatively brief outline is to describe the way in which an employer and employee responsibility might lead

you to an employer mandate.

We talked about demographics of the uninsured. We talked about the way in which people are insured. We talked about structures of the delivery system, the variety of health plans that are available. We talked about the nature of subsidies, this great debate we have over 100 million people being subsidized or is everyone being subsidized.

There is a variety of issues that we lay out here that are critical to the issue of what do you mean when you are going to share responsibility. That leads me to the final point that I think it is important to make. If we enact an employer mandate to pay today, it simply enshrines the existing cost shifting in this system.

The Majority Leader made the argument yesterday that we need universal coverage in order to limit cost and to limit cost shifting. The reality is that one-thirds of the amounts of medical costs that are cost shifted today are cost shifted to private payers from the uncompensated care. Excuse me, are from uncompensated care to private payer.

Two-thirds of the cost shift is from underfunded public programs to the private payers. Right in this room -- Medicare and Medicaid. I think we are currently averaging across the country something in the neighborhood

of 59 cents on the dollar of charges in Part B and 72 cents of the charges on Part A.

I think the great concern that --

The Chairman. Those are facts.

Senator Durenberger. -- many of us who favor Bob Packwood's amendment and oppose imposing an employer mandate today have is that we will continue in this body and in the larger context of the Congress to under fund our commitment to public subsidies for the elderly, the disabled and low-income persons.

And all the difference in those costs will be shifted onto the employed population, making more difficult the effort to bring costs under control and in effect keeping the spiral of cost increases going. So it is not just an ideological knee jerk opposition to shared responsibility. It is that we do not do our responsibility if, in fact, we use an employer mandate to shirk our responsibility to adequately fund those public subsidies.

The Chairman. Thank you, Senator Durenberger.

I believe Senator Dole has got the novocaine sufficiently worn off.

Senator Dole. Well, I appreciate it. I will just take a minute. I think one question we have to raise is binding a future Congress. And again, let me say what I have said before, I do not know anybody on this committee

that objects to the goal of universal coverage, that every American should not be covered.

But I am reminded I think by a statement the Chairman made, that we have only been able to count 98.5 percent of all the people in America. We do not have them all counted yet. I do not know what we mean by universal coverage, what the President means by universal coverage.

Depending on what statistics you look at, in Hawaii it is 94 percent with employer mandates. That has been in effect a long time. We are asking for even higher numbers, 95 or above. And we were told by Gayle Jensen, who I thought was a very outstanding witness from Wayne State University that you do not get there with employer mandates. You do not get universal coverage with employer mandates because so many people are in the work force.

I think we have to also recognize that health care is not free. If the employer is going to pay for it, somebody else is going to pay for it. It is going to be the consumer or it is going to be lower wages for the employee.

And the fact that a poll shows that 72 percent of Americans believe in employer mandates probably should have been taken just with employers. Obviously, if somebody else thinks somebody is going to pay the bill and it is going to be free, I do not know why it was only 72

percent. I did not think there were 27 percent or 28 percent were employers.

So I am not certain that was a fair question. But the bottom line is that this is a tax. We in effect would be saying that it is a delayed tax. It is not delaying the effective date. This is just delaying Congress has to do something or whatever. If not, if we do not reach a certain point, then it triggers in. We do not have that opportunity.

I think certainly the Chairman, I understand, favors employer mandates and I do not go out with anybody who has a different position. But I think there are a number of reasons that I think we should reject this amendment and make certain that we remember that the trigger was first used in Massachusetts. It was called the Massachusetts Miracle in 1988.

But because of the collapse of the economy and other problems in Massachusetts, triggers have never been imposed. So there is a lot of evidence out there. But somebody has to pay the bill. The one thing that I think the midstream group was talking about was cost. Who is going to pay for it? That is the bottom line I think finally we have to come to grips with, hopefully, on a bipartisan basis.

Thank you.

The Chairman. Thank you, Senator Dole.

If it is possible, Senator Breaux has asked to make just one concluding remark.

Senator Breaux. Thank you, Mr. Chairman. I am going to vote for the motion to strike the provision that is in the Moynihan mark. The provision that I am voting to strike certainly has a familiar ring to it.

(Laughter.)

Senator Breaux. I think at one time it was pretty good idea and carefully crafted. It is easier to vote to strike. It is going to be much more difficult to replace it with something. I mean, this vote to strike is not difficult at all for many of us. But the next vote, and the votes to proceed this, as to what is put into this piece of legislation in order to reach the goal of universal coverage is the real challenge that I think this committee has.

This is not very complicated, to strike something out of a piece of draft legislation. But it really is going to be a task to try and put something in it that is going to help us get to the goal of universal coverage. I think we can do that.

I came to the conclusion that it is almost impossible for those of us in this committee or those of us in this Congress to decide what is the best course of action in

the year 1999 or the year 2002, to bring us to universal coverage. I do not think we can do that.

No matter how well thought out the suggestion is, we do not know what the economy is going to be doing on this situation or anything else in the year 2002 or the year 1999.

That is why I think that it is really asking too much for anybody in this Congress to be able to project out what is the best solution in five years or in eight years. So I think that what we have to replace this section of the bill with is a provision that gives us a real good recommendation, from a commission of experts, and have that Congress in that year, whatever year we decide, make a decision on whether they have given us a good recommendation.

This suggestion in the bill says we have already made a decision as to what is the best solution and that is an employer mandate. That may be, but it may be a combination of an employer mandate and an individual mandate. It may be something else. It may be some tax incentives. It may be some more incentives to improve the marketplace, which we have not thought of and we cannot think of in 1994. But we could in 1999 or in the year 2002.

So I am going to vote to strike out the requirement

and hope to be recognized to offer a recommendation so that Congress can look at it in the year in which we have to make the decision.

The Chairman. Fine. Thank you, Senator Breaux. Since you made reference to your own earlier proposal, may I make the point that hard trigger, which is about to be voted on, is essentially that which the Pepper Commission proposed in 1990, as Senator Rockefeller very well knows.

That is it. The Clerk will call the roll.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Boren?

Senator Boren. Aye.

The Clerk. Mr. Bradley?

Senator Bradley. Aye.

The Clerk. Mr. Mitchell?

Senator Mitchell. No.

The Clerk. Mr. Pryor?

Senator Pryor. No.

The Clerk. Mr. Riegle?

Senator Riegle. No.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Daschle?

Senator Daschle. No.

The Clerk. Mr. Breaux?
Senator Breaux. Aye.
The Clerk. Mr. Conrad?
Senator Conrad. Aye.
The Clerk. Mr. Packwood?
Senator Packwood. Aye.
The Clerk. Mr. Dole?
Senator Dole. Aye.
The Clerk. Mr. Roth?
Senator Roth. Aye.
The Clerk. Mr. Danforth?
Senator Danforth. Aye.
The Clerk. Mr. Chafee?
Senator Chafee. Aye.
The Clerk. Mr. Durenberger?
Senator Durenberger. Aye.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Hatch?
Senator Packwood. Aye, by proxy.
The Clerk. Mr. Wallop?
Senator Wallop. Aye.
The Clerk. Mr. Chairman?
The Chairman. No.
The vote is 14 yeas, 6 nays. And the amendment by

the Senator from Oregon, Mr. Packwood, is agreed to.

Now,may I say that we had originally suggested we would have three votes before we break. But I wonder if the members of the mainstream would not like to have us conclude now and come back, so rather than have a vote on your proposal we will give you time to set it forth and describe it and make the argument for it.

Senator Breaux. I am certainly ready to offer the amendment, Mr. Chairman. I think the debate is basically on the same thing.

The Chairman. Do you want to vote now?

Senator Dole. No.

The Chairman. You do not want to vote. Very well, we will see you at 2:30.

Senator Chafee. Was the suggestion that we might discuss it now because we --

The Chairman. No, we have Mr. Kantor at a policy lunch and then you will have all the time you want to make the case you want and vote when you want to.

(Whereupon, at 12:48 p.m., the above-entitled meeting recessed, to resume at 2:30 p.m.)

(Continued on page 116.)

AFTERNOON SESSION

Gilmour

75 pp.

(2:36 p.m.)

The Chairman. A very good afternoon to all of our witnesses, experts, journalists and citizens. We said that we would come back at 2:30 to address two measures that had been put forward by the mainstream group, as I believe they are. And we will have to have the attention of our guests.

We have before us a Breaux-Chafee amendment. Senator Breaux being here, I think that it would be entirely appropriate if we just proceeded to ask Senator Breaux if he was ready to explain the amendment.

Senator Breaux. Do we have enough members here to do business?

The Chairman. Yes.

Senator Breaux. Good.

Well, Mr. Chairman, to paraphrase Congressman Sam Rayburn, he said something to the effect that, any mule can kick down a barn, but it takes a carpenter to build one. I think that what we have done, Mr. Chairman, with the Packwood amendment, is to kick down the barn. I voted for it and I supported it. I do not say that disparagingly at all.

But I think it is now time for us to build something, because when it comes to the question of universal coverage, the draft as it stands now, I think, is really

silent in regard to how we might get to the goal of universal coverage.

The amendment that I am presenting to the committee is a product of an effort made by the so called Mainstream Coalition. Our senior active Republican involved in it is Senator Chafee, and Senator Conrad, to my right, was actively involved in that effort as well, and there were many others, both Republicans and Democrats. And this amendment really reflects an effort to reach a consensus on trying to build something which addresses the very important question of universal coverage.

We start off in our amendment with a statement that universal health care coverage is a national goal of this legislation. I think it is important to say that we do, in fact, recognize that universal coverage is important and is something that we should reach.

What we also say in the legislation, Mr. Chairman, is that we create a commission, and the legislation spells out that it would be composed of seven members nominated by the President, but, of course, confirmed by the United States Senate to service six-year staggered terms.

That commission, Mr. Chairman, is given the responsibility of reporting to Congress bi-annually on the status of health care insurance coverage in the Nation to give us a report on what is happening. And we spell out in

the amendment on the second page those areas on which the commission must report, and we talk about demographics, we talk about levels of enrollment, success of the marketplace. We make them report on the adequacy of subsidies and make them give informal recommendations.

Then on the third page of our amendment, Mr. Chairman, we say that if 95 percent of all Americans are not covered by the year 2002, this commission that we have created must submit formal and specific recommendations to the Congress. And these recommendations, according to our amendment, shall include methods to reach this goal of 95 percent coverage.

It is important to note that we make those recommendations in the market areas that have not yet reached 95 percent coverage, because some areas will clearly have reached 95 percent, and plus, and other areas of the country will not yet have reached that. So we tell the commission to look at the areas where the goal has not been reached and make specific recommendations to the Congress as to what should be done.

We also say that those recommendations must include recommendations on a number of things. For instance, a schedule of assessments or contributions on employers; a method of encouraging full coverage without such assessments; we call for them to make recommendations on

adjustments to the actuarial value of the benefits package; recommendations on adjustments to subsidies they may think are important; and also, finally, they must make recommendations on adjustments to the tax treatment of health benefits as to what they think we should be doing in that area.

And then, Mr. Chairman, and finally, to ensure that Congress does more than just receive those recommendations, we have spelled out specifically in legislative language a recommendation for the way in which Congress will consider those recommendations and will actually vote on those recommendations.

For instance, we point out that in the United States Senate, that there will be, ultimately, 30 hours for consideration of those recommendations, and then after Congress passes those recommendations, a conference report that could come back, we would have 10 hours of debate.

So what it does, Mr. Chairman, is to ensure that Congress will not only receive these recommendations, but will, in fact, vote on those recommendations. I think that is a very important ingredient in our bill.

Now, Mr. Chairman, just a more general note, if I may, because this, indeed, is a very important amendment. Some people will argue that this does not reach universal coverage. I make two points, basically. Number one, our

proposal--and, indeed, the Chairman's proposal--says that we address those who do not have insurance in two very important ways, and we do nothing to subtract from that.

The people who do not have insurance basically do not have insurance for two reasons. Number one, because they are too poor to buy it. Our recommendation, your recommendation, and the President's recommendation provides for subsidies to those poor people. That is still part of this package. Poor people who cannot afford to pay their premium will be subsidized in order for them to be able to buy insurance. That will take care of a large number of the uninsured.

Second, Mr. Chairman, many of the uninsured are uninsured because of insurance problems. They have lost their job, and, therefore, lost their insurance, they got sick and their insurance was canceled, or they had a pre-existing condition and they could not buy insurance in the first place. We have included in our package strong recommendations, as in your package, for insurance reform which corrects all three of those problems.

So, Mr. Chairman, I think that this proposal of a commission recommendation is just part of the overall package. It is a small part, an important point, but you cannot detract from the fact that, with subsidies and with major insurance reforms, we go a very, very long way to

insuring everybody who needs insurance in this country, and at an affordable price.

So, Mr. Chairman, the bottom line is that I do not think this Congress and this committee, or any group of wise people in 1994 can make a determination of what the best procedure is to reach universal coverage in the year 2002. I think the President has recognized that universal coverage must be phased in.

This Mainstream Coalition's recommendation merely says that at the date that we decide we should be at that goal, let us make those recommendations at that time when we have all of the information available in front of us with a recommendation of specifics from a commission designed to do just that, and then force and make the Congress vote on those recommendations. I would submit that that is exactly what this Mainstream Coalition's recommendation does.

The Chairman. Thank you, Senator Breaux. Would you help with one clarification? It says, "The recommendation shall include methods to reach 95 percent coverage in market areas that have failed to meet that target." Do you have a working definition of market areas?

Senator Breaux. The market areas we are talking about would be the community-rated areas that we have spelled out. So, each area that is community-rated for the purpose of buying insurance, you would look to that market area

which will be a specified area, which is a defined area.

The Chairman. States will do that deciding.

Senator Breaux. The States will do that. And then you will look at that area to see if they reach 95 percent coverage. And many of these areas, I would submit, with all these other improvements, will have reached 95 percent, so we are only talking about those that have not reached the goal are being affected by this.

The Chairman. But you do not want a situation in which one area, say, has 70 percent, but the national average is 95, so the 70 percent stays.

Senator Breaux. This, I think, addresses that and would make sure that those who are not at the goal will be brought up to the goal, and that those who are at the goal will not be adversely affected one way or the other.

The Chairman. Thank you very much.

Just to turn to Senator Chafee, this being an amendment on behalf of Senator Chafee and Breaux.

Senator Chafee. Thank you very much, Mr. Chairman. Senator Breaux has explained this very well, I believe. I think the key point here, Mr. Chairman, is there is a difference in approach to the automatic trigger that goes in for the employer mandate.

As you note in here, it is required, if you look on page two--and I know you heard Senator Breaux go through

these, so I will not--what it does, is it requires that the report look at these other features that might possibly have affected the lower than thought for percentage. In other words, demographics. In Number 8, what succeeded and what has not.

So, I think it is very, very important that those be covered because, as I mentioned in my remarks previously in opposition to the employer mandate, my belief is that the solution of using an employer mandate may not be the right solution under certain circumstances as we look ahead. There may be other factors that have influenced the situation.

So, Mr. Chairman, we believe that this is a very good proposal. I would note that the recommendations can be amended, although they could not be filibustered.

The Chairman. On the Senate floor.

Senator Chafee. Excuse me?

The Chairman. On the Senate floor.

Senator Chafee. On the Senate floor.

The Chairman. You provide for that.

Senator Chafee. That is right. In other words, it is subject to time, but there can be amendments.

The Chairman. Two hours.

Senator Chafee. So, therefore, it is not just some ephemeral goal of nothing happening, things will happen.

Thank you.

The Chairman. Thank you, Senator Chafee.

Senator Packwood. I have a question.

The Chairman. Senator Packwood.

Senator Packwood. Yesterday--and I do not know who of our experts can answer this--Senator Grassley said, as I recall, you have 92 percent insured in Iowa.

Senator Grassley. Yes. 92 percent of the working people are insured. Yes.

Senator Packwood. And, Dave, what do you have in Minnesota?

Senator Durenberger. 92.5 percent of the total.

Senator Packwood. Obviously, there must be State by State figures. Could somebody give us these? We have been operating on 85 or 83 percent nationwide, but I assume that that is an aggregation, somehow. Are they available?

The Chairman. It has to be. Kathy says they are available.

Senator Packwood. Could I get a copy of them?

The Chairman. I have seen them. They are -- work force as against population. But we will have them.

Yes, Senator Baucus.

Senator Baucus. Mr. Chairman, I see the Leader here. I would just like the Leader's thoughts about the provisions in this proposal which pretty much limit the

Leader's hands in scheduling legislation. I know one of the prerogatives of the Majority Leader is to schedule legislation. It is one of the prerogatives available to the Leader, and this is pretty tight here.

That is, the dates by which either the Leader or a Senator can call up, or must call up the recommendations of the commission. I am just curious if the Leader has any thoughts on whether this is too constrictive or not, and whether it is something the Leader, or whoever is Leader here, can live with.

Senator Mitchell. Well, Mr. Chairman, I noted when I read it that the first line says January 1, 2002. I, therefore, considered it in an abstract manner.

(Laughter)

Senator Baucus. It was an abstract question.

Senator Mitchell. And I would simply say that I intend to vote for this amendment, but for broader reasons, which I will state at the appropriate time. I have some concerns about this aspect of it, although I understand the necessity of so called fast-track procedures. I am going to vote for it, notwithstanding those concerns, because they are outweighed by other reasons for support, in my mind.

Senator Baucus. But, standing alone, the procedural provisions -- you know, you are not going to be Leader in

the year 2002; someone will be. Are we putting an unfair or improper burden or restriction on your leadership prerogatives?

Senator Mitchell. My answer is no, because there are numerous existing mechanisms which impose certain requirements on the Leader that do have the effect of bringing --

Senator Baucus. This additional one --

The Chairman. Would Senator Dole wish to comment on that?

Senator Dole. I just received a copy. I borrowed Bob's here.

The Chairman. Would Senator Daschle wish to comment?

Senator Daschle. Thank you.

Senator Mitchell. Mr. Chairman, may I comment on --

The Chairman. Senator Mitchell.

Senator Mitchell. First, Mr. Chairman, I commend the Senators who were involved in the drafting of this proposal, Senator Breaux, Senator Chafee, Senators Durenberger, Danforth, Conrad, Boren, Baucus, and Bradley.

Senator Baucus. At one point.

Senator Mitchell. At one point, Senator Baucus says. I do not agree with every aspect of this proposal. Indeed, on one of the more central points, I would prefer other alternatives. But I recognize that there is no way in

which any member of this committee will have a bill before us that will be precisely as we individually could write it, including the Chairman, Senator Dole, myself, and every other member of the committee. I think the most important thing, is that we move the process forward. The House Ways and Means Committee is expected to report a bill today.

The Chairman. I believe it has done so.

Senator Mitchell. It has done so already.

The Chairman. Yes. A vote of 20-18.

Senator Mitchell. Yes. That means two of the major committees in the House have reported. The Senate Labor Committee has already reported here, and this will complete the action of those committees with major jurisdiction when we act, and I think that will be a significant step forward, Mr. Chairman, one for which you will deserve a great deal of credit.

So this is a credible effort. Again, I commend those who drafted it. It is not my preference, but I think it does represent a very significant step forward and I will vote for it for that reason.

The Chairman. Thank you, Senator Mitchell.

Senator Rockefeller. Mr. Chairman.

The Chairman. Senator Rockefeller.

Senator Rockefeller. I just have a couple of questions. The year 2002 is a long time. And the history

of the last several years, Senator Breaux, has been that people have been losing insurance under a voluntary system. I mean, that is a fact.

I met with the president of Safeway yesterday. It has 105,000 employees. That is not a small business. And he said that he was seeing a time when he was going to have to start cutting back on his benefits, or worse.

And, if you look at even the State of New York, which has gone to community-rating, un-age adjusted, but does not have universal coverage, they are losing covered people.

So, my premise on this, I think, is a fair one. That is, if this bill is to pass, people will at least hold steady, or, I think, accelerate, in the way that they lose their health insurance.

And I wonder, therefore, is this commission which you have, does it have the ability, if it sees after two or three years that this trend is continuing, that more and more working American families are being subject to no health insurance, does it have the ability to intervene and change something or are we simply stuck until the year 2002?

Senator Breaux. Let me respond by saying, as briefly as I can, that this amendment, as I said earlier, cannot be considered in isolation. This is part of the package which does other things to address why people do not have

insurance, and, most of all, insurance reforms, so people who get sick do not get canceled, people who change jobs do not lose insurance.

Senator Rockefeller. Remember, I have already addressed that in my premise.

Senator Breaux. So what is happening during this process, in addition to the subsidies for people who do not have insurance which are now provided by our package, the commission makes bi-annual recommendations.

And I would suggest that if, in the second year, or the third year, or the fourth year, they make recommendations which they must make that are good, solid, reasonable, and fair, the Congress has the opportunity to adopt those recommendations long before the year 2002.

And Congress will have the advantage at that time of good, solid recommendations based on experience as to what is happening because of insurance reform and the subsidies. But there is no way that we would recommend, I think, that the commission somehow has the right to legislate without action by the Congress.

Senator Chafee. Could I just amplify on that?

The Chairman. Senator Chafee.

Senator Chafee. Did Senator Breaux mention, on the top of page two, that they report bi-annually, every two years?

Senator Rockefeller. He did.

Senator Chafee. I think that is important.

Senator Rockefeller. But that was not my question. My question was, does the commission have the authority before the year 2002 to take action to stem the flow of what is clearly an increasing number of uninsured families in this country?

Senator Breaux. They have an obligation to report bi-annually. They have no authority to act, the Congress must act.

Senator Rockefeller. Under the original Breaux plan, the so called 91 percent plan, one of the interesting things that happened was the CBO looked at it, and CBO came to, I believe--correct me if I am wrong, Senator Breaux, or Senator Chafee, or anybody else--that it would cause about 25 million American families not to have insurance, and that was only under the condition that it would be fully paid for. Then CBO came to the conclusion that it was not fully paid for, and that there was a $300 billion shortfall.

Now, you are talking about a 95 percent goal, and I am trying to figure out what the result is going to be. We are talking, among those 25 million families in the previous Breaux iteration, which was not paid for -- and one of my questions will be, is this paid for? And CBO will not be able to make up their minds on that before we

vote this afternoon. How would you answer that?

But my real question is, in the previous Breaux iteration, it had 25 million American families uncovered, and 16 million American families who are working, or some member of their family is working every single day. Working American families would not be covered. What is the difference between that and this?

Senator Breaux. If I understand the question, I would respond by saying the following. Number one, we provide subsidies to poor people. Every bill has the problem of paying for it, and any bill that gets to the floor is going to have to be paid for. And every single plan is going to struggle to find out how to pay for it, so ours is no exception in that regard. We have to pay for it. We will have to figure out a way to do it to make sure we pay for the subsidies.

The second thing, with the insurance reforms, many of those people who do not have insurance now will be able to get it because of the insurance reforms. But the Senator's question states the answer. And his question is, we do not know what is going to happen. So, if we do not know what is going to happen now in 1994, how are we going to write laws that go into effect in the out years until we get to the out years?

Senator Rockefeller. But we do know what is happening

right now in New York State, and that is that there is pure community rating, there is not universal health coverage, and people are losing their health insurance. We know that. And we know that millions more Americans over the last several years have lost their health insurance under the voluntary system which you, I believe, suggest should be continued under review until the year 2002.

Senator Breaux. Well, I would just respond by saying, you have to look at what we are offering in the totality of the package. Number one, we have purchasing cooperatives to allow people to buy insurance as a large employer, like a Xerox or an IBM, to get a much better deal. We bring about competition for the first time, which will bring about reduced prices.

We do insurance reform, which will allow people to make sure they do not lose their insurance, and we subsidize poor people so they can afford to buy their premium. When you add all of that up, you bring in a very, very large portion of the uninsured. And we are suggesting that, at that point, you determine what else is necessary, get a specific recommendation, and send it to Congress, and Congress must vote.

The Chairman. Thank you, Senator Breaux.

Senator Packwood?

Senator Packwood. I have a couple of questions. One,

as I look at this, it is a much more expedited and firm process than even our fast-track process on trade now, if I read it correctly. There is no way, under any circumstances, that the Senate can avoid voting.

Senator Chafee. I agree with that. The only thing that possibly is a way of avoiding a vote is if you go to conference.

Senator Packwood. And come out with nothing in conference.

Senator Chafee. That is right. I must say, I am not totally sure of every procedural point. It seems to me that, as you so often mention, if the thing goes to conference and they do not do anything --

Senator Packwood. Nobody can mandamus this.

Senator Chafee. Nobody can get a writ of mandamus and make them do something. That, to me, is --

Senator Packwood. Yes. If you get no conference. The second question I have on this --

Senator Conrad. Senator Packwood, might I just reflect on your first question?

The Chairman. Senator Conrad.

Senator Conrad. We considered a range of options with respect to, under what conditions would a commission recommendation come before Congress? We considered the base closure process, which is an up or down vote. We

considered the trade example, which is an up or down vote.

Responding to what our colleagues have talked about in previous sessions, we adopted, instead, really, the budget reconciliation process which allows for debate, allows for amendment, allows for substitution, allows for Congress to present alternatives.

The one thing it restricts is a filibuster, and that was the compromise we reached. So I think it is fair to say this is not as strong as fast-track trade legislation, is not as strong as base closure legislation, but does prevent a filibuster.

The Chairman. Thank you, Senator Conrad.

Senator Packwood. The second question. There is no guarantee this goes to the Finance Committee, if I read it correctly. Am I correct on that?

Senator Chafee. A whispering voice behind me says, yes.

Senator Packwood. There is no guarantee it goes to the Finance Committee. The answer is yes?

Senator Chafee. Yes.

Senator Packwood. All right. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

Senator Dole, did you want to make some concluding remarks?

Senator Dole. Well, I want to see that I understand

this. What we are saying, in effect, is that we do not trust the Congress that is going to be around here in 2002, so some of us who are here and some of us who are leaving this year have to be sure we do it in advance. To me, I do not think that is necessary. I mean, if we are prepared to make substantial progress on health care, we ought to, I think, hope whoever is here in 2002 will have the same dedication that we indicate we have.

The Chairman. Senator, we count on you for that.

Senator Dole. In 2002, Strom Thurmond will be here, but I am not certain about the rest of us.

(Laughter)

Senator Dole. So, having said that, it says here, "In addition to other recommendations it submits, the commission must make separate recommendations on the following." Are all these considered in one package, or do you have separate recommendations and a separate process; would you have six votes or would you have one vote?

Senator Breaux. Senator, the idea is, the commission makes a recommendation that comes to Congress, and Congress receives that recommendation just like we would receive any other bill. It is fully amendable. You can adopt all their recommendations, you can amend some of them out, you can add things that they have not considered.

I think the conclusion, if I can respond to what the

Senator said initially, is just the opposite. We do trust our future Congress. In fact, we trust the future Congress with better information to make a better decision than we are trusting this Congress to make a decision without that information. But it is fully amendable, and you can take all of it, half of it, none of it, or whatever.

Senator Dole. Well, why do you not just make it acceptable by taking out this budget language? We have got a lot of bad stuff in the budget these days. People stick things in there without hearings, or anything else.

I am not certain whether that is going to be possible. Because we cannot have extended debate, the Democrats, or Republicans, or a mix, we have to accept the budget for better or for worse, and now we are going to repeat that process here. What happens if Congress did not do anything?

Senator Breaux. If Congress decides not to accept any of the recommendations of the commission?

Senator Dole. I mean, did not even vote. What if you never got to a vote?

Senator Breaux. Well, there would be a vote. The procedure that you have outlined here guarantees that you would have a vote. You have 30 hours to vote in the Senate, and then you have 10 hours on the conference report. So you would be guaranteed a vote.

Senator Dole. But it says, if the Majority Leader does introduce the bill, any Senator may do so. What if nobody does so?

Senator Breaux. Well, the committee would be discharged. There is a discharge provision from the committee to make sure the committee does send a bill to the Senate floor.

Senator Dole. It says, "The bill will be referred to the appropriate committee." I assume that is after it has been introduced. If nobody introduces it, where is the part on the discharge?

Senator Breaux. I am just a betting person in a sordid way. I think somebody might introduce it.

Senator Dole. I do not think it is an answer to anything. It seems to me that we are trying to bind another Congress here with a procedure that is highly unusual. And we had a lot of hearings on the budget process before we adopted the Budget Act in 1974, I guess it was. I am not so certain a lot of people think that has worked perfectly, if that is what you are taking this from. But I assume there are the votes for this, because something has to happen, at least in this committee.

Maybe there are other precedents. You have got fast-track, you have got the budget process, you have got the Base Closing Commission. But I would hope that we might

let Congress -- I think the commission idea is fine, and I think reporting is fine. All the things you have outlined are certainly not objectionable. But why not just let Congress act like we normally act?

Senator Breaux. Well, we patterned like we acted on NAFTA, which so many people supported. That was a fast-track, guaranteed vote procedure. Most members of this committee supported that process to handle NAFTA, to guarantee a vote. And that is exactly what we are doing here, we are guaranteeing a procedure that would ensure that it cannot be filibustered by Democrats or Republicans.

Senator Packwood. Yes. But we do fast-track on trade for a different reason. And that is, when we are attempting to negotiate with foreign countries, they are hesitant to give up something, which they have to do to get something, if they think it is going to get sandbagged here. And most countries that we deal with are either parliamentary democracies, in which case the Prime Minister can delivery, or dictatorships, in which case the dictator can usually deliver.

And the only reason for the fast-track is not really to expedite our procedures, but to guarantee to those whom we are negotiating with that they have a fair shot of getting out of the Congress what the administration has negotiated, because they know full well if there is no fast-track we

would pick it to pieces.

Senator Breaux. Well, one difference in NAFTA that should be made a point, I think, for the record, is that NAFTA is not amendable. This is fully amendable, which is a different procedure. We used other examples here. If you do not want to talk about NAFTA, I mean, the Budget Reconciliation is a measure that gets to the floor in a timely fashion, and requires a vote in a designated period of that. That is what this does.

The Chairman. Senator Conrad, would you like to say one final remark?

Senator Conrad. Well, Mr. Chairman, if I could, I just wanted to say, I think this is an important proposal. Number one, it is a bipartisan proposal.

The Chairman. Yes. Sure.

Senator Conrad. There are six of us who stand by this proposal, at least six, perhaps a seventh, at least with respect to this procedure. It creates a mechanism to respond if you are not meeting the goal of 95 percent coverage by the year 2002. It does not predetermine the outcome. It does not say today what Congress should do in the year 2002.

It does say they ought to have a chance to consider a commission report under procedures that allow full debate, that allow it to be fully amendable, but that prevents a

filibuster. That is the nature of compromise. Others wanted a stronger guarantee that Congress would consider it, like a base closure, up or down vote, like trade procedure, where there is not amendment allowed. This is a compromise, a bipartisan compromise that I think is reasonable and fair.

Senator Roth. Mr. Chairman.

The Chairman. Senator Boren had asked to be heard, then Senator Roth.

Senator Boren. Thank you, Mr. Chairman. I want to underline what Senator Conrad just said. This really is an effort in good faith to offer a bipartisan compromise. I think we all realize that if we are to have legislation, it is going to take the concurrence, not only of a significant number of Democrats and a significant number of Republicans in the Congress, it is also going to take the concurrence of the President to be willing to sign it into law, or to be willing to allow it to become law.

And I think this is an effort for all parties to meet each other half way. I agree with what Senator Dole said earlier, that we should not tie the hands of a future Congress in terms of any preconceived solution. That is the reason that I have opposed mandates, that is the reason I have opposed a triggered mandate.

In other words, that proposals presented, if we have

not reached 95 percent, we automatically trigger some kind of mandate, either on employers or employees. I have opposed that because our experience in this country between now and the year 2002 may direct that a different approach will work better and will be in the national interest, and, therefore, we should not tie our hands or bias ourselves toward any particular approach between now and then.

But, on the other hand, if we are going to have a bill we are all going to have to meet part-way. This bill would be fully amendable. We would not have to vote up or down on it, but we would have to come to grips with the problem and we would have to vote on a final proposal. It does not mean we have to pass it. If it does not pass, then we go back to the board and the Congress at that time will start over to work toward a solution.

But I said yesterday that I think one of the worst things that could happen to the country is for us to have a partisan outcome here, and one which would leave the country uncertain, subject to reversals with every passing election. And I think the other thing that would be bad is to have no decision now. That also leaves the country with tremendous uncertainty. We are in the midst of a health care debate. There is already tremendous movement in the marketplace. In fact, many changes in health care have been accomplished just since we began this debate about a

year ago. Things are happening already.

But the country needs to have some certainty about our direction, and, therefore, I think we should find a way to act and I think we should find a way to come to consensus, and I do think that this, while imperfect, strikes that fair balance toward trying to bring us together on something that might, hopefully, also win the acquiescence of the White House.

I am sure this is not what they want. I know it is not what they want. But at least it does give the President, who has insisted upon the opportunity that we would take some kind of action if we do not get to near universal coverage, a procedure that would force us to at least consider what to do, but not bias us as to what we would do.

Senator Dole. Mr. Chairman.

The Chairman. Thank you, Senator Boren.

Senator Dole?

Senator Dole. Yes. I think we are operating now as a rules committee. We are going to be like the House. This is a rule we are going to get. We are going to give them an advance rule for 2002 that gives them so much debate, and all this. But I assume there is also some flexibility here. If you assume you are probably going to go to conference, you have got the year 2002. Could you tell us

what your bottom line is, is it 1998, or 1996, or 1997, or is it 2002?

Senator Boren. Mr. Chairman.

The Chairman. Senator Boren.

Senator Boren. Speaking as one individual, mine is 2002. I think that that is as far as we should go in terms of pushing it back. In the overall proposal by the moderate group, there is another trigger mechanism. If we do not stay within the budgetary guidelines, we also have the paring back of some of the incentives. For every year that we fail to meet the budgetary guidelines, that final date, that 2002, gets pushed back. So there is further protection if we are not able to move ahead on schedule. So I think that what, obviously, will have to happen will, perhaps, be clear by the time the committee finishes its deliberations.

If we start with a bottom line here that is able to command the majority out of this committee and we go to the Senate floor, it would be very unwise, I think--and the administration has not asked my political advice on this matter, but if they did--for them to try to move the bill in conference away from what we are able to pass because they could run a grave risk of sending something back out of conference that would have absolutely no chance of passing the Senate. So I think that what we are doing

here, as far as this Senator is concerned, is pretty close to his bottom line.

The Chairman. Senator Roth, a final comment?

Senator Roth. Well, I have a question as to whether there is any limit as to what the commission can recommend. It seems the language here is extremely broad, so that the commission would be in a position that it could make almost any recommendation it wants. In fact, if you look at the specific language, it does not appear it would even necessarily have to be directly relevant to the goals of 95 percent.

So, I wonder if the authors of this legislation intend to give such a broad charter, or whether they intend to have some limitations or boundaries as to what they can --

Senator Breaux. If the Senator would yield.

The Chairman. Senator Breaux, then Senator Danforth.

Senator Breaux. I would respond, we tried to make it broad and we tried to make it specific at the same time. There were certain things that we felt the commission should consider. They should consider what the role of the employer should be. They should consider what the role of the individual employee should be. They should consider what type of subsidies may be needed or not needed, and what type of tax treatment should be needed or not needed.

So those are specific things we said they must

consider, but that does not limit, if they have other ideas that may be better than that. So we want to get the maximum recommendation from the commission as to what should be done, but, at the same time, to make sure that they cover some items that we right now know are specific recommendations. Now, what they recommend on that we do not prejudge, but they are given a wide range of latitude, but some specific requirements as to what they have to touch upon.

The Chairman. Thank you.

Senator Danforth?

Senator Danforth. Mr. Chairman, I think it is important to realize that the commission is not a decision-making body. The point is, the decision is to give Congress advice, to examine the issue, to examine the problem, to give us biennial reports, then to make a suggestion in the year 2002, then those suggestions, presumably, are put in bill form.

And they proceed through the Congress, just as any bill proceeds through the Congress, and Congress makes whatever decision it wants to make, including changing any of those recommendations, dismissing any of those recommendations, accepting any of those recommendations, or defeating any legislation that might be passed.

On the other hand, what we have offered here is a

proposal in which Congress will do something, even if the something is to decide to oppose everything, at least, that some decision should be forthcoming one way or another from Congress, and that it is not going to be resolved totally by inaction. So the decision-making body is going to be the Congress of the United States, not somebody else.

The Chairman. Thank you, Senator Danforth.

Senator Roth, if you want to make one last comment, sir.

Senator Roth. Well, the thing that concerns me is that the charter seems to be without limitation, that any kind of recommendation, relevant or irrelevant, can be made. And the Majority Leader must introduce the report as a bill. Now, this is a delegation of authority that I think is unprecedented. I do not know of any other situation. Even in the case of trade, we drafted legislation implementing this.

So, what concerns me, if you get an ambitious commission, they may stray very far from what the intent is here, and they have at least set up the process in which Congress will be forced to act on those issues, even though they may not be relevant.

Senator Breaux. Would the Senator yield on that point? The point that should not be overlooked is the fact that when we do the NAFTA type of recommendation, those

recommendations are not amendable by the Congress. So we are forced to vote on something that may come to us that has off the wall recommendations in it that we have to either accept or reject, up or down. This allows us to say, this particular recommendation is unreasonable, and reject it out of hand. We get to vote on anything we think is unreasonable.

The Chairman. I am forced to say to the committee that we have a responsibility here to move this measure, so I am going to have to just arbitrarily ask Senator Hatch for a last comment.

Senator Hatch. Well, Mr. Chairman, I agree with Senator Roth. I think it is more important than just the fact that the commission makes a recommendation. It says, if 95 percent of all Americans are not covered by 2002, then the commission must submit formal and specific recommendations to Congress by January 1, 2002 as draft legislation.

It is called draft legislation, but then it comes down to the fact that it is really a bill that we have to vote up and down on, and there is no circumscription here. I question whether this is even constitutional.

Now, maybe others have looked at that a little more seriously than I have, but I just do not think you can set up a separate entity that drafts legislation that becomes

a bill that we have to vote up and down on. We have the right to amend, but, nevertheless, under only the most stringent fast-track circumstances. And I question whether this is a wise thing to do, let alone the right thing to do.

The Chairman. Well, may I say, that is why we vote in this committee.

Senator Dole. Could I just add one other comment?

The Chairman. Yes. And that will have to be the concluding comment.

Senator Dole. This is probably better than what we have had, but nobody has had a chance -- there are all kinds of things they can do, or a whole page full of things. I assume everything you do not get in President Clinton's package you will get in 2002 if the commission recommends it. Maybe abortion coverage, and all the other things that people are concerned about. It is all going to be covered. There is no limit to what you can recommend here by the commission.

And it is a commission, a commission that gives us legislation. It has to be introduced as a bill, and I think that is a departure from trade, or anything else. The budget is put together by Congress. The trades are negotiated by an administration, by a President. This is a seven-member board who is going to tell us, and we have

to introduce that bill, that this is what our health policy should be after the year 2002.

The Chairman. Thank you, Senator Dole.

And the Clerk will call the role.

The Clerk. Mr. Baucus.

Senator Baucus. Aye.

The Clerk. Mr. Boren.

Senator Boren. Aye.

The Clerk. Mr. Bradley.

Senator Bradley. Aye.

The Clerk. Mr. Mitchell.

Senator Mitchell. Aye.

The Clerk. Mr. Pryor.

Senator Pryor. Aye.

The Clerk. Mr. Rockefeller.

Senator Rockefeller. No.

The Clerk. Mr. Daschle.

Senator Daschle. Aye.

The Clerk. Mr. Breaux.

Senator Breaux. Aye.

The Clerk. Mr. Conrad.

Senator Conrad. Aye.

The Clerk. Mr. Packwood.

Senator Packwood. No.

The Clerk. Mr. Dole.

Senator Dole. No.

The Clerk. Mr. Roth.

Senator Roth. No.

The Clerk. Mr. Danforth.

Senator Danforth. Aye.

The Clerk. Mr. Chafee.

Senator Chafee. Aye.

The Clerk. Mr. Durenberger.

Senator Durenberger. Aye.

The Clerk. Mr. Grassley.

Senator Grassley. No.

The Clerk. Mr. Hatch.

Senator Hatch. No.

The Clerk. Mr. Wallop.

Senator Packwood. No, by proxy.

The Clerk. Mr. Chairman.

The Chairman. Aye.

Senator Riegle votes no, by proxy.

The vote is 12 yeas, 8 nays. The amendment is adopted.

The bill is open to amendment. The Chair recognizes Senator Bradley.

Senator Bradley. Mr. Chairman, I would propose an amendment that would strike the section of the bill that deals with cost containment and premium targets that sets premium targets and then establishes a commission to

recommend how to meet those targets. I would replace that with what I think is a much better cost containment mechanism.

I was struck in our run-through yesterday when it came to this section of the bill, and I asked, is there a premium cap in this bill, and the answer was, no. Is there a tax cap in this bill? The answer was, no. Is there a tax on high-cost premiums in this bill? And the answer was, no.

And the only mechanism that we have to contain costs here is this kind of premium target and commission. I believe we need a stricter cost control mechanism and I believe that we can do that in a way that enhances the assumption of managed competition. The assumption of managed competition is that you will have competition to provide the lowest cost, highest quality health care.

If that is so, then the pressure on premiums will be downward, and it will work, and everybody will be happy. Consumers will have high quality, low cost, the government will not have to be financing higher subsidies, and the deficit will not be going up.

In the event, however, that that does not happen, in the event that an insurance company chooses to have a higher cost plan, or charge more than it should, then what I would suggest in this amendment is that the difference

between the average cost of a premium in a region and the actual cost of a premium in a high-cost plan, that difference would be taxed at 25 percent, with the revenues for this dedicated to the subsidies for low-income Americans.

There would be two separate pools, an average cost in the community-rated pool, and an average cost in the non-community-rated pool. And the objective here would be to put a downward pressure on costs.

If managed competition works it will not raise much revenue, and there will not be many taxes assessed, but everybody will have low-cost, high quality health care. If, for some reason, insurance companies are charging more, some of that increased amount will be taken away with a 25 percent tax. Now, this is the proposal that I would offer for the committee.

The Chairman. Thank you, Senator Bradley.

Senator Packwood. Can I ask a question?

The Chairman. Senator Packwood.

Senator Packwood. How does it work? Let us assume 10 plans, and the first plan costs $100 a month, the second one costs $200, and the last one costs $1,000 a month. So if I add up all the costs, I come to $5,500 for the total plans. You say the IRS sets a target amount. But tell me how this works, now, if this is what you have got with 10

plans and a total cost of $5,500.

Senator Bradley. You would take all the plans in a region that would be offered, all of the premiums.

Senator Packwood. All right.

Senator Bradley. You would average those. And whatever was the average cost of all of the plans offered would be the taxable base.

Senator Packwood. All right.

Senator Bradley. And the tax would then be assessed on the difference between that average and the cost of the plan itself.

Senator Packwood. Given this example then that I am using, 10 plans, Plan 1 costing $100 a month, Plan 2 costing $200 a month, and so on, and Plan 10 costing $1,000 a month, so you would have $5,500 in premiums, the average being $550. So, Plan 7, which is $700 a month, would pay a 25 percent tax on $150.

Senator Bradley. The difference between the average and its plan.

Senator Packwood. Between $550. And Plan 10, at $1,000, would pay a 25 percent tax on $450.

Senator Bradley. That is roughly correct.

Senator Packwood. All right.

Senator Bradley. That is roughly correct.

Senator Packwood. I am trying to get the theory down.

Senator Bradley. Now, it is not absolutely correct because there are a few other details.

Senator Packwood. Now, this is sort of a presumption that Plans 1-6 are pretty good, and they are staying at or below average, although my hunch would be there would be a tendency for Plans 1, 2, 3 and 4 to want to start raising their prices because they are below the average and they are not going to be taxed anyway.

But now let us say that Plans 10, 9, 8 and 7 say, holy mackerel, we are getting hit hard, we are going to start putting the clamps down, we have got to get our premiums down. So they get them down, or maybe they drop out of the market; I do not know what they do. But they try to get their premiums down.

You then readjust the base again so that, now, Plans 1, 2, 3, 4, 5 and 6, if 7, 8, 9 and 10 have dropped out, are still charging $100, $200, $3,00, $400, $500, but now the base becomes significantly lower because high-priced plans have dropped out, so plans that were previously efficient and not taxed will now be taxed.

Senator Bradley. You will have, if not an annual, a periodic adjustment of what is the average price in a region. If it is all working and the prices are dropping, you could end up in that circumstance where, in year one, an insurance company might offer a plan and not be taxed,

in year eight or nine it might end up having to pay the 25 percent tax.

But keep in mind the purpose here. We are going to establish a standard benefit, a standard benefit that we believe every American should have, and we are going to tell insurance companies or self-insurers that they should compete to provide that standard benefit at the lowest possible cost. If they succeed, the price drops. If they fail or choose not to, there will be tax assessed and there will be increased tax.

Senator Packwood. Now, let us assume you have got a plan that is well-run, an efficient plan, but it is insuring basically older and, therefore, sicker people, so it has got relatively high premiums as opposed to a plan that is inefficient, but it is, by and large, demographically, insuring younger people who are healthy. Does the plan for the sick, aged still get hit because the standard is cost, not who you cover, or efficiency, or anything else?

Senator Bradley. It would depend. You have set a standard benefit to be provided and the average cost which is your taxable base is set in the community-rated pool, which includes older and younger people. It is a community-rated pool. Then, for the experience-rated pool, or the self-insured pool, you would have the actuarial

value that would be established as the average, and from that you would make your calculation.

So, in the community-rated pool you would not have that. If you were in the self-insurance pool where you might have a lot of older people, it would be the actuarial value, which, of course, is very complicated and involves 32 different calculations, which I would be glad to turn to staff to describe to you if you would like.

Senator Packwood. I know what you mean by actuarial value. So, when you are trying to determine self-insured companies, their average employee is 50. Their average is not going to be what their cost is, their average is going to be an actuarial average based upon the benefits, which would be lower, I assume, because of the age.

Senator Bradley. It may or may not.

Senator Packwood. Should be. All right. Last question. At the moment, the plans, on average, that you are likely to hit are probably going to be the older, unionized plans that have been established for a long period of time.

And, frankly, the benefits were bargained when there was not much international competition and they are relatively sweet deals, but very expensive plans. They would be in the higher tier, I am assuming.

Senator Bradley. They may or may not, it depends on

what happens.

Senator Packwood. Well, I mean, at the moment they would be in the higher tier. On average, a unionized plan in the manufacturing, transportation, or airline sector are higher cost plans. Thank you.

Senator Baucus. Mr. Chairman.

The Chairman. Let me see. I think Senator Baucus, first; Senator Rockefeller, next.

Senator Baucus. Just following on the question that Senator Packwood asked, as I understand the present bill, at least up to a two to one risk adjustment for age, geography, and all other factors exist.

So, as I understand it, let us say even though a pool is community-rated, within that same pool there can be, say, at least a two to one adjustment in premium charged because of age, or because of geography.

Senator Bradley. Whatever the bill says about community-rated pools.

Senator Baucus. So the net effect would be that a higher cost plan could be a group that is older within the pool, even though it is community-rated, or a certain geographic area, even though it is community-rated.

Senator Bradley. No. You would have targets for different age groups.

Senator Baucus. So you take the average of each. So

you take all the different pools.

Senator Bradley. And you would average those.

Senator Baucus. But if it is the average, there are going to be some above the average for reasons unrelated to the cost --

Senator Bradley. That is correct. When you are in a region --

Senator Baucus. -- of efficiency in a plan.

Senator Baucus. In every region there will always be some plans that will be above the average, and there will always be 40 percent of the plans that will be subject to the tax.

Senator Baucus. Mr. Chairman, I understand the purpose of the amendment, but, to be quite candid, I do not think it is going to have the intended effect. I think the intention here is to lower costs of health care in this country.

My sense is, it is going to have the exact opposite effect in the main on those persons in the higher, say, 40 percent premiums that they are paying because insurance companies, as they have in the past, will largely pass it on in the form of higher premiums than they will in lower payments they are going to make to providers. I do not know if that is right.

In fact, I know it is not right. Frankly, it is

hard to know what the actual effect is going to be, but, from the calls I have made to various experts and economists, the vast majority do believe the effect is going to be higher premiums, higher taxes on people rather than lowering health care costs, and add to complexity. I understand very much what the Senator's intention is, but my sense is it is going to not have that result. And, for that reason, I am just not sure it is a good idea.

Senator Bradley. If I could just answer the Senator's point, because I think it is a legitimate point. It is on a lot of people's minds. If you do not believe in competition, if you are so locked in to the way we have been doing business, which is get the bill and just pass it on whatever the cost, if you do not believe that competition is going to drive down the cost of health care, then your argument would be correct.

If you believe competition is going to actually work, that people are going to be competing to provide the lowest possible cost for the highest quality, then the argument would not work because the insurance company that would simply add the cost of the tax to its premium would be red meat out there for someone that wanted to compete with it for a lower cost plan.

So this amendment goes very much to the heart of whether you think that you can achieve what is one of the

core elements of the Republican bill and the Clinton bill, which is managed competition.

Will it actually work? I mean, we see it occurring out there in the country today. We see it anecdotally. We have not had enough experience to have anything other than anecdotal, but we do see that companies are restructuring and reducing their health care costs.

If this works, then you will not have the phenomenon that you mentioned. If somehow or another the premise of all this health care legislation is wrong, then you could very well have your result.

Senator Baucus. Just quickly, Mr. Chairman. As I understand it, though, the community rate of a sicker population would be higher than the community rate of a healthy population, and that is a fact. If that is the case, the sicker, less healthy will be paying the tax for the benefit of the healthy. I just do not think that is what we want to do here.

The Chairman. Thank you, Senators.

Senator Rockefeller, you asked to be recognized.

Senator Rockefeller. Yes, sir. I have just two brief questions. One, does the Senator know how much money this will raise?

Senator Bradley. We have a rough estimate, yes. Would you like me to share it with you?

Senator Rockefeller. I am comforted by your knowledge. I was hoping you could share it.

Senator Bradley. The rough estimate, because this is a very complicated issue--revenue estimating in health care, generally, is extremely complicated and we have basically what the administration has shared with us, not what CBO has shared with us--it is in the range of over a 10-year period, of about $14-17 billion.

Senator Rockefeller. The second question has to do with the comments that you made about, if you believe in the marketplace, and I do.

The Chairman. As you have reason to.

Senator Rockefeller. And I have very grateful, everlasting, cherished, joyful reasons to. I would say, as it existed in the 19th century.

(Laughter)

Senator Rockefeller. But this is the Nation's business we are at here. For example, Senator Durenberger has used Minnesota often as an example of how the marketplace has kind of driven things down fairly dramatically. It is a very well-educated State, relatively high-income State. It has its areas, Hibbing, and those places which are having a hard time.

But the uninsured rate in Minnesota has really not changed appreciably under managed care. It started at

about 10.4 percent in 1988, and it is about 10 percent today, et cetera. What I worry about, quite frankly, is this so called high-cost premium. I share Senator Baucus' concern about it being passed on, which I think it would be.

But my concern is, would this affect States that tended, unlike West Virginia, to have relatively high-cost plans, namely New York, California, Massachusetts, and the like, and that some would pay and others just would not, and, therefore, is it equitable?

Senator Bradley. I am sorry. I do not want you to repeat the whole thing.

Senator Rockefeller. I put everything I had into that question, Senator.

(Laughter)

Senator Rockefeller. I had a question. A lot of areas will not have high-cost plans.

Senator Bradley. Right. Right.

Senator Rockefeller. And, therefore, is it a plan that would be paid for inequitably more by the Californias, the New Yorks, Massachusetts, than by the --

Senator Bradley. It is true that a region that has higher cost plans would pay more than a region that has lower cost plans, but I do not think that you can look at this funding mechanism and this cost containment mechanism

in isolation, you have to look at it full purpose. And that is, it raises money that will be used for low-income subsidies, so those same States that have the largest number of low-income Americans would be receiving a larger proportion of the money that is raised in the areas that are high-cost. That is true.

But I also think that the national goal is to decrease health care cost, and this would be a mechanism that would decrease health care costs. Those States that have higher cost have further to go than those States that have lower costs. No question about that.

The Chairman. Very well. Thank you.

Senator Conrad. Mr. Chairman, might I respond also to this question?

The Chairman. Well, of course. And then Senator Danforth is next. Senator Conrad.

Senator Conrad. I do not want to interrupt if Senator Danforth was next in line, but I did want a chance to respond.

The Chairman. Just respond.

Senator Conrad. Mr. Chairman, I say to our colleague, Senator Rockefeller, there are a series of adjustments made in this proposal to reflect geographic differences, and also age and health status differences, and we believe that is going to take pressure off. For example, the question

Senator Baucus raises, and also the question that Senator Rockefeller raises. I had a deep concern about this issue as well because we have very few HMOs, we have very little managed care in my part of the country. So we have done our best to take note of those very legitimate concerns.

The Chairman. Thank you, Senator Conrad.

Senator Danforth, you asked to be heard.

Senator Danforth. Yes, Mr. Chairman. Thank you very much.

Mr. Chairman, yesterday a number of very good statements were made by members of the committee, and Senator Mitchell said that we all have to have a lot of give and take in developing legislation, and that is certainly true in any idea for legislation. But you said, Mr. Chairman, and I think Senator Roth did, that the number one question is whether we are going to do any harm, and the requirement is that we do no harm.

It is with that admonition in mind that I want to say to this committee that the issue that Senator Bradley has brought before us is an essential component of the legislation. It would have to be, because when we are concerned about doing harm, what we are concerned about is creating a big, new program.

No matter whose program we are going to adopt, whether it is yours, Mr. Chairman, or whether it is the one that

our group has put together, or Senator Dole's program, all of these are big programs. Even the most modest of the programs, Senator Dole's, is a big program. This is big legislation and it is going to have a major effect on this country.

And I think that the one mood that describes members of the Finance Committee has time has gone on as this process has evolved over the past year or so, is an increasing sense of nervousness.

I know I feel that way, that we are dealing with something huge and something that will have dramatic consequences for this country, dramatic consequences for the future of this country, for the economy of this country, for our ability to grow as a country.

One thing that characterized the seven of us that met last week was a concern about what is happening to the cost of health care. There were two considerations. One was universal coverage, and one was containing the cost of health care.

Most of the discussion that has been going on in the national media has been about universal coverage. Most of the discussion that has been going on has had to do with mandates, how to achieve universal coverage. How do you get to 95 percent, or 96 percent, or whatever the percentage point is supposed to be; how do we expand

coverage?

But the problem with all of that attention on universal coverage and on mandates is that that discussion tended to obscure the question of cost containment, and we down played it, the press down played it, the media down played it, and we, in the Congress, down played the cost of cost containment.

Yet, in our meetings last week, hour after hour of meetings, what we talked about most was cost containment, and what we talked about most was the danger that we faced, the danger of creating something big that does not work.

Now, there are a lot of ideas about cost containment and the dominant idea in this legislation is that managed competition will work. If we can replicate the marketplace somehow, if we can create a system whereby people can buy through co-ops, and people can bid for standard packages and there can be a knowledge of what they are bidding for in competition, that competition works. And it is a very good concept, except it is a concept that has not worked in health care in the past.

So we are hoping to make it work. We are hoping to make competition work. But the fear is, what if it does not? What if something that is theoretically very good does not work out in practice? What happens to the country if we take what we have now and simply expand it and make

it much bigger than it is now, then what happens? What happens to the budget? What happens to the government? What happens to the private sector? How much more health care can we load on the country? That is what we were discussing.

Several ideas have been put forward about containing the cost of health care in addition to the purely market mechanism of managed competition. One idea, the most centralized, governmental type of idea, is price controls. That is something that we can do, we can have price controls.

Or we could have premium caps. That is one thing we could do. I guess it is the same as price controls, as a matter of fact, but it is very centralized.

Then there was another approach, and this was in Senator Chafee's legislation, and I do not know who else, maybe it was in Senator Breaux's, but it was tax caps. I happened to think that tax caps was a very, very good idea because the idea of tax caps was to say that there was a limit to how much we would subsidize very high-cost health care through the Internal Revenue Code.

So we would not continue with a system that says, as we do now, that the higher the price you pay for health care, the higher your deduction will be. The more you pay for health care, the higher your deduction will be if you are

in business, and the more your exclusion will be if you are an employee.

I mean, right now we have created a perverse incentive where employees have an incentive to bargain for the highest cost health care that they can get because their wages are taxed and their health care benefit is not taxed. So we have provided an incentive in our Tax Code for high-cost care.

And I believed, and do believe, that the best thing we could do is to address that anomaly through the tax cap and to limit the amount of exclusion and to limit the amount of deduction. Politically, that idea, which I believe is the best idea, is a non-starter. We have had many discussions in our back room discussions in the Finance Committee about this.

The Democratic members of the committee, by and large, do not like the idea of tax caps. Fine. That is the political reality. So we are not going to have tax caps and we are not going to have price controls. What are we going to have? What do we do next? Do we cross our fingers and hope that managed competition will work, that this new concept will work, and develop a new entitlement program, a new expanded program, hoping that theory of expanding coverage and managed competition will control costs, or do we have something that is a little more solid

than that? What Senator Bradley is proposing is something that is more solid than that. It is not a tax cap, it is not price controls, it is something different. It is designed to do two things, it is designed to create a disincentive for very high-cost health care plans, and it is designed to get the insurance companies competing with each other to give them an additional reason to compete with each other to keep the costs down. That is what it does. That is what the mechanism is. And I believe it is a very creative mechanism, and I think it works.

I talked last night on the telephone to Paul Elwood. We all know who Paul Elwood is. He is the father of the idea of managed competition. We talked about just this idea. He has got some technical corrections he would like to make, but he thinks it is a very important concept, and it is an important thing that has to be done. He strongly supports this idea.

Now, Mr. Chairman, I do not like to be the kind of persons who says, well, it has to be my way or it is not going to be any way, but I can tell you, I really do not want my last act in public life to be to create something that turns out to be a monster without any solid mechanism in place to control the cost of it.

And I cannot support a bill -- I just want you to know this. I do not mean to say it in a threatening way, I just

want you to know where the votes are. I think that the other people in our group, because we have talked about it, feel exactly the same way. We cannot support legislation without this. We cannot support legislation, we cannot vote for legislation without this.

This is not, therefore, simply a question of yet another amendment. It is not a question of yet another amendment, it is a question of whether we can have some confidence that we are not doing something that is really terrible to the country in this legislation.

The Chairman. Thank you, Senator Danforth.

Senator Dole?

Senator Dole. Well, Senator Danforth has indicated how important this amendment is. We have not had five minutes of hearings on it. It is the key to his vote, and votes of six or seven others. I wonder if the Joint Tax Committee or the IRS can tell us if this can be administered. Has anybody here had a chance to look at it? Tell me what you base it on, whatever your answer is. And tell me who you are.

(Laughter)

The Chairman. This is John Buckley, the staff --

Senator Dole. Just passing through town.

(Laughter)

Mr. Buckley. Senator, this is my first opportunity to

be here.

The Chairman. He is the new staff director of the Joint Committee on Taxation.

Mr. Buckley. John Danforth, Jr.

To be honest, Senator, I saw this for the first time about two hours ago, so we do not have a real good analysis of what this does. We have done no revenue estimate on this at this point.

The Chairman. I wonder, I see Secretary Samuels very patiently and discreetly at the back of the room. Would you like to come forward and just comment as you will? You may not have any more comment than Mr. Buckley.

You are taking your time, I notice.

Secretary Samuels. I have had a chance to look at it. Actually, I was feeling like I was back in law school on the back bench.

We have just had a short period of time to look at this, and I think, on the question of administrability that Senator Dole asked about, from the point of view of the IRS, from our perspective, the question is, how many calculations would have to be made? It is not exactly clear from the amendment, but I think that would be a question that I think, if one was dealing with the details of drafting, we would have to consider.

Senator Dole. All right. Could you make some of the

data available to us now?

The Chairman. I think not, Senator Dole. I wish we were asking them --

Senator Dole. Well, if this is the key to seven votes, we ought to have some testimony on it. We have not had any hearings on this, and I have got a series of questions I would like to address to somebody because I think it is very important.

Senator Bradley. Is it the key to your vote?

Senator Dole. Pardon?

Senator Bradley. Is it the key to your vote?

Senator Dole. Not necessarily. But how much of a tax increase is this, $17 billion?

Secretary Samuels. That is a very preliminary estimate, as I understand it, over a 10-year period.

Senator Dole. And, as I understand it--again, I am not the expert that some are here--health plans could be more expensive for a number of reasons, you may have less healthy enrollees, you may offer broader benefits. I do not know whether that would be addressed to IRS or somebody else, but I assume that is true, where you have higher risk people, whatever, you are going to have higher cost.

The Chairman. Surely that is true.

Mr. Buckley. I think there have been some adjustments to try to take into account those factors, though, in this

amendment.

Senator Chafee. Yes. Except it would not involve different benefits. We are dealing always with a uniform benefit package here. I did want to make that clear, that you are not so called punishing somebody who has a better package, the package of benefits is all the same.

Senator Dole. I understand that.

Senator Chafee. It is the system of delivering them that varies.

Senator Dole. And there are geographic adjustments. I wonder if somebody could apprise us, how are these regions defined?

Mr. Buckley. I believe they are the same regions that are used for community rating.

Senator Bradley. They are defined in the bill. They are defined in the underlying bill.

Senator Breaux. Yes. There would be specific regions defined by the State, the same regions that you use for community rating.

Senator Dole. According to a Foster Higgins survey, the average health benefit costs by those in the manufacturing industry are greater than those in the wholesale/retail industry. How would this tax affect the various industries? Anybody. This is so critical.

Senator Bradley. If you are self-insured, or you are

experience-rated and you have a high-cost plan, you are going to be paying more in tax than if you have a lower cost plan. That applies across sector. It is not sector-specific.

Senator Dole. I have a series of questions.

The Chairman. Please.

Senator Dole. Are adjustments made for the number of employees per company?

Senator Bradley. It would be a weighted average based upon the number of plans and people in the plans, and we would give Treasury the authority to write those regulations.

Senator Dole. And could the tax kick in in the case of a small manufacturer who could not lower their premiums because it does not employ large numbers of employees?

Senator Breaux. If the Senator would yield on that question. The tax is not on the individual employers or the employees, the tax is on the insurance company.

Senator Dole. It's on the insurance company. I understand. Right.

Senator Breaux. So they are all selling the same standardized package, as Senator Chafee has pointed out. So you always are comparing apples to apples and oranges to oranges.

Senator Dole. I understand that, but somebody is going

to pay it. So there is not any answer to that question.

Could companies avoid the tax by increasing their deductibles, thereby reducing their premiums?

Senator Chafee. For your standard package.

Senator Dole. It would not make any difference, they could still increase their deductibles.

Senator Chafee. No. That is part of the package.

Senator Dole. And the whole process is supposed to be bringing down the cost to consumers. The tax is paid by the insurance company; is that correct?

Senator Chafee. That's right.

Senator Dole. Not by those who ultimately buy the insurance, right?

Senator Chafee. Right.

Senator Dole. You believe that?

Senator Bradley. If you believe in competition you would believe that.

Senator Dole. What about, does it apply to self-insured? Would that be yes?

Senator Bradley. Yes.

Senator Dole. And does it as an effort to end fee-for-service?

Senator Bradley. Oh, no. Not an effort to end fee-for-service.

Senator Dole. Why not?

Senator Bradley. Under the bill fee-for-service is one of the three options that must be offered.

Senator Dole. As I understand it, if carriers offering fee-for-service do not raise their deductibles, they would be required to pay this new tax. So these products would become affordable for virtually all consumers, and so would cease to be offered in the marketplace. And fee-for-service are valuable options for consumers, and I think it is a fair question.

I mean, this is a very important provision and we have had nobody from the outside give us any information. Nobody who is going to be impacted by this had a chance to respond. We are asked to vote on it without having any information at all.

Senator Bradley. Well, let me just provide you just a little bit of information, because on the last question it would apply in the same way that the tax cap applied in the bill that you co-sponsored.

Senator Dole. Tax cap.

Senator Bradley. This particular aspect.

Senator Dole. I may have been wrong, too.

(Laughter)

Senator Dole. It would be eight of us wrong, in that case. But, I mean, I think there are just a number of questions. I guess we do not want to ask questions, we

want to vote something out of here. But this is a big tax increase. We do not have any idea how it is going to work. It seems to me that there are a series of questions that should be addressed or we are not going to have any hearings, and we are being told by one of the chief sponsors that this is critical. If we do not pass this, he is not going to vote for it. Again, I am certain the seven people who got together have maybe made major improvements, but I think this is a key issue.

I agree with Senator Danforth, this is a critical issue, it ought to be addressed. Somebody out there in the community who is going to be affected ought to be able to at least give us some information. We do not have any information. We are being asked to vote without any information, and that is highly unusual. Thank you.

The Chairman. Thank you, Senator Dole.

Senator Bradley. Mr. Chairman, if I could, I would say the same thing applies to the bill that Senator Dole introduced yesterday.

Senator Dole. We may have hearings on that.

Senator Bradley. You know, everything applies to the bill that you introduced yesterday that you asserted applies to this particular provision.

The Chairman. Could I ask Secretary Samuels, does the administration have a position on this amendment?

Secretary Samuels. Mr. Chairman, we have estimated this amendment and we are sympathetic with its objectives and we think we understand what it is trying to do. We have had some technical questions about it, and that is --

The Chairman. But the administration is sympathetic with the objectives of the amendment.

Senator Baucus. Mr. Chairman.

The Chairman. I hear votes, so just a second. If you would not mind, Senator Baucus, Senator Roth, and then Senator Mitchell, to wrap up.

Senator Baucus. Thank you, Mr. Chairman. This is a critical subject here, that is, cost control, cost containment. I think Senator Danforth is correct in saying it is core to what we are doing here. I firmly believe that we are kidding ourselves basically in this bill if we think we are going to control costs in any meaningful way. Senator Conrad has, several times, said that he hears in North Dakota, I hear in my State, I am sure most of us do in most of our States, that the real problem in health care is costs, because costs are just going up at such a rapid rate, for individuals, for businesses, for State governments, federal budget, whatnot. It is cost. It is the rate of increase in health care costs.

And I understand the dilemma here. We talk about tax caps, and I think the Senator is right, tax caps are just

off the table. We have a commission in this bill, now, which is supposed to look at costs and make recommendations back to us. It is not perfect. It is not going to do much because it is only making recommendations. It is not going to address cost in any direct way.

I personally--it is not a view held by the majority--believe that the only meaningful way to address the cost issue is premium caps or some kind of global budgeting, which I do not think definitely are wage price controls, as some characterize it, because just a premium cap would say, all right, these are the caps.

They can be CPI plus two, or three, or whatever, a fail-safe, and a stop-gap provision. Then let the market work its way as to how to make the adjustments within the marketplace to squeeze out unnecessary increase in costs.

Now, I understand the intention of the amendment before us, but I firmly believe it will have the exact effect that worries the Senator from Missouri, that is, it is something that we are going to be doing that is harmful, that is going to create a bigger problem. It is not going to do what I think its proponents like to think it will do, lower health care costs.

I think, very firmly, the effect will be increased health care costs for consumers. I think insurance

companies will take the assessment on the plans and pass much more of it onto premium increases than they will in reducing charges or payments they make to doctors, hospitals, and whatnot.

I, therefore, come back to the only fall-back conclusion, which is the provisions in this bill which allow a commission, a group, to try to assess what is going on, and make recommendations back to us. We are not going to be able to predict with very much certainty how managed care is going to work. We have got some ideas, but really do not know.

But, if we assess this tax now, it is a big tax. It is a tax on consumers. That is what this is, a tax on consumers. I do not think consumers should pay an increased tax when it will not have the effect of lowering their health care costs and, in fact, will increase their health care costs because they will be paying a greater tax, and their health care bills will not be lower.

The Chairman. Thank you, Senator Baucus. We are going to have to close out now, just to move on.

Senator Roth, Senator Rockefeller, and Senator Mitchell will have the last closing statements.

Senator Roth. Yes, Mr. Chairman. I would like to ask Mr. Samuels a question or two. As I understand it, he has made a preliminary check on it. I agree with what Senator

Baucus says, that, in effect, this is a tax increase. It is a substitute for a so called tax cap.

I wonder, Mr. Samuels, if you could tell us, in effect, assuming that this is passed on, how many workers will be impacted by a tax increase, and what industries would be impacted the most? Is it not true that many of the plans that are unionized are the ones that are going to be hit by this?

Secretary Samuels. Senator Roth, I do not have the information on how many people would be impacted.

Senator Roth. What is your impression as to who it will impact on, as an expert in this area?

Secretary Samuels. I would say that it will impact, as the purpose of the proposal, on the higher-cost plans. We have some technical comments that it would achieve the results that --

Senator Roth. Senator Baucus said that these costs are going to be passed on. So, in effect, how many enrollees will be impacted; how many will have a tax increase?

Secretary Samuels. Senator, I do not have that information, nor do I have the information as to how the tax would be distributed.

Senator Roth. Do you have anything in writing on this, Mr. Samuels?

Secretary Samuels. We have done preliminary,

unofficial estimates.

Senator Bradley. I could maybe help a little bit, Senator, in saying that 60 percent of all plans would not be taxed at all, in every region.

Senator Roth. Forty percent would be.

Senator Bradley. Forty percent would, 60 percent would not.

Senator Roth. But that would impact on how many of those 40 percent, do you have any idea?

Senator Bradley. I do not have a number off the top of my head. It would be a rough rule of thumb.

Senator Roth. It would be a very significant number.

Senator Breaux. Would the Senator yield, Senator Roth, on that? I mean, the whole idea, and I think Senator Danforth spelled it out, is competition. If a plan is a high-cost plan, they will not be selling it. I mean, those plans that are high-cost, people will not be buying those high-cost plans, they will buy the low-cost plans. They have that option, and that is the incentive.

Senator Roth. I would just point out that we are talking about 40 percent of the plans, and many of those plans cover unionized plants where there are a large number of workers. So I think this is going to have a very, very direct impact on the blue collar worker.

The Chairman. Thank you, Senator Roth.

Senator Rockefeller?

Senator Rockefeller. Thank you, Mr. Chairman. We have, I think, had ample discussion on this, and I can count votes like everybody else can. I think it is very clear. I think you could tell from the nature of my questioning that I am not pleased about this, to say the least.

But, on the other hand, I agree very much with what I felt was the urgency in Jack Danforth's voice, that sometimes you just do not get everything you want and you have to do something you do not necessarily want to do so you can keep a process going. So I just wanted to explain before you came to the vote, Mr. Chairman, that I will vote aye on this matter.

The Chairman. Thank you, Senator Rockefeller.

Senator Mitchell? And I guess the last one. Senator Bradley, then Senator Mitchell.

Senator Bradley. I just want to kind of clarify Senator Roth's concern. Some of the highest cost plans are really in law firms and in lobbying firms. So, I mean, if you want to pick a group that is going to be hit hard by this tax, I would pick that group.

The Chairman. Can we take a sample out there?

(Laughter)

Senator Roth. I would say that would be a very small

percentage compared with the unionized plans.

The Chairman. Senator Mitchell, the final concluding remarks.

Senator Mitchell. Mr. Chairman, when Senator Danforth stated my remark of yesterday that there would have to be give and take, I did not expect to have to act so early and often on my words.

(Laughter)

Senator Mitchell. But I will repeat what I said with respect to the last amendment, that I do have reservations about it. I share the objective. I believe that cost control is an absolutely essential ingredient in health care reform, and, as I previously stated, I believe it is inextricably bound to health insurance for all Americans. I know that there are some members of the committee who disagree with that, and I respect their view.

I respectfully disagree with the characterization of the premium caps. That is an honest disagreement. I think it would be a more effective way to accomplish the goal. But, as with the previous amendment, this is a serious, credible effort by serious legislators of both parties. It is imperative that we move this process forward.

And, while I--as I believe others do here--have concerns about some aspects of it, and it is obvious there will have to be a good deal more analysis and reporting,

which will occur, I will vote for the amendment.

The Chairman. Thank you, Senator Mitchell.

The Clerk will call the roll.

The Clerk. Mr. Baucus.

Senator Baucus. No.

The Clerk. Mr. Boren.

Senator Boren. Aye.

The Clerk. Mr. Bradley.

Senator Bradley. Aye.

The Clerk. Mr. Mitchell.

Senator Mitchell. Aye.

The Clerk. Mr. Pryor.

Senator Pryor. Aye.

The Clerk. Mr. Riegle.

Senator Riegle. No.

The Clerk. Mr. Rockefeller.

Senator Rockefeller. Aye.

The Clerk. Mr. Daschle.

Senator Daschle. Aye.

The Clerk. Mr. Breaux.

Senator Breaux. Aye.

The Clerk. Mr. Conrad.

Senator Conrad. Aye.

The Clerk. Mr. Packwood.

Senator Packwood. No.

The Clerk. Mr. Dole.

Senator Dole. No.

The Clerk. Mr. Roth.

Senator Roth. No.

The Clerk. Mr. Danforth.

Senator Danforth. Aye.

The Clerk. Mr. Chafee.

Senator Chafee. Aye.

The Clerk. Mr. Durenberger.

Senator Durenberger. Aye.

The Clerk. Mr. Grassley.

Senator Packwood. No, by proxy.

The Clerk. Mr. Hatch.

Senator Hatch. No.

The Clerk. Mr. Wallop.

Senator Wallop. No.

The Clerk. Mr. Chairman.

The Chairman. No.

There are 11 yeas, 9 nays. The Bradley amendment is agreed to.

May I say two things? First, what a Chairman has to say, there have been no hearings, and we may yet learn more information. We hope Mr. Buckley and Mr. Samuels will be seized of this subject in the hours ahead.

Senator Grassley has indicated that he would like to

take a little more time before his nurse practitioner amendment is ready, and that will be our next order of business.

But, for the moment, we have changed the structure of the mark that we began with quite a bit, and the staff respectfully requests that we might adjourn now until 6:00 o'clock, by which time they can put the pieces back together again in a more coherent fashion. Is that agreeable?

Senator Baucus. Yes.

The Chairman. I am sure it is. Thanking everybody. We will be back at 6:00 o'clock.

(Whereupon, at 4:13 p.m., the meeting was recessed, to reconvene at 6:00 p.m.)

AFTER RECESS

(6:26 p.m.)

The Chairman. Good evening to our friends. Senator Grassley is still not ready with his amendment, and we have a lot of staff work that needs to be done, putting together some of the things we have done today, getting a list of things we want to do tomorrow, so we will not be meeting formally for the rest of the evening.

The staff will be at work and the Senators will be about, so that we will proceed in the morning with things when we feel we have reached some consensus and stay on the bill. Is that agreeable to you, Senator Packwood?

Senator Packwood. A good idea, Mr. Chairman.

The Chairman. Senator Breaux suggested in the interest of domestic tranquility, he would like to --

Senator Breaux. Something like that.

The Chairman. Something like that. And that is our agreement, and we will just work it out.

Senator Pryor. Mr. Chairman.

Senator Packwood. At 10:00 in the morning.

The Chairman. 10:00 in the morning.

Senator Pryor. Do we have a goal as to when we might finish?

The Chairman. We will know more in about two hours, will we not? We will see how much agreement we get.

Senator Chafee has a bit of a list, a couple of lists around here. Senator Conrad has a particular list.

Senator Rockefeller. And there are a couple of amendments that some members want to offer.

The Chairman. Of course.

Senator Rockefeller. Yes.

The Chairman. Well, we have 50. That is a little too many, but somewhere between two and 50 is where we are going to come out.

Senator Pryor. Mr. Chairman, I respectfully bring this up. The Defense authorization is getting ready to be placed on the floor, I think within the hour. I think there are 100 amendments there. If we have about 50 amendments here, and we are trying to do all this tomorrow or Saturday, I am just asking the question, respectfully, if it is possible.

The Chairman. It is possible. And we will get through that, and we will get through this. We may end up not being finished by Saturday, but we are going to try and find out.

Senator Pryor. Thank you, Mr. Chairman.

The Chairman. Well, thank you all very much. And I hope we did not bring you all back unnecessarily.

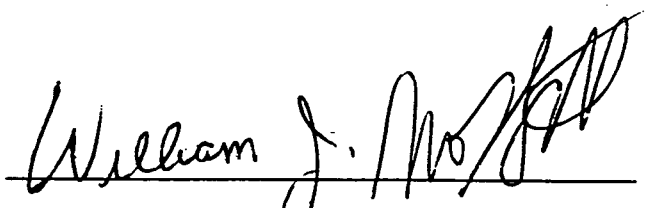
Senator Chafee. 10:00 o'clock tomorrow?

The Chairman. Yes, sir. 10:00 o'clock tomorrow.

(Whereupon, at 6:28 p.m., the meeting was recessed, to reconvene on Friday, July 1, 1994 at 10:00 a.m.)

C E R T I F I C A T E

This is to certify that the foregoing proceedings of an Executive Committee Meeting of the Committee on Finance, United States Senate, held on June 30, 1994, were transcribed as herein appears and that this is the original transcript thereof.



WILLIAM J. MOFFITT
Official Court Reporter

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