

original book
given to Herman
1st.

To Alexis/Daer
N. What are
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THE PRESIDENT HAS SEEN

10 2 95

10/02/95

ALEXIS HERMAN:

Please forward this book
to Don Baer once you have
reviewed. Thanks.

DON BAER:

Please return this book
to the Staff Secretary's
office once you have
reviewed. Thanks.

Robert H. Waterman, Jr.

Co-author of *In Search of Excellence*

**WHAT
AMERICA
DOES
RIGHT**

**LEARNING FROM COMPANIES
THAT PUT PEOPLE FIRST**

WHAT
AMERICA
DOES
RIGHT

For Bill Clinton

From an Arkansas
Traveler and supporter —

Bob Lister

5/94

original book
sent to
Marsha
Scott
10-2-95

To Marsha
Scott

Fyl- Be copy to
RM

THE PRESIDENT HAS SEEN
10-2-95

I'll Not Go Quietly

MARY FISHER SPEAKS OUT



Mary Fisher

Author of Sleep with the Angels

I'LL NOT GO QUIETLY



*To Mr. President
and Mrs. Clinton,
for all of us
who have
walked this
road... stay with
us.*

MARY
FISHER
SPEAKS
OUT

MARY FISHER

WITH AN INTRODUCTION BY KATIE COURIC

SCRIBNER

New York London Toronto Sydney Tokyo Singapore

*With Love
May 14/95*

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SCRIBNER

1230 Avenue of the Americas
New York, NY 10020

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Designed by Jennifer Dossin

Manufactured in the United States of America

1 3 5 7 9 10 8 6 4 2

Poem beginning with "Your death blows a strange . . ." from *A Grief Observed*
by C. S. Lewis. Copyright © 1961 by N. W. Clerk. Reprinted by permission of
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I ' LL NOT GO QUIETLY

THE WHITE HOUSE
WASHINGTON

95 OCT 2 P5: 48

Sent

OFFICE OF THE STAFF SECRETARY

Fax Transmittal Sheet

TO:

Barry T. Orr

Martha Foley

Fax Number:

Phone Number:

FROM:

T. O. O. Stem

SUBJECT:

DATE:

10-2-95

NUMBER OF PAGES (including cover sheet):

MESSAGE:

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62271

STATEMENT BY THE PRESIDENT

Today I have signed into law, H.J. Res. 108 "Making Continuing Appropriations for the Fiscal Year 1996, and for Other Purposes."

H.J. Res. 108 provides for a temporary extension of appropriations for all government operations from October 1 to November 13, 1995, and prevents a shutdown of the Government.

I have been urging Congress to send me all 13 appropriations bills for FY 1996, in a form that I can accept, before the October 1st start of the new fiscal year. Regrettably, Congress has been unable to do that.

I am committed to balancing the Federal budget. While I do not share the same priorities as Congress, I look forward to working with the Members to achieve a budget that serves the American people.

I am pleased that we could work with Congress to develop an acceptable, short-term continuing resolution that will give Congress time to finish its work and ensure the continuation of normal Government functions.

Sooni

THE PRESIDENT HAS SEEN

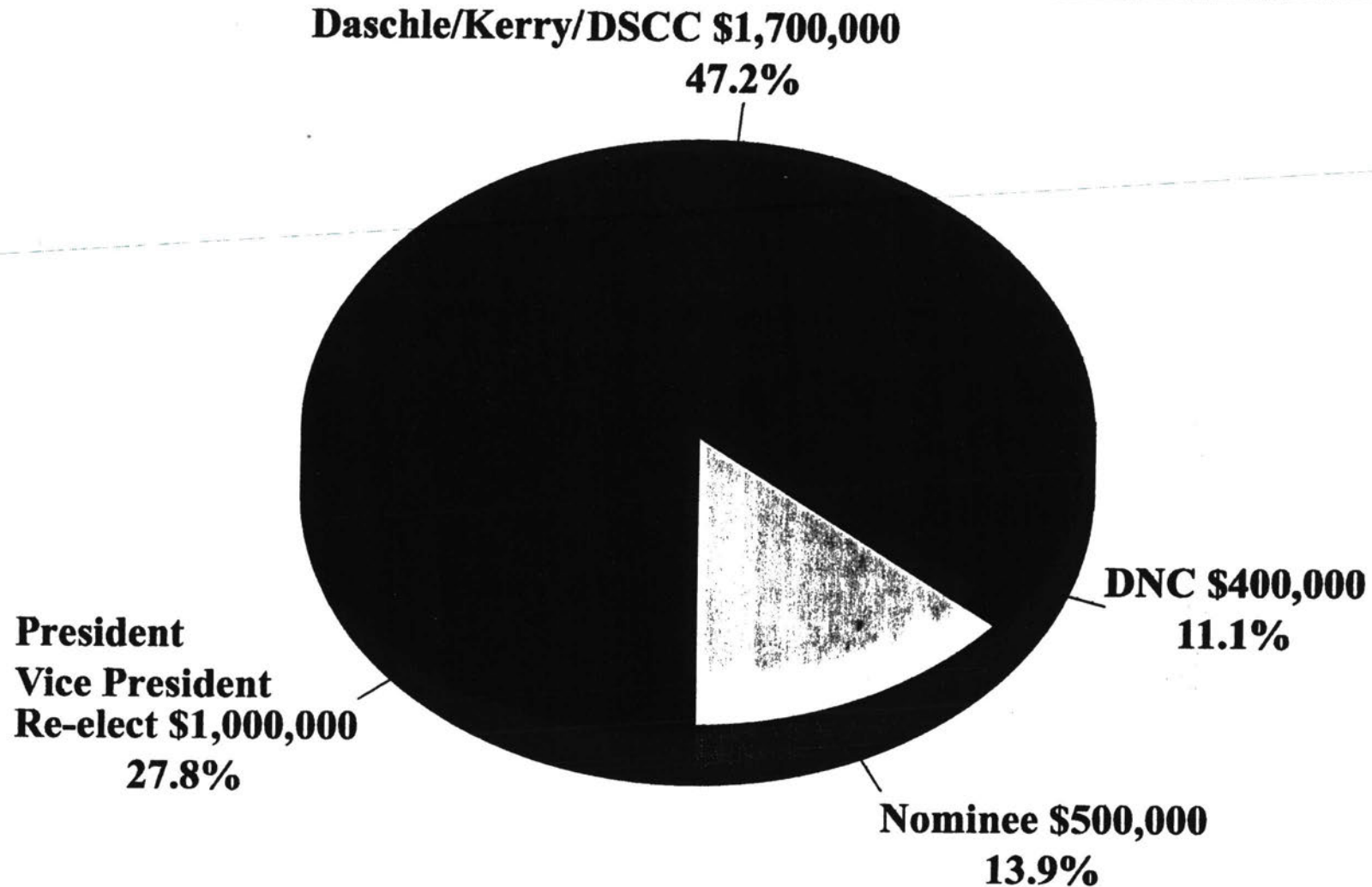
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DEMOCRATIC SENATORIAL CAMPAIGN COMMITTEE



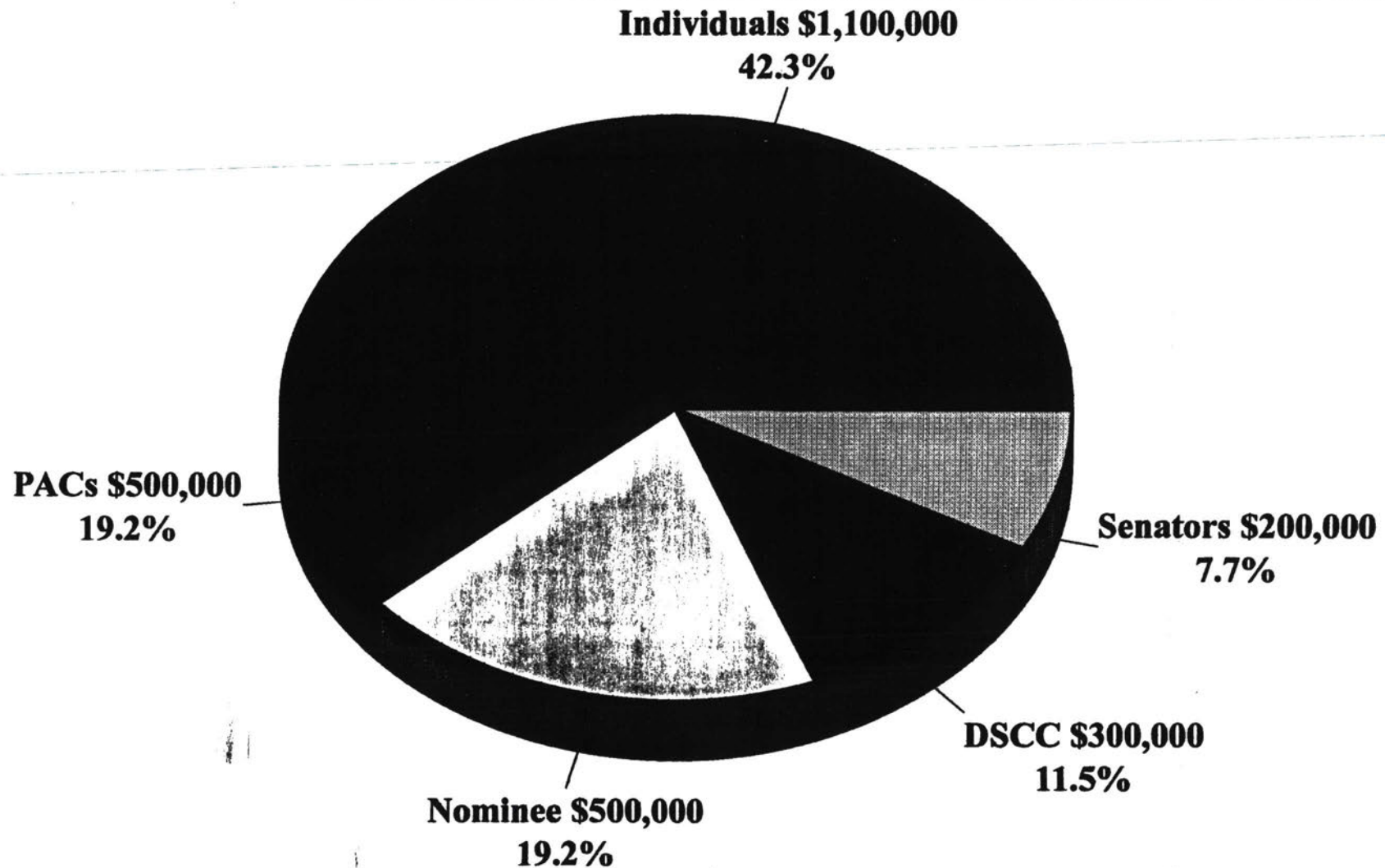
Oregon Special Election

Suggested Breakdown of Responsibility



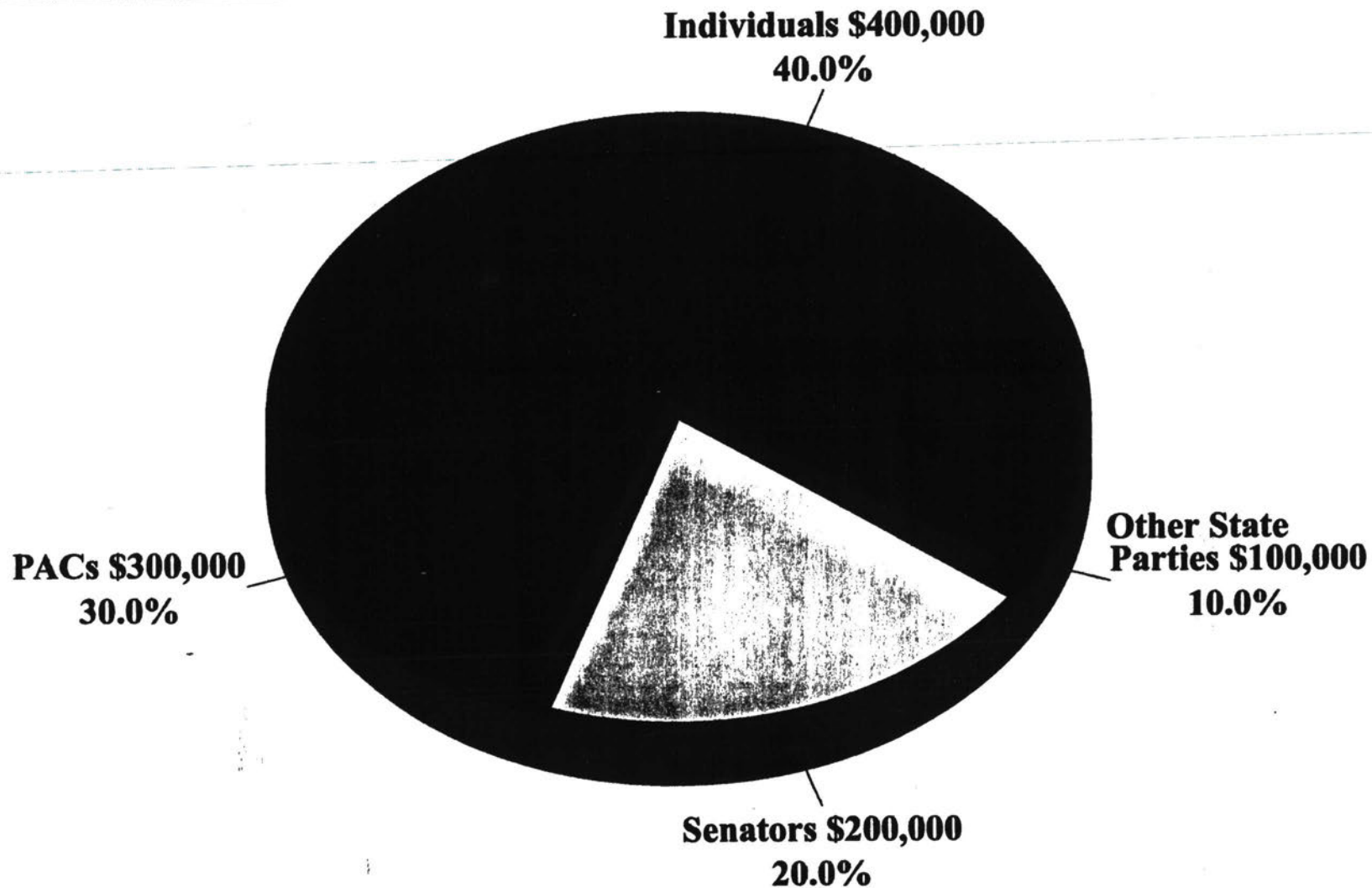
Oregon Special Election

General Election Budget -- \$ 2.6 Million



Oregon Special Election

Democratic Party of Oregon Budget -- \$ 1 Million



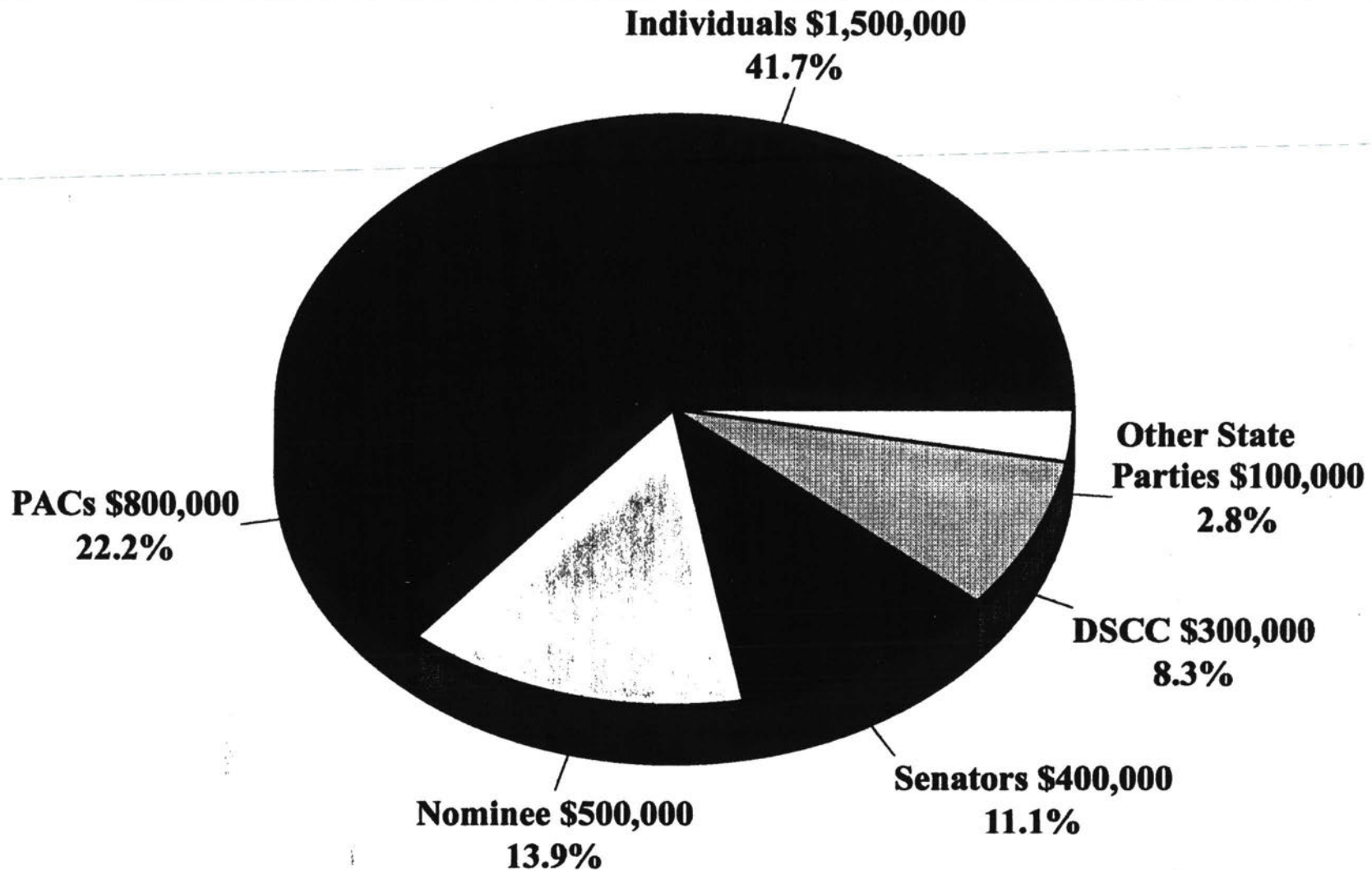
Oregon Special Election

December Schedule

Key Date Campaign Day No GOTV Holiday Blackout						
SUN	MON	TUE	WED	THU	FRI	SAT
					1	2
3	4		5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					
New Year's Eve						

Oregon Special Election

Total Contributions Needed -- \$ 3.6 Million



Oregon Special Election

January Schedule

Key Date Campaign Day No GOTV Campaign Day with GOTV Holiday Blackout						
SUN	MON	TUE	WED	THU	FRI	SAT
	1 New Years Day	2	3	4	5	6
7	8	9		11	12	13
14	15	16	17	18	19 50% of Ballots Expected In	20
21	22	23	24	25	26	27
28	29		31			



J. Robert Kerry, NE
Chairman

Democratic Senatorial Campaign Committee

430 South Capitol Street, S.E., Washington, D.C. 20003 • (202) 224-2447

Internet: info@dsc.org

CONTRIBUTIONS FOR THE DEMOCRATIC NOMINEE IN THE OREGON GENERAL ELECTION

Program Chairs

Next Majority Trust

John Breaux, LA

Women's Council

Barbara Mikutski, MD
Barbara Boxer, CA

Leadership Circle

Kent Conrad, ND

Labor Council

Russ Feingold, WI

DSCC Roundtable

David Pryor, AR
Carol Moseley-Braun, IL
Patty Murray, WA

OREGON VICTORY FUND

The DSCC will raise funds jointly with a search committee organized to support the eventual Democratic nominee in the Oregon special election. Once the nominee is selected, the candidate will authorize this committee as his or her own and its funds will be immediately available for his or her use. The nominee will receive 95% of the proceeds and the DSCC will accept 5% which will be tallied to the Oregon race.

Checks should be made payable to:

Oregon Victory Fund

Contributions should be mailed to:

Democratic Senate Campaign Committee
430 S. Capitol Street, S.E.
Washington, DC 20003

Contribution Levels:

Individuals: \$1,000 - general election
Partnerships: \$1,000 - general election
PAC's: \$5,000 - general election

More Information Contact:

Rita Lewis
Deputy Executive Director
Democratic Senate Campaign Committee
PH: 202-224-2447
FAX: 202-485-3120



Democratic Senatorial Campaign Committee

430 South Capitol Street, S.E., Washington, D.C. 20003 • (202) 224-2447

Internet: info@dsc.org

J. Robert Kerrey, NE

Chairman

CONTRIBUTIONS TO THE OREGON STATE PARTY

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Kent Conrad, ND

Labor Council

Russ Feingold, WI

DSCC Roundtable

David Pryor, AR

Carol Moseley-Braun, IL

Patty Murray, WA

Checks should be made payable to:

Democratic Party of Oregon

Contributions should be mailed to:

DSCC

430 S. Capitol Street, S.E.

Washington, DC 20003

Contribution Levels:

Individuals:	\$5,000 each calender year - federal money
Partnerships:	\$5,000 each calender year - federal money
PAC's:	\$5,000 each calender year - federal money

NOTE: They can only accept federal contributions. People can contribute \$5,000 in 1995 and \$5,000 in 1996.

More Information Contact:

Rita Lewis

Deputy Executive Director - DSCC

PH: 202-224-2447

FAX: 202-485-3120

Oregon Special Election DSCC Campaign Plan Summary:

Plan components:

Vote Goal Scenario: 65% Turn out -

Oregon Secretary of State estimates a 65% voter turnout for the Oregon special election based on previous turnout in Oregon general and special elections.

Key numbers: **Democratic Base - 43%**
 Republican Base - 36%
 Unaffiliated Base - 21%

Minimum votes needed to win 596,203.

Based on obtaining 50% plus 1 of the expected 1,192,404 votes cast.

Targeting: Complete 1996 NCEC precinct data will be available for analysis on September 30th; the voter file will be complete October 15; and polling will be conducted post-primary. Based on NCEC data, high Democratic performance and persuasion precincts will be targeted for identification/persuasion and GOTV efforts.

Voter File: Two voter files exist from 1994 with voter history, including participation in the two statewide special elections conducted by mail. DSCC has access to the Count Books via Electronic Bulletin Board. An updated voter file will be completed October 15th, paid for by the DNC, Democratic Party of Oregon, and Democratic Coordinated Campaign participants. The voter file vendor will provide, as required by contract, a full-time administrator in Portland for the duration.

The voter file will contain the following data in addition to the name, address and phone number of the voter:

1. Party
2. Age
3. Gender
4. Voter History
5. Previous Voter ID responses
6. Mail-In Special Election History

Field Plan:

Voter Identification:

A paid phone bank will call Democratic, Independent and some Republican (i.e. pro-choice GOP) voters in targeted geographic and demographic areas to identify those voters that are for, against and undecided in their support of the Democratic candidate. Identified supporters of the Democratic nominee will be placed in the GOTV universe. Voter ID calls will begin **early December and continue through early January.**

Persuasion Universe:

Targets for persuasion have been estimated on a 65% turn-out and on demographic selections based on GOP opponents and the Democratic candidates.

Mail: Undecided voters from the voter ID program will receive three pieces of persuasion and comparative mail. This mail will hit **between Jan. 2 - 10.**

Phone: Just prior to the ballots arriving, (Jan. 10-11), phone calls will be made to the undecided voter universe asking a new ID question and containing a "push" message. Identified Democrat and other voters will be added to the GOTV universe nightly. Persuasion targets are identified based on a 65% phone match; with mail and door to door to cover the 35% non-match households.

Canvass: Targets, walkable precincts and follow-up mail.

Get-out-the-vote

Democratic Performance targets have been calculated and estimated budgets for calls and canvass.

Mail: GOTV mail will be sent prior to the election, **Jan. 5-10**, (2 pieces to the universe) and periodically to those in the universe whose ballots are still outstanding. An additional mail universe is planned for the households that we have been unable to ID due to an inaccurate phone match and in rural and suburban areas difficult to canvass.

Paid

Phone: GOTV call to identified supporters will begin in those areas ranking highest in GOTV universe **Jan. 9-10**, just prior to the arrival of the ballots, urging early voting. GOTV calls will continue throughout the twenty day voting period to those yet to vote. The call list will be pared down as votes are recorded. Estimated phone targets have been identified for high Democratic performance and likely demographics on a pre- and post-ballot mail schedule. Special universe for rural and suburban precincts.

Volunteer

Canvass: GOTV door-to-door canvassing will occur in GOTV precincts and possibly some persuasion precincts the weekend before ballots are mailed (**Jan. 6-7**). Canvassing will continue throughout the twenty day period, with maximum numbers of doors hit the five days immediately following the arrival of the ballots (**Jan. 11-16**) and the four days before the close of the election (**Jan. 27-30**). Until NCEC data is complete, estimates are just that, but for planning purposes, it will take approximately 1000 canvass shifts to cover the entire universe, with that number decreasing over the twenty day period as ballots are cast, recorded and gleaned from the GOTV universe. Precincts will be canvassed in descending priority order.

Visibility: GOTV visibility will occur throughout January, with heavy emphasis on shopping centers, day care centers, senior centers etc. in the highest target areas.

Media: GOTV public service announcements on TV, radio and in the print media will be explored with the Governor, Secretary of State and friendly interest groups.

Vote Tracking:

The process for tracking ballots which have been voted and delivered to the election office and following up with identified Democratic voters who have not yet voted is critical.

1. Six of the seven largest counties provide information on disk. This will be matched to the voter file and then matched to the phone and walk lists as frequently and quickly as data is provided. Estimates are for a 48 hour turnaround time from the clerk's offices.
2. In counties where the data is provided on paper, lists will be input in the county and sent via modem to the appropriate entities.

Technology:

Technology will be a key component of the field program, given the need for immediate turnaround of information in this election, particularly as it relates to the tracking of ballots. In order to achieve and be certain of an efficient tracking system during the general, a trial run, tracking republicans in targeted precincts, is proposed for the primary. All computer decisions will be made by October 30.

Opposition Research:

Research on GOP candidates started September 11, with team on the ground in Oregon. The team is responsible for rapid response as well.

1. Complete packages on Republican candidates is underway through the DSCC

and will be completed by December 5th. The DSCC is receiving weekly briefings on the progress of the research and will coordinate communication between the research consultant and the primary candidates upon request.

2. Research team to work with DSCC communications staff to define GOP candidates pre-primary.
3. Daily video field tracking of Republican candidates will be a top priority.
4. Media watch program throughout the state, as well as radio call-in and letter to the editor programs will be implemented.
5. Dan Carol's research contract includes pre-primary and post-primary rapid response responsibility.

Communication/press:

Coordination between DSCC, candidates, and research. Steve Jarding, one press secretary at DSCC, and a press secretary in Oregon at state party office.

1. Orchestrate attacks on Republican candidates prior to primary election.
2. Build third-party surrogate operation for message-driven hits post-primary.
3. Initiate national spin on the election with Democratic pundits and donors.
4. Responsible for producing and distributing the Oregon line.
5. Coordinate rapid response with nominee's communications and research teams and DSCC research consultant (Dan Carol).

Volunteer Recruitment:

1. Primary responsibility for field staff throughout December is to recruit volunteers for canvassing, visibility events and phoning, if phone calls in addition to the paid calls become necessary. Daily goals and strict reporting will be implemented.
2. A full-time staffer will work recruiting volunteers to travel to Oregon from out of state, concentrating on western states. Sources include, college campuses, elected officials and staff, Democratic committee members, constituencies (women, labor, environment etc.) A staffer at the DSCC will also be responsible for recruiting Hill staff and others from DC to go to Oregon.

Training:

Training will be conducted for field staff prior to the primary to ensure they are able to hit the ground at full speed on Dec. 6. Additionally, training in key areas for activists is advisable given the complexity and scarcity of time in this election.

Offices:

At a minimum, there will be staffed offices located in Portland and five of the Congressional Districts. A number of local offices will also be established. The locations of which will be determined by the vote tracking procedures utilized in each county. Offices of primary campaigns and the state party will also be incorporated in to effort.

OREGON SPECIAL ELECTION STAFFING: KEY HIRES

DSCC Liaison

Pending approval, Gail Stoltz will function as a full-time liaison between the DSCC, the GOTV staff, candidate, Democratic support groups and other party entities to facilitate coordination.

GOTV Director

Hire: Immediately

The GOTV Director will be responsible for the overall planning and implementation of the turnout and persuasion operation for the Oregon special election. Includes development and refinement of both phone and mail universes; hiring and managing the phone and mail vendors; responsible for all budget decisions, in consultation with the DSCC; and direction of field effort.

Field Director

Hire: October 15

The field director reports directly to the GOTV director and is responsible for supervising all grassroots GOTV activity. Duties include: hiring of a senior deputy field director, 5 Congressional District organizers and 25 local field staff; refinement of canvass plan; establishing iron clad daily reporting systems for all field staff; responsibility for ensuring all data transmission to and from field offices is completed timely and efficiently.

Communications Director:

Hire: October 15

Although the primary will be capturing most of the coverage, it is imperative that one person wakes up every day with the task of positioning this race in a positive light locally and nationally and that no opportunity to score a hit against the Republican candidates is squandered. This person will work closely with nominee's communication director to immediately begin implementing a free press message schedule post-primary.

Compliance Director:

Hire: October 15

Given the large amount of money that will be raised and spent in a short period of time, this position is critical to both allow legal and budget decisions to flow smoothly and quickly and to ensure no legal problems arise after this election.

ORGEON BUDGET

	A	B	C	D	E	F	G
1			October	november	December	January	Total
2							
3	Mail		0	0	0	0	0
4		GOTV	0	0	0	320000	320000
5		Consfee			5000	5000	10000
6							330000
7							
8	Technology						0
9		Computers	0	45000	0	0	45000
10		Faxes	0	2500	0	0	2500
11		Printers	0	2500			2500
12							50000
13	GOTVStaff						0
14		GOTV Dir.	3000	6000	6000	6000	21000
15		Field Dir.	0	4000	4000	4000	12000
16		Dep. Field	0	3000	3000	3000	9000
17		CDCoord(5)	0	5000	10000	10000	25000
18		FStaff(25)	0	0	25000	25000	50000
19		VolCoord(2)	0	2000	4000	4000	10000
20		Commun. D	2000	4000	4000	4000	14000
21							
22		Compt.	2500	5000	5000	5000	17500
23		AstComp	0	2000	2000	2000	6000
24		FinanceDir.	2500	5000	5000	5000	17500
25		Fin Asst	0	0	1000	1000	2000
26		Constit. Co	0	1500	3000	3000	7500
27		Ofc. Manage	0	0	2000	2000	4000
28		Ballot (2)	0	0	4000	4000	8000
29							
30							203500
31	Phones						0
32		Voter ID	0	75000	0	0	75000
33		GOTV	0	0	0	200000	200000
34		Portland	0	5000	6000	6000	17000
35		FOffices	0	3000	6000	6000	15000
36		Cell/Pagers	0	1000	2500	4000	7500
37		fax	0	0	6000	6000	12000
38							378000
39	Rent/Overhead						0
40		Portland	0	0	2000	2000	4000
41		FOffices	0	0	3750	3750	7500
42		Utilities	0	0	700	700	1400
43		Copiers	0	0	1750	1750	3500
44		OfcSupp.	0	0	1200	1200	2400
45							18800
46	Travel						0
47		Mileage/Air	500	2000	4000	6500	13000
48		Lodging	1000	2000	3000	4000	10000
49		CarLeases	250	500	1250	2500	4500
50		Vans	0	0	0	2000	2000
51							29500
52							
53	Misc.		0	0	10000	10000	20000
54							0
55							1029800

OREGON SPECIAL ELECTION TIMELINE

The following are key organizational and programmatic activities for the Oregon Special Election. Many activities (staff hiring, Oregon line, press hits, door to door canvassing, visibility etc.) will be ongoing and are not listed again each week.

Week of October 2

October 2-6: * Meeting with candidate/staff to gain input and commitment to this plan.

October 6: * GOTV Director hired
* Compliance Staff hired
* Communications Director hired
* General Election Field/GOTV plan complete

October 2: * Election rules issued by Secretary of State

October 6: * Minor revision of GOTV plan based on Secretary of State's ruling

Week of October 9

October 9: * DSCC team (Foley, Stoltz, Pribyl, Bauer) meets with Oregon party, clients and coordinated campaign
* Draft Communications plan complete

October 9-13: * Meetings held with key Oregon constituencies by DSCC staff

Week of October 16

October 16: * New, updated voter file complete
* GOTV Director starts (sooner if possible)
* Communication Director starts
* Field director starts. Interviews and hiring of organizers begins
* Researcher hired. Daily taping of GOP candidates begins.
* Finance Director starts

October 19: * Communications plan complete

Week of October 23

October 27: * Technology plan for field program agreed upon

Week of October 30

November 1: * Coordinated Campaign roundtable with key political and constituency leaders

November 1: * Mail and phone vendor contracts signed

Week of November 6

November 8: * Coordinated Campaign roundtable

November 10: * Phone match complete, actual numbers inserted into budget

Week of November 13

November 15: * Primary Ballots Mailed

- * Five Congressional District Organizers start

- * Constituency Coordinator starts

- * Deputy Field Director starts

- * Coordinated campaign roundtable

November 19: * Constituency plan complete

Week of November 20

November 22: * Draft Training agendas and materials complete - DNC

- * Coordinated Campaign roundtable

November 26: * Training material finalized

Week of November 27

November 29: CC roundtable

December 1: 25 Field Organizers hired

December 1-3: Field Staff training

Dec. 1: * Draft General Election poll questionnaire submitted for review

Week of December 4

DECEMBER 5 : PRIMARY

December 6: * Meeting held with nominee's field operation to review successes/failures of turnout effort

- * Daily field staff reports commence: vols recruited for canvass, visibility projects etc.

December 7: *CC roundtable

December 8: * Draft of persuasion mail pieces submitted for review

- * Phone script for ID calls completed

December 10-13: * Poll in field to aid in refining final mail/phone universes

Week of December 11

December 11: * Persuasion mail pieces signed off on

December 14: * Poll results digested, any changes made to final persuasion, GOTV universes agreed upon

December 11-18: * ID Calls to persuasion universe start

December 14: * CC Roundtable

December 15: *Draft GOTV mail pieces submitted from vendor

Week of December 18

December 18: * GOTV pieces finalized

December 18: * ID calls complete

December 21: * CC roundtable

Week of December 25

* December 27: * First persuasion piece dropped

Week of January 1

* January 2: * Second persuasion piece dropped

* January 4-5: * Statewide door to door canvass: undecideds and entire walkable GOTV universe

* January 6: * ID calls to undecided universe begin

* January 6: * Third persuasion piece dropped

Week of January 8

* January 8: * First GOTV piece dropped
* Fourth persuasion piece dropped
* ID calls to undecided universe complete

* January 9-10: * GOTV calls to most likely Democratic voters

* January 10: **GENERAL ELECTION BALLOTS MAILED**

* Jan. 11-14: * Door to door canvass in all walkable GOTV areas

* Jan. 11-14: * GOTV calls to entire universe

January 14 - January 30

The following activities will occur constantly throughout this 16 day period:

- * Ballot tracking
- * Matches of those who have voted to file, paring down phone and walk lists
- * Mail to those in targeted areas who have not yet voted
- * Paid calls every 2-3 days to those who have not voted
- * Door to door canvassing each day, with large efforts concentrated on the weekend of Jan. 20-21 and Jan 27-30
- * Ballot replacement program, including transportation to take voters who have lost ballots/never received to clerks' offices

Legal:

October 2: The Temporary Rule will be issued; the rule will adopt the regular Oregon election laws for this special election. The regular administrative rule addresses most of our concerns about replacement ballots, handling and delivering of ballots, postage, and absentee requests. Two issues remain unresolved prior to the adoption of the rules.

Unresolved Legal Issues:

1. Drop-off sites for ballots: the criteria for establishing additional sites will be set forth in an additional rule adopted on October 10th. This process will have a comment and review period.
2. Poll watching activities: Oregon law allows for extensive poll watching activities to occur on election day. We have asked for a clarification and uniform regulation in order that lists of who voted each day are available either on paper or computer disk. This issue will be addressed Friday September 29 in the rule or be included with the extended review on October 10.

DATES:

October 2: Issue rule adopting regular election procedures for the Oregon Special.

October 2-10 Public comment and review

October 10: Adopting Rule for unresolved issues of drop sites or poll watching lists availability. Bauer in Portland meet with Secretary of State October 9th-10th.

Legal Strategies:

DSCC: Bauer has written a memo addressing any unusual requirements in this special election. Memo is attached.

Bauer will produce the 441 (a) (d) authority letters for the DNC and the State Party. The state party will sign the authority over to the DSCC.

DNC: Sandler, DNC general council has reviewed the plan to assure all the activities are allowable for the state party and use a minimum of 441 (a) (d) authority. Including voter file development; voter identification and GOTV activities.

The Democratic Party of Oregon's activities will be reviewed by Sandler and Bauer.

1. Exempt Activities: Administrative/Party Building
2. Grassroots/volunteer exemption
3. Generic party activity

GOTV Activities:

Paid GOTV Calls: Paid GOTV phone calls will be completed by non-profit organizations, labor unions, and non-partisan voter registration and citizen participation projects. Goal is to complete 500,000 calls through alternative strategies the cost is \$250,000.

This effort will have at least one staff or consultant to coordinate the interested groups: labor unions, H. Philip Randolph, NARAL, Oregon Fair Share, Human Right Campaign Fund, etc.

Recount Strategy:

This could be a very close election: We have planned for the possibility of a recount. The entire plan and election procedure process will be reviewed by DSCC and DNC legal council and the recognized recount experts for Democrats. They will recommend and design needed documentation and random ballot checks to use in a recount situation.

- * Bob Bauer/ Joe Sandler
- * Tim and Tom Downs

PERKINS COIE**September 25, 1995**

TO: Don Foley
FROM: Bob Bauer
RE: Oregon Activities

This memorandum briefly describes two initiatives of the DSCC in preparation for the Oregon special election.

(1) Joint Fundraising with "Search Committee,"

DSCC will raise funds jointly with a "search committee" organized to support the eventual Democratic nominee in the Oregon special election. The purpose of the search committee is to raise funds in the name of the eventual nominee, before he or she is selected, which will be available to that candidate thereafter. The committee will operate like any other principal campaign committee: it may accept up to \$1,000 from any individual, and up to \$5,000 from a multi-candidate committee, and it must maintain these funds in accounts subject to regulation by and reporting to the Federal Election Commission. Once the nominee is selected, that candidate will authorize this committee as his or her own and its funds will be immediately available for his or her use in the general election.

The search committee and DSCC will share in each contribution jointly raised as follows: DSCC will accept 5 percent of each such contribution, typically "tallied" to the eventual Oregon nominee, while the search committee will receive 95 percent of each contribution.

The DSCC/search committee joint fundraising will take place through a special "fundraising representative" organized in accordance with the Federal Election Commission's "joint fundraising" regulations. The joint fundraising representative, acting on behalf of both committees, will manage the joint fundraising effort, taking responsibility for accounting for all funds received; paying necessary expenses; reporting to the FEC; and eventually transferring to DSCC and the search committee their shares of contributions received.

In short, the search committee/DSCC's joint fundraising arrangement will operate like many other such arrangements DSCC has made with other candidates -- with the exception that the candidate for this particular committee will not yet have been selected.

(2) Fundraising for the Oregon State Party.

The Oregon State Party will also cooperate with DSCC in raising money for its activities in Oregon for the special election. The money that it raises will be money subject to the limitations, source prohibitions and reporting requirements of federal law. Oregon will maintain an additional account in Washington, D.C. available for the immediate deposit of all monies that it raises jointly with DSCC. All monies deposited in that account will be transferred to Oregon for use by the party there. The Oregon Party will also amend its Statement of Organization now on file with FEC to reflect the addition of this Washington, D.C. account.

RFB:smb

Should be this
to Mr. [unclear]

We have also received the following information items:

● **Immigration Message.** An editorial in the September 16 *Washington Post* on "Immigrants With Skills" talked of the need to put American workers first and cited some suggestions from Barbara Jordan on this subject. You noted that this message "needs to become a more explicit part of our message." In response, Rahm reports that he advised Commissioner Meisner and Secretary Reich to incorporate this message into their testimony at Senate immigration hearings on September 28.

● **9th Circuit decision on religion in schools.** From Steve Neuwirth. On Friday, the court ruled that a public high school receiving federal funds could not prohibit a student religious club from meeting on high school premises during the lunch period, when other extracurricular student clubs are permitted to meet. The court's decision was based on the Equal Access Act and confirmed a key principle in Secretary Riley's guidance to schools; DOJ filed an amicus brief in the case supporting the position the court took. The Christian Legal Society issued a statement praising the Administration's participation in the case stating, "[t]his was teamwork at its best, religious advocates and the White House successfully fighting the pervasive discrimination against free religious expression."

● **Vesco extradition from Cuba.** From Richard Nuccio via Harold. Cuba never offered to extradite Vesco. When our government indicated an interest in having him, Cuba backed off. Castro has publicly stated that it would be "immoral" to extradite him. While we are still interested in Vesco, we would not back off our embargo to secure his return.

● **Return of Hope, Arkansas Pilot's Remains.** From Tony Lake. The remains of Lieutenant Commander John F. Barr, USN, from Hope were among those of 18 servicemen from Vietnam and Laos returned to Travis AFB in California on September 27 from the processing center in Hawaii (which you have visited). Barr was previously unaccounted for after his aircraft was lost during a strike over North Vietnam on October 18, 1967. Barr's remains were returned to Hawaii in 1988 and recently positively identified based on a match of blood samples from his mother and sister. He will be interred with full military honors October 18 at National Cemetery in Houston, where his family lives. Also, a set of group remains to be buried at Arlington October 12 includes those of Captain Earl R. Michles, USA, of Pocahontas, Arkansas. He was in a helicopter shot down on June 13, 1968.

9
C. J. St. Mach
We should write
the families to say
that the remains have been
successfully identified.

THE WHITE HOUSE

WASHINGTON

September 29, 1995 SEP 29 P 5 : 29

MEMORANDUM FOR THE PRESIDENT

FROM: STEPHEN NEUWIRTH 
ASSOCIATE COUNSEL TO THE PRESIDENT

SUBJECT: COURT DECISION ON RELIGION IN SCHOOLS

Yesterday, the United States Court of Appeals for the Ninth Circuit ruled that a public high school receiving federal funds could not prohibit a student religious club from meeting on school premises during the lunch period, when other extracurricular student clubs are permitted to meet.

This was a major decision affirming a key principle in the guidance on religious expression in schools recently distributed by Secretary Riley to each of the nation's 16,000 public school districts.

The Justice Department filed a friend-of-the-Court brief in the case, supporting the position that the student religious group should be permitted to meet during the lunch period.

The Ninth Circuit's decision was based on the Equal Access Act, the federal statute designed to prohibit discrimination against religious expression in our public schools.

Attached is a copy of a press release from the Christian Legal Society, praising the Administration's participation in the case.



Center for Law and Religious Freedom

• 4208 Evergreen Lane, Suite 222 • Annandale, VA 22003 • (703) 658-3000 FAX (703) 642-1075

Date: September 29, 1995

Contact: Gregory S. Baylor,
Asst. Director, CLRF

FOR IMMEDIATE RELEASE

STUDENT RELIGIOUS CLUBS ENTITLED TO MEET AT LUNCHTIME; FEDERAL APPEALS COURT BREAKS NEW GROUND FOR EQUAL ACCESS

Federal law requires public high schools to allow student Bible studies on campus during lunchtime if they permit other noncurricular student clubs to meet at that time, a divided federal appeals court ruled yesterday in California. The case of Melanie Cenicerros v. San Diego Unified School District is another significant victory for free religious expression by students, a victory won by the combined efforts of The Rutherford Institute (which represented Melanie), Christian Legal Society (which filed a brief in support of Melanie and convinced the White House to support her cause), the American Center For Law And Justice (which also filed a brief), and the White House (which persuaded the Justice Department to file a brief in support of Melanie's arguments).

"Eleven years after Congress passed the law, it's now official - lunchtime Bible studies are federally protected from discriminatory suppression," exclaimed Steven T. McFarland, Director of CLS' Center For Law And Religious Freedom. If the Surf Club meets over sandwiches, so can the Bible club meet over Scripture at noon."

President Clinton recently issued guidelines to all school superintendents summarizing existing law surrounding religion in the schools, including the Equal Access Act, the statute under which Melanie won yesterday. In the guidelines, Mr. Clinton correctly predicted yesterday's ruling, calling on schools not to discriminate against religious student meetings at lunch. In addition, the White House Office Of Legal Counsel intervened at CLS' request, convincing the Justice Department to support Melanie's legal claims under the Act. "This was teamwork at its best, religious advocates and the White House successfully fighting the pervasive discrimination against free religious expression," McFarland commented.

Joining CLS' brief were the National Council of Churches, the National Association of Evangelicals, and the Christian Life Commission of the Southern Baptist Commission.

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~~SECRET~~ Chris Jennings

Pls analyze this for me —

Thanks

RC

THE PRESIDENT HAS SEEN

10/2/95

AL FROM Sept. 21, 1955-

Dear Mr. President,

Good to talk to you last week. Don't
let the forces of the status quo get you down
on welfare. Attached, as promised, is our attempt
to get beyond the demagoguery on medicare. I
hope you find it useful.

Al

A New Deal for Medicare and Medicaid *Building a Buyer's Market for Health Care*

David B. Kendall

In this paper, the Progressive Policy Institute (PPI) proposes a five-year, step-by-step plan to convert the health care entitlements—Medicare and Medicaid—from an inefficient, arbitrary system of government-run health insurance into an efficient and self-regulating system of private health insurance, supported by a market-priced government subsidy.

Building on a sequence of changes in the existing system, PPI's proposal would spawn a health care network organized around the principles of competition and informed choice. The central mechanism would be a system of consumer health care cooperatives which would offer a choice of competing menus of private health insurance plans.

The immediate goal of this plan is to change government's role in health insurance from *entitlement of beneficiaries* to *empowerment of consumers*. Its ultimate goal is to create a fair and efficient health care marketplace that will promote better care—at a lower cost and with maximum choice—for all Americans: *a buyer's market providing the best possible value for the consumer and for the taxpayer.*

The Medicare/Medicaid Challenge

The health care entitlements are profoundly archaic programs, governed by arbitrary political and budgetary goals, managed by command-and-control regulation, and reproducing their own enormous inefficiency throughout the entire health care system.

As such, the current Medicare and Medicaid programs constitute an immovable obstacle—structural, fiscal, and political—to the progressive goal of ensuring all Americans access to health care.

The Political Logjam

Unfortunately, the year-long congressional "debate" on the future of Medicare and Medicaid has little or nothing to do with fundamental reform.

Republicans deserve some credit for making the case to the American people that Medicare needs to be changed. Democrats, for their part, have rightly pointed to the bad faith and bad budgeting that characterize the Republican proposals. Beyond that, the behavior of both parties in the Medicare mud-wrestling match supplies a prime example

of how the traditional Left-Right debate discourages real debate, and government from solving problems.

Republican proposals fall short of any real change in Medicare's structure, offering little more than a more tightly regulated version of the status quo—the welfare state on the cheap—that could actually *increase* Medicare's reliance on bureaucratic fiat to manage costs.

Democrats have failed dismally to take a single step toward a constructive alternative, choosing instead to take cheap shots from the sidelines that reinforce their party's image as an intellectually bankrupt coalition of stakeholders in the welfare state.

Lost in the partisan squabbling is any clear recognition that: (1) it is not only possible but essential to restrain Medicare and Medicaid costs through fundamental reform that exposes health care entitlements to the same competitive forces and delivery strategies now transforming the private health care sector; and (2) only through such fundamental changes in the health care entitlements can the nation afford to move toward comprehensive health care reform.

The Need for Structural Reform

The most fundamental problem of Medicare and Medicaid is obvious: soaring costs. After adjusting for inflation, the total cost of Medicare and Medicaid has grown sixfold in the 30 years since both programs were created. As a percentage of the gross domestic product (GDP), the cost of these two programs doubled from 1967-73, doubled again from 1973-87, and will double a third time from 1987-2000 under current projections, at which point it would represent 6 percent of GDP. Once the baby boom generation starts to retire in 2008, the explosion in the number of people receiving Medicare and Medicaid benefits will overwhelm the program. A declining base of workers to support future retirees, as well as longer lifespans, will cause health care entitlement costs to double by 2030 even if reforms eliminate medical inflation.

Aside from rising numbers of eligible beneficiaries, the structure of Medicare and Medicaid boosts costs. Put simply, the health care entitlements fail to employ rudimentary market mechanisms to govern the supply and demand—and thus the price—for services, relying instead on arbitrary and politically driven regulations.

The primary cost containment strategy used by the federal government has been regulation of provider payments. But arbitrary limits on provider payments have produced three by-products that seriously undermine their effectiveness. Providers have: (1) circumvented fixed payments by simply performing more services for each patient; (2) shifted costs by charging higher rates to private payers, thus contributing to private sector medical inflation; and (3) refused to accept Medicare or Medicaid patients, reducing the availability and quality of care.

The most recent cost-containment effort is the national experiment with allowing beneficiaries to enroll in Health Maintenance Organizations (HMOs). But this experiment has been fundamentally flawed from the beginning by the decision to peg Medicare's payments to HMOs to the current cost of the fee-for-service program, making significant

savings literally impossible. Privatization of health insurance for beneficiaries without competition over price is self-defeating.

The PPI Proposal

Over five years, the proposal would:

- ▶ **Privatize Insurance for Medicare Beneficiaries.** Medicare would be changed from a government-run, fee-for-service health insurance plan to a system in which Medicare beneficiaries would choose private health insurance plans, selected from menus offered by competing, voluntary private sector consumer cooperatives. The government would subsidize insurance purchases through individual Health Purchasing Accounts, at an amount set by the average price of competing plans, keyed to a benchmark benefit package, rather than to budgetary goals as Republicans have proposed. Beneficiaries could choose cheaper plans and secure broader coverage or cash rebates; or they could choose more expensive plans, including a fee-for-service option and pay a premium for the difference.

This approach is superior to conservative proposals to voucherize Medicare in three crucial respects: It preserves Medicare's collective purchasing power; it strengthens the position of individual beneficiaries through negotiation by cooperatives; and it protects the value of the subsidy against inflation.

- ▶ **Cap and Deregulate Medicaid.** Per capita Medicaid payments to the states would be capped with states given broad latitude to cut costs by enrolling beneficiaries in private health insurance plans, preferably by adapting the competitive system of consumer cooperatives set up by the federal government for Medicare. After an extensive campaign to promote the use of private long-term care insurance, total spending in each state for Medicare long-term care would be capped to avoid a massive influx into the program of middle-class nursing home patients when the baby boom generation begins to retire.

Unlike Republican block grant proposals, this approach would instill budget discipline in Medicaid while accommodating future demographic changes, and without rewarding states for poor cost management practices in the past.

- ▶ **Make Health Care Subsidies Fair.** To deal with the current crazy quilt of excessive subsidies for some Americans and no health care insurance for others, a sustained effort would be made to make subsidies fair. The tax subsidy for employer-sponsored health benefits would be capped at the national per person average, with the savings used to cover the uninsured

under Medicaid up to the poverty line. Because the current universal and equal entitlement to Medicare services taxes low-income workers to support many affluent retirees, subsidies would be gradually reduced according to income, and eliminated entirely for those with high incomes. Further, because the intergenerational transfer of resources by Medicare has been exacerbated by longer lifespans, the age of eligibility would be increased gradually to age 70.

- ▶ **Create a Universal Health Care Marketplace.** The emerging new marketplace of competing private health insurance plans, open to Medicare and Medicaid beneficiaries and private employers and purchasers as well, would be linked by a "health net," a government-catalyzed but privately operated information network linking consumers, providers, and purchasers of health insurance. The effect of the health net would be to create an infrastructure whereby all Americans, beginning with Medicare beneficiaries, could enjoy a *buyer's market* with the features of the best current health insurance system, combining collective purchasing power and individual freedom of choice, at market-based prices. The health net could also be used as a central clearing point for private sector health care transactions, including medical records and payments.

Alternative Proposals

So far, neither party has proposed in 1995 the kind of system change for Medicare which PPI proposes—much less a path to comprehensive health care reform.

For the most part, congressional Democrats have supported the status quo approach to health care entitlements in the face of conservative demands for deep budget cuts. The President's Medicare proposal calls for \$124 billion in savings, to come primarily from cuts in provider payments. However, it does propose more extensive and effective experimentation with managed care and thus moves in a direction that lays the groundwork for a truly competitive system in which market forces set the price for Medicare services.

The Republicans' long-awaited Medicare reform proposal, unveiled on September 14, 1995, appears to abandon any effort to achieve Medicare savings through a competitive system, opting instead for regulatory measures to squeeze savings from beneficiaries and providers. Comprehensive health care reform is out of the picture altogether.

PPI's analysis of the GOP proposal concludes that it is seriously flawed, in that: (1) it does little or nothing to encourage market efficiencies in Medicare; (2) it will do little to reduce government spending, as the anticipated savings produced by expanded enrollment in private health plans are retained by beneficiaries; and (3) ironically, the GOP plan relies decisively on government-imposed reductions in payments to providers to achieve its fiscal goals—to an extent never before proposed by either party.

Two other "reform" proposals from the conservative side are discussed in the PPI paper. They are:

- ▶ **Medicare Vouchers.** The basic thrust of voucher proposals is to allow beneficiaries to individually purchase health insurance in an amount roughly equal to current per capita Medicare spending. The federal government's role would be limited to financing the voucher; its actual purchasing value would be determined by the marketplace.

The advantage of vouchers is that they would both simplify the current system and eliminate its inefficiencies that encourage undisciplined demand, offer open-ended subsidies, and set arbitrary prices. The disadvantage lies in what gets substituted: an unregulated private insurance market, with its much higher administrative costs, risk-based pricing, and risk-skimming practices that leaves too many citizens unprotected. By dismantling Medicare's collective purchasing power, vouchers would also expose many Medicare recipients to higher prices.

Assuming that the voucher amount would be fixed or otherwise arbitrarily limited to accommodate yearly budgetary needs, the voucher approach would "save" Medicare's financial solvency quite explicitly at the expense of beneficiary health care: individually, because the price of insurance would depend on each beneficiary's risk analysis, and collectively, because beneficiaries would not have the advantage of Medicare's buying power.

- ▶ **Medicaid Block Grants.** The GOP's focus on insulating the federal budget from health care cost increases at the expense of beneficiaries is especially well-illustrated by the popularity of the Medicaid block grant proposal.

In its most straightforward form, a Medicaid block grant would abolish all national eligibility rules for the program, along with state responsibility to serve a specific population or appropriate its own funds, and would then give each state a fixed sum for indigent health care based on recent federal match payments.

By converting federal Medicaid payments to the states to a discretionary account, Congress could, and undoubtedly would, limit future increases to achieve its own budgetary targets, and let the states sort out the implications in terms of eligibility, services, and cost. However, the impact on beneficiaries and providers of having the states re-create our most complex domestic program virtually overnight is impossible to calculate. Major questions of fairness and accountability arise (remember no-strings attached revenue sharing?).

The problem with Medicaid today is *not* the national set of eligibility standards, or a federal formula based on eligible population. The real problem is the open-ended subsidy for state spending. Limiting that subsidy by budget-driven caps rather than competitive forces ensures that Medicaid spending will remain a political football, and Medicaid reform will remain a dream.

Advantages of the PPI Approach

Unlike all other proposals currently on the table, the PPI proposal begins with the proposition that fundamental reform of the health care entitlements—to address the features that drive up costs—should come before, not after, enactment of a long-range budget plan.

Both the President's and the Republicans' budget plans for Medicare and Medicaid cynically backload potential savings, without providing any clear mechanism for achieving them. Neither plan even begins to deal with the long-term health entitlement budget problem, which will mushroom when the baby boom generation reaches age 65 in 2011.

The PPI proposal offers a much more realistic guide for health care budgeting. It does not include specific budget projections because we acknowledge we do not know exactly how much or how fast a competitive system will generate savings.

By maximizing the savings achievable through efficiency measures, the PPI plan thus makes it possible to focus on the real policy choices the country must face, about how much health insurance we can afford to subsidize and for whom.

Fully implemented, the PPI proposal will make all public subsidies for health insurance explicit, measurable, and subject to market forces. In effect, we will have a true national health care budget with the cost of all subsidies capped by market competition. Only the actual competition will determine whether the tax resources supporting these subsidies are adequate. If not, Americans will have to decide whether to cut back or pay more, but the choice will be far more clear than it is today.

*David B. Kendall is senior analyst for health policy
for the Progressive Policy Institute.*

To receive a copy of the full report, please send a check or money order in the amount of \$5.00 to: Progressive Policy Institute, 518 C Street, NE, Washington, DC 20002, Attn: Publications Department. For more information please contact us by: phone: (202) 547-0001, email: info@dlcppi.org, or WWW: <http://www.dlcppi.org/>.

A New Deal for Medicare and Medicaid

Building a Buyer's Market for Health Care

David B. Kendall

A Call for a Third Way

For Americans whose aim is to transform the paternalistic welfare state into an instrument for empowering citizens to solve their common problems, Medicare and Medicaid represent an urgent challenge.

The health entitlements are profoundly archaic programs, governed by arbitrary political and budgetary goals, managed by command-and-control regulation, and reproducing their own enormous inefficiency throughout the entire health care system.

Furthermore, the current Medicare and Medicaid programs constitute an immovable obstacle—structural, fiscal, and political—to the progressive goal of ensuring all Americans access to health care.

Modernizing Medicare and Medicaid requires a fundamental shift in the concept of government's role in helping the elderly and the poor secure health insurance. Instead of offering beneficiaries an unconditional entitlement to a government health insurance plan at whatever arbitrary price the federal budget will bear, we should help beneficiaries become responsible consumers of private health insurance in competitive markets that maximize their buying power. These reforms are all the more urgent because the costs associated with the health entitlements will soon begin to explode once the baby boom generation begins to reach retirement age. Indeed, Medicare and Medicaid will eventually make public investments that are critical to America's future, unaffordable.

Unfortunately, the year-long congressional "debate" on the future of Medicare and Medicaid has little or nothing to do with fundamental reform.

Republicans deserve some credit for making the case to the American people that Medicare needs to be changed. But their *goal* in addressing Medicare is entirely misguided: a blind obsession with securing the budget savings necessary to finance the contradictory objectives of the Republican's Contract with America. More importantly, their *proposals* fall far short of any real change in Medicare's structure, despite a few bells

and whistles that create the false impression of a step towards a private, competitive system.

If anything, Republican proposals would actually *increase* Medicare's reliance on bureaucratic fiat to manage costs. Their effort to wring huge savings from providers and beneficiaries under the current inefficient system, instead of reforming it, is a high-risk strategy that will either fail or lead to genuinely drastic cuts in provider payments or benefits in the future.

At best, the Republican plans to "save" Medicare offer little less than a more tightly regulated version of the status quo—the welfare state on the cheap.

Through their Medicare proposals, Republicans are posing as bold reformers who are deeply concerned about protecting the interests of beneficiaries and taxpayers. This pose reverses their true position. In terms of reforming Medicare, Republicans are sheep in wolves' clothing. But in terms of the future impact on beneficiaries and taxpayers, they are wolves in sheep's clothing.

While Democrats have rightly attacked the bad faith and bad budgeting that characterizes Republican Medicare proposals, they have so far dismally failed to take a single step towards a constructive alternative. Indeed, the very subject of Medicare has a fatal attraction for traditional liberals, appealing to their faith in the popularity of entitlements, their attachment to government programs, their alignment with organized constituency groups, and their snail's-eye view of political tactics.

If Democrats win the Medicare battle in Congress by mobilizing resistance to any significant change in the program, they will lose the war in two crucial respects: by fortifying Medicare's status as an obstacle to comprehensive health care reform, and by reinforcing their party's image as an intellectually bankrupt coalition of stakeholders in the welfare state.

The behavior of both parties in the Medicare mud-wrestling match supplies a prime example of how the traditional Left-Right debate discourages real debate, and disables government from solving national problems.

There is, however, a third way. In this paper, the Progressive Policy Institute (PPI) proposes a fundamental reform of Medicare and Medicaid that will maintain the nation's commitment to health care for the elderly and the poor, but through a radically different system appropriate to the Information Age. In effect, PPI proposes a "new deal" on Medicare and Medicaid based on the principle of securing progressive goals through market means. Its immediate goal is to change government's role in health insurance from *entitlement of beneficiaries* to *empowerment of consumers*. Its ultimate goal is to create *a fair and efficient health care marketplace that provides universal access*, thus reviving the promise of comprehensive health care reform from the debris of last year's debate on President Clinton's health plan.

The proposal's central thrust is to convert the health care entitlements from an inefficient and arbitrary system of government-run health insurance into an efficient and self-regulating system of private health insurance, supported by a market-priced government subsidy. Its overall aim is to create a fair and efficient health insurance marketplace that will promote better care—at lower costs and with maximum choice—for all Americans: *a buyer's market providing the best possible value for the consumer and for the taxpayer.*

Over five years, the proposal would include the following reforms:

- ▶ **Privatize Insurance for Medicare Beneficiaries.** Medicare would be changed from a government-run fee-for-service health insurance plan to a system in which Medicare beneficiaries would choose private health insurance plans, selected from menus offered by competing, voluntary, private sector consumer cooperatives. The government would subsidize insurance purchases through individual Health Purchasing Accounts, at an amount set by the average price of competing plans, keyed to a benchmark benefit package, rather than to budgetary goals as Republicans have proposed. Beneficiaries could choose cheaper plans and secure broader coverage or cash rebates; or they could choose more expensive plans, including a fee-for-service option, and pay a premium for the difference. This approach is superior to conservative proposals to voucherize Medicare in three crucial respects: It preserves Medicare's collective purchasing power; it strengthens the position of individual beneficiaries through negotiation by cooperatives; and it protects the value of the subsidy against inflation.
- ▶ **Cap and Deregulate Medicaid.** Per capita Medicaid payments to the states would be capped with states given broad latitude to cut costs by enrolling beneficiaries in private health insurance plans, preferably by adapting the competitive system of consumer cooperatives set up by the federal government for Medicare. Unlike Republican block grant proposals, this approach instills budget discipline in Medicaid while accommodating future demographic changes, and without rewarding states with poor cost management practices in the past. After an extensive campaign to promote the use of private long-term care insurance, total spending in each state for Medicaid long-term care would be capped to avoid a massive influx into the program of middle-class nursing home patients when the baby boom generation begins to retire.
- ▶ **Make Health Care Subsidies Fair.** To deal with the current crazy-quilt system of excessive subsidies for some Americans and no health care insurance for others, a sustained effort would be made to make subsidies fair. The tax subsidy for employer-sponsored health benefits would be

capped at the national per person average, with the savings used to cover the uninsured under Medicaid up to the poverty line. Because the current universal and equal entitlement to Medicare services taxes low-income workers to support many affluent retirees, subsidies would be gradually reduced according to income, and eliminated entirely for those with high incomes. And because the intergenerational transfer of resources by Medicare has been exacerbated by longer lifespans, the age of eligibility would be increased gradually to age 70.

- **Create a Universal Health Care Marketplace.** The emerging new marketplace of competing private health insurance plans, open to Medicare and Medicaid beneficiaries and private employers and purchasers as well, would be linked by a "health net," a government-catalyzed but privately operated information network linking consumers, providers, and purchasers of health insurance. The effect of the health net would be to create an infrastructure whereby all Americans, beginning with Medicare beneficiaries, could enjoy a *buyer's market* with the features of the best current health insurance systems, combining collective purchasing power and individual freedom of choice, at market-based prices. The health net could also be utilized as a central clearing point for private sector health care transactions, including medical records and payments.

This paper also provides a critique of alternative proposals for restraining Medicare and Medicaid costs, including the old bipartisan approach of regulating provider payments and the new conservative panaceas of Medicare vouchers and Medicaid block grants.

Finally, we will show how reforming Medicare and Medicaid through competition creates a clear series of choices about how to budget for health care, especially in view of the real Medicare and Medicaid spending crisis that is just over the horizon.

What's Wrong With Medicare and Medicaid

The success of Medicare and Medicaid is obvious: It has delivered health care coverage for millions of poor, elderly, and disabled and long-term care for many as well. Before their enactment in 1965, half the elderly and most of the poor were uninsured. Today, none of the elderly and only half the poor are uninsured.

The most fundamental problem is equally obvious: soaring costs. After adjusting for inflation, the total cost of Medicare and Medicaid has grown sixfold in the 30 years since both programs were created. As a percentage of gross domestic product (GDP), the cost of these two programs doubled from 1967-73, doubled again from 1973-87, and will double a third time from 1987-2000 under current projections, at which point it would represent 6 percent of GDP.¹ Since Medicaid and Medicare already account for 31

percent of total national health care expenditures, these programs both contribute to and reflect overall health care inflation.

Some of this enormous growth, of course, is attributable to deliberate policy changes that have expanded eligibility and the scope of services to address fundamental social needs such as coverage for the disabled.

But there are two demographic trends that have significantly increased eligibility—and overall costs—without any change in government policy.

First, Americans are living longer, which means the average beneficiary of Medicare and of Medicaid long-term care is receiving services for a longer period of time.

And second, a variety of familiar social and economic forces have steadily reduced the number of families able and willing to supply custodial care for the elderly at home. This trend has intensified demand for Medicaid long-term care services, especially in middle-class families who were never anticipated (or intended) to be beneficiaries.

Half of Medicare's increased inflation-adjusted spending and one-third of Medicaid's over their first 30 years is attributable to increased per capita spending, reflecting rising per-unit costs and utilization rates. Moreover, coverage factors are becoming less significant in explaining the Medicaid/Medicare spending spiral, in part because the eligible population has stabilized, and in part because the era of expansions in eligibility and services ended nearly a decade ago for Medicare and in the early 1990s for Medicaid. Over the next five years, for instance, only about 10 percent of Medicare's cost increases, and 33 percent of Medicaid's, will be attributable to more beneficiaries.²

Once the baby boom generation starts to retire in 2008, the explosion in the number of people receiving Medicare and Medicaid benefits will overwhelm the program. A declining base of workers to support future retirees, as well as longer lifespans, will cause Medicare and Medicaid costs to double by 2030 even if reform eliminates medical inflation (see chart on page 31).³

There are undoubtedly factors external to the health entitlement programs that contribute to rising costs, such as malpractice insurance costs, trends in medical education and specialization, and use of life-extending medical technology. But there are also several structural features unique to Medicare and Medicaid that boost costs.

No Market Discipline—Government-Set Prices

Put simply, the health care entitlements fail to employ rudimentary market mechanisms that govern the supply and demand—and thus the price—for services, relying instead on arbitrary and politically-driven regulations.

Medicare and Medicaid disconnect beneficiaries and providers from the cost implications of services. Because it acts as a monopoly insurer for the aged, disabled, and poor, the government cannot rely on consumer choice and competition between health plans to set prices and allocate resources. Instead, the government seeks to achieve the right balance of price, quality, and availability of services by crude estimates that are a poor substitute for market signals.

Reflecting the political value of insulating beneficiaries, who are also voters, from health care costs, the primary cost-containment strategy used by the federal government has been regulation of provider payments. By making provider payments a matter of law, Congress has assumed the responsibility to restrain increases in Medicare payment rates for budgetary purposes, invariably encountering resistance and predictions of system failure from providers.

Regulation of provider payments for Medicare has helped to hold down public costs, as was demonstrated by the reduced rates of increase in Medicare spending during the 1980s. However, arbitrary limits on provider payments have three by-products that seriously undermine their effectiveness.

First, and most importantly, providers have recouped income lost through fixed payment rates by simply increasing the volume of services performed for each patient. For example, after Congress first regulated payments to doctors in 1989, there was a significant nationwide jump in a variety of specialized tests and procedures reported to Medicare. Congress's own Physician Payment Review Commission estimated that in 1990, doctors on average recouped 60 percent of reduced Medicare payments by performing more services.⁴ This cat-and-mouse game between regulators and providers not only short-circuits the cost savings obtained through fixed rates, but also produces serious distortions in practice patterns and the overall quality of care.

Second, many providers responded to lower fixed rates for Medicare and Medicaid patients by charging higher rates to private payers: the classic "cost-shifting" problem. Two major studies of hospital cost-shifting in the late 1970s and early 1980s showed that 50-90 percent of price discounts demanded by Medicare, Medicaid, and other high-volume insurers were offset by higher prices charged to patients with private insurance.⁵

In more recent years, the cost-shifting ability of providers has been increasingly limited by the growth of managed care in the private insurance market, as more patients are covered by plans with the purchasing power to resist cost-shifts.

Third, government-imposed price constraint has increasingly placed the quality and even the availability of care under Medicare and Medicaid at risk, especially as providers exhaust opportunities to recoup income by increasing volume or shifting costs. For example, the historically low rates paid by states for Medicaid patients have led to

a virtual abandonment of the program by certain categories of providers, especially primary care physicians.

The notorious Disproportionate Share Hospital (DSH) program under Medicaid offers an especially striking example of how the law of unintended consequences can thwart efforts to control health entitlement costs by arbitrary regulation.

DSH was created to allow states to draw down federal dollars for additional payments to public and private nonprofit hospitals with high percentages of indigent patients—basically, those without the private-payor patient base to absorb Medicaid expenses through cost-shifting. In other words, DSH is designed to ameliorate the impact on key providers of arbitrary Medicaid pricing. Yet DSH has itself become a massive new cost center for the federal government, increasing from less than 1 percent of total Medicaid spending in Fiscal Year 1988 (\$449 million) to 14 percent of total Medicaid spending in Fiscal Year 1993 (\$17 billion).⁶

Privatization Without Competition

The most egregious example of counterproductive cost-containment efforts in Medicare and Medicaid is the recent national experiment with allowing beneficiaries to enroll in Health Maintenance Organizations (HMOs).

Paying providers a fee for each service, rather than a fixed amount per beneficiary, encourages use of more services than necessary. That is why fee-for-service indemnity policies are a rapidly declining share of the private health insurance market, while maintaining an anachronistic hold on Medicare (and to a lesser extent, Medicaid) patients. Only one-third of participants in private sector, employer-sponsored health insurance plans are enrolled in fee-for-service policies, compared with 91 percent for Medicare and 77 percent for Medicaid.

Instead of negotiating with HMOs to secure the best market price in a particular region, the federal government decided to set a uniform national formula that paid HMOs for each enrollee 95 percent of the average area per capita cost of insurance in Medicare's fee-for-service plan, even though managed care plans typically reduce costs by 10-20 percent. Moreover, a disproportionate percentage of Medicare patients initially signing up for HMOs were relatively low health risks, which in a market setting would reduce the price even further.

Ironically, the Medicare HMO program has often been cited as an example of managed care's limited potential to produce cost savings. That conclusion is not surprising given the current structure. If you fix the price of managed care at a high percentage of current costs, and then fail to make a reimbursement adjustment for risk-skimming, then savings will by definition be meager. Privatization without competition is self-defeating.

Generally speaking, states have been much more willing to fully utilize managed care strategies to hold down costs for Medicaid beneficiaries, either by enrolling them in managed care plans, or by adopting case management systems for beneficiaries' primary care. However, the federal government has historically frustrated state use of managed care in Medicaid. A fee-for-service system was required for Medicaid until 1981, and under the Reagan and Bush Administrations, waivers to experiment with managed care had limited participation. The Clinton Administration has moved aggressively to give waivers for managed care to the maximum extent allowed by federal law, but the law itself still strongly favors the fee-for-service approach.

Building a Buyer's Market in Medicare and Medicaid

The most efficient and equitable way to restrain Medicare and Medicaid costs is to make a fundamental commitment to a competitive system. Such a system should:

- ▶ use market mechanisms to determine the proper levels of supply, demand, and price for health care services;
- ▶ protect the value of the subsidy offered to beneficiaries, while avoiding unlimited subsidies;
- ▶ maintain the collective purchasing power of Medicare and Medicaid and, to the maximum extent possible, increase it through active negotiation of terms among competitors;
- ▶ enable beneficiaries to become informed and cost-conscious consumers of health care services, rather than passive recipients;
- ▶ align Medicare and Medicaid with trends towards cost-effective care in the private sector;
- ▶ create a privately run, decentralized system to deliver health insurance for beneficiaries, reflecting regional market conditions and maximizing consumer choice;
- ▶ limit government's role to its essential functions: setting and enforcing ground rules for fair and effective competition, and financing the subsidy to beneficiaries.

The basic model that meets these criteria is "managed competition," in which the sponsor of health benefits (whether it is a private employer or a government) organizes and negotiates a menu of health plans for its beneficiaries and lets the market set the

price paid for a pre-established set of benefits. As Paul Elwood and Alain Enthoven, the leading experts on managed competition, have observed: "the market works in health care because multiple purchasers, not just the government, can introduce bold new methods of buying health care and because providers and insurers can respond with new approaches to organizing and paying for care."⁷

In other words, competition among private health plans creates a market for health insurance, while managing the competition creates a buyer's market. Sponsors aggregate the purchasing power of thousands of consumers so they can demand higher quality care at lower prices.

It is important to avoid confusion between managed competition, which is a system, and "managed care," which is a frequently successful strategy for competing in such a system. Managed competition leads to managed care only to the extent that the latter delivers high-quality care at a lower price than alternative strategies.

By increasing competitive pressures on providers, managed competition has accelerated the movement toward managed care. Managed care plans are rapidly replacing the traditional model of independent doctors working on a fee-for-service basis. Today, three out of four of the nation's doctors participate in a managed care plan.⁸ Managed care organizes primary care providers and specialists into networks that charge a fixed sum for each patient, arrangements which gives providers a strong incentive to do more with less.

Managed care networks consequently stress primary and preventive services that reduce future costs, while avoiding procedures that do nothing to improve a patient's health. For example, patients in fee-for-service plans who have had hip replacement surgery receive rehabilitation training while they are in the hospital rather than before surgery, thereby extending hospital stays for more than two weeks. In contrast, hospitals in California's competitive marketplace and elsewhere have begun to provide the rehabilitation training before the surgery which has helped patients return home within an average of three days when combined with home health care.⁹

Critics of managed care say the incentives to lower costs will lead to under-treatment. But a managed care plan that under-treats its patients risks damaging its bottom line as well as its reputation, since it will be responsible for the higher costs of remedial treatment and payments to settle malpractice suits. The same incentives for lower costs, to be sure, can lead poorly managed plans to restrict doctors' ability to order necessary tests and treatments. Worse yet, unscrupulous plans might scrimp on care to the seriously ill, hoping to drive them to other plans. That's why advocates of managed competition propose "report cards" that consumers can use to hold health plans accountable by grading their patient retention, satisfaction, and outcomes.

More importantly, managed competition stimulates continued innovation in the form of a delivery system taken by managed care plans. This process is well under way

in the private sector. To compete, providers and insurers form networks that coordinate care. Some organize as HMOs, which tightly manage the delivery of medical care but eliminate most of the extra charges to patients who need care. Other networks such as Preferred Provider Organizations (PPOs) are more loosely organized and curb patients' demands by requiring them to pay a portion of the cost of their care and by restricting choice of physicians to those who are willing to accept PPO payment levels. As consumers choose from among competing HMOs and PPOs, their preferences help to shape the evolution of the delivery system.

As applied to Medicare and Medicaid, managed competition would not dictate any particular model of service delivery. It would, however, eliminate the current system's strong bias for a particular model—fee-for-service medicine—that as currently constituted is not competitive in terms of price or value.

Reforming Medicare

Step 1: Privatize Insurance for Medicare Beneficiaries. The first and most crucial step in applying managed competition to Medicare is to create real competition among private health plans in the Medicare market.

The current practice of pegging Medicare's payment to private health plans to the average area per capita cost of fee-for-service coverage would be abandoned, and along with it the requirement that private plans offer additional services to attract recipients.¹⁰

Instead, private plans in each regional health care market would post bids for the price they would charge to deliver the current benefit package for HMOs as defined in federal Medicare law. The price would be the same for both sick and healthy Medicare beneficiaries and no one could be excluded from coverage if they had a pre-existing condition. Medicare would then fix the payment level in each market at the average of the posted bids.¹¹

The HMO benefit package has been chosen as the initial benchmark for setting the government's contribution to private plans for a simple reason: HMOs are the only private plans that the government currently allows to compete for Medicare business.

The reform effort should immediately allow plans offering similar coverage through different delivery system models to compete for Medicare beneficiaries. (PPOs, for example, offer coverage similar to that of HMOs, but with higher cost-sharing by beneficiaries.) Their posted prices, however, would not be taken into consideration in establishing the government's contribution, because they are not offering the benchmark benefit package. As will be discussed later in this paper, the benchmark benefit package must be continuously revised to allow greater flexibility in how benefits are organized in the private sector.

Plans whose posted prices were below the market price for the benchmark benefit package could offer enrollees the difference, either as a cash rebate or as additional services. Conversely, beneficiaries who enrolled in plans with a posted price above the market average would pay the difference as a premium.

This system would obviously exert powerful downward pressure on prices for private plans competing for Medicare business. But even those plans with posted prices above the market average would maintain considerable competitive appeal since enrollees would typically avoid out-of-pocket costs for medigap policies (private insurance covering Medicare's deductibles and copayments) that far exceed any likely premium. To encourage direct competition between managed care plans and the combination of fee-for-service Medicare and medigap policies, Congress should prohibit medigap underwriters from denying coverage to beneficiaries who have earlier switched to managed care and want to switch back.

As soon as possible after the introduction of real competition among private health plans, Medicare's own fee-for-service plan should be made to compete with private plans on an equal basis.

Congress should give the Health Care Financing Administration (HCFA), which currently administers Medicare, new authority to operate the fee-for-service plan as a competitive enterprise, with the same kind of cost-management tools that are commonly used by private health plans. For example, case managers could coordinate the care of high-cost patients to avoid duplications or unnecessary treatments. A recent study of the Medicare fee-for-service plan by health policy expert Lynn Etheredge concluded: "Like Gulliver tethered by many bonds, the Medicare program's effective use of its purchasing power is held back by numerous technical constraints, some of which are appropriate to a rule-making administrative style, but not to a business-type operation."¹²

HCFA should also have the authority to set its premiums, provider payments, and cost-sharing measures just as private plans do. Medicare's fee-for-service plan would have to find the right balance between charging higher premiums at the risk of losing patients, or lowering provider payments at the risk of losing providers.

Alternatively, Congress could authorize HCFA to contract with private insurers to manage the fee-for-service plan on a local or regional basis. By requiring direct competition—and requiring beneficiaries to pay any differential between the regional market price and the fee-for-service premium—the new system will in effect abolish the current Medicare program's unconditional entitlement to fee-for-service health insurance.

Until this competitive reform is fully implemented, Congress and Medicare administrators would continue their current regulatory efforts to hold down excessive payments to providers in the fee-for-service plan, and to increase cost-sharing for beneficiaries. These efforts are important as a source of federal budget savings, and can

also strengthen the competitive position of private health plans, especially in high-cost markets.

To create and oversee the new pricing system, and to reflect a basic shift in Medicare's philosophy, Congress should divert funds from HCFA to endow a separate "Office of Competition" within the Department of Health and Human Services. This step would create a clear separation between Medicare's old role of operating its own fee-for-service plan, and its new role of setting the ground rules for competition among private plans.

Another key reform that should be taken early is to begin encouraging Medicare beneficiaries to act as informed, responsible consumers with a real stake in the choice of coverage rather than as passive recipients of a government entitlement. Once the proposed Office of Competition is up and running, it would establish for each Medicare beneficiary a Health Purchasing Account, which is simply the amount Medicare will make available for the purchase of a private health plan.¹³ Beneficiaries would receive an annual statement that would include this figure along with clear and useful information on their choices. In addition, the statement would include HCFA's estimated price for its fee-for-service plan (for information purposes only during this first phase).

Step 2: Create Voluntary Consumer Purchasing Cooperatives. The second key step in reforming Medicare is to shift the arena of competition for Medicare business from a single, government-run menu of options to multiple, competing menus organized by private consumer cooperatives. This step can be taken within three to five years, perhaps phased in by regions of the country.

Under a government-run competitive system, the administrator is a "price-taker," with no real leverage over private health plans. Private employers, by contrast, are "price-makers," who bargain actively to get the best possible deal.

To give Medicare beneficiaries (and indirectly, taxpayers) the economic value of a price-making buying agent, they should have the opportunity to join voluntary consumer cooperatives with the power to negotiate on their behalf and create a menu of competing plans. These cooperatives would be financed by retaining a small, fixed percentage of the insurance premiums they handle.

Though a health care co-op may sound exotic, it is really nothing more than a voluntary, private sector version of the Federal Employee Health Benefit Plan (FEHBP), which offers its members a broad choice of competing private health plans, at prices that are negotiated by its administrators. Of course, most employer-sponsored health programs do not give employees much choice in plans, and even FEHBP does not give employees the opportunity to choose from different *menus* of plans. Thus, health care co-ops capture the best features of employer-negotiated health insurance while vastly increasing the choices for beneficiaries.

A broad array of institutions could help establish consumer health care co-ops for Medicare beneficiaries. The American Association of Retired Persons is an obvious candidate. Large companies (or even governments) might form co-ops for providing benefits to their retirees. All co-ops would be chartered by the federal government to negotiate with health care plans to get the best price and present beneficiaries a menu of choices along with comparative information. They would also provide a basic educational role as beneficiaries learn how to make their own choices.

If not enough co-ops are organized in any given regional market such as rural areas, the federal government could offer its own menu of options, as in the earlier phase of reform. An even simpler fall-back approach would be to allow FEHBP to offer its health benefit menu to Medicare recipients in a region unserved or under-served by private co-ops such as rural areas.

Co-ops would play a key role in monitoring quality. They would collect and disseminate report cards on each plan. The development of report cards recently received a major boost when leaders of the nation's largest private and public purchasing systems, representing more than 80 million Americans including Medicare and Medicaid beneficiaries, agreed to establish a common checklist of quality indicators. The aim is to provide consumers with information to differentiate among health plans based on their actual results in treating several diseases, including breast cancer and asthma.¹⁴

The government's contribution to each beneficiary's health purchasing account would be tied to the average price for the benchmark package of benefits offered by health plans competing in the co-ops for a given region. As in Step 1 of Medicare reform, plans with a lower-than-average price (including those offering a somewhat different benefit package, like PPOs) could make available rebates or additional services, while those with above-average prices would charge a premium. The federal government would continue to send beneficiaries an annual statement of their Health Purchasing Account, which would now focus on informing consumers of their choice of co-ops rather than individual plans.

This dual competition feature—among plans and among co-ops in each region—would help hold down costs while maximizing consumer choice. Co-ops could be expected to market themselves to potential members on the basis of their record in negotiating prices below the market average and in offering a good variety of options. Beneficiaries would be locked into a particular co-op no longer than the term of the particular plan they choose.

Meanwhile, the federal government's Office of Competition would continue to refine the definition of benchmark benefits for private plans enrolling Medicare beneficiaries. The goal should be to shift the benchmark of what government ensures beneficiaries from an entitlement for specific medical services to coverage of treatable health conditions. This approach would give insurers the flexibility to design benefits

packages that promote effective prevention, diagnosis, and treatment of health conditions. In fact, health care co-ops should be given the power to experiment with variations on the government's benchmark package (e.g., providing greater cost-sharing or eliminating services that beneficiaries do not want), so that competition among co-ops would influence the design of benefits as well as their price.

One type of benefit design in which careful experimentation is especially needed is the high-deductible policy under which beneficiaries accept higher personal risk for health care expenses in exchange for lower insurance premiums. The strong cost-sharing feature of such policies arguably makes them effective in reducing demand for unnecessary routine health services. On the other hand, they are especially attractive to beneficiaries who are in good physical and/or financial health, especially in a system that allows consumers to retain a portion of the government's subsidy to pay for out-of-pocket expenses (through a Health Purchasing Account or some more restricted mechanism like a Medical Savings Account). Thus, the availability of high-deductible policies in a competitive system creates a strong tendency toward concentrating high- and low-risk beneficiaries in separate plans, which defeats the risk-spreading purpose of group health insurance.

Co-ops should be required to test the use of high-deductible policies before making them widely available, and also to design remedies to compensate for any problems they create.

Step 3: Means-Test the Medicare Subsidy to Promote Efficiency and Equity. The third step in reforming Medicare, which should be enacted once the competitive system of private co-ops and market-based prices is in place (i.e., in five years), is to take a fresh look at the current uniform eligibility rules for the Medicare subsidy.

In fact, the shift to a competitive system makes this re-evaluation a logical development. Medicare beneficiaries will no longer be entitled to an unconditional, uniform set of "free" medical services. Instead, they will be receiving a market-based subsidy for the purchase of private insurance. The amount of the subsidy will vary by market and by year, and each beneficiary will determine the percentage of the subsidy they actually spend on health insurance (within the limits of the available co-ops and plans).

The competitive system itself creates one strong argument for reducing the Medicare subsidy for affluent beneficiaries.

As economist Mark Pauly and others have observed, in order to make consumption of health care equal among different income levels, the level of insurance coverage, and hence the amount of the subsidy must be unequal.¹⁵

Over-utilization of services is clearly part of the cost problem affecting Medicare. Both managed care strategies and cost-sharing requirements are aimed at reducing this

over-utilization. But affluent beneficiaries are much less attracted to managed care plans, and much less sensitive to deductibles, than low-income beneficiaries. Lowering the subsidy would likely lead many of the affluent to choose plans with deductibles high enough to affect their rate of utilization. Recognizing this economic principle, about 10 percent of the nation's largest employers now require a higher deductible policy for their highest-paid employees.¹⁶

If income-based adjustments to the Medicare subsidy are helpful to the system's efficiency, they are essential to its fairness. Medicare's most glaring inequity is that low-wage workers—many of whom lack health insurance—pay taxes that fund the health care of wealthy older Americans. Most of the country's 41 million uninsured are workers earning moderate to low wages and their dependents.¹⁷ The burden of Medicare's payroll tax falls most heavily on those least able to pay, because payroll taxes are a fixed percentage of wages or salary.¹⁸

A more equitable and efficient subsidy would be based on beneficiaries' income. In determining how to reduce the subsidy for affluent beneficiaries, two important considerations must be kept in mind.

The first consideration is to avoid reducing the subsidy in a way that will lead beneficiaries to simply drop coverage. This could occur even at relatively high levels of income: In the non-Medicare population, 12 percent of workers and their families with annual incomes over \$50,000 are uninsured for at least some portion of each year.¹⁹ Of course, retirees are generally more risk-averse than the young and more likely to need care, and would thus be less likely to forgo coverage if they had no subsidy. But the problem is real even for Medicare beneficiaries. For this reason, all but the wealthiest should receive some subsidy.

The second consideration is to avoid creating a disincentive for work and savings. Like a high marginal tax rate, a sharp reduction in the subsidy as incomes rise will naturally discourage income-generating activity.

For both these reasons, it would be best to spread the reduction in benefits over as broad an income range as possible. For example, phasing out Medicare's current average benefit level of \$4,800 over an individual income range from \$25,000 to \$125,000 would mean that retirees would lose only 48 cents for every \$10 of additional income, which is equivalent to a 5 percent marginal tax rate. Of course, with lower marginal tax rates, less revenue will be generated.

When the subsidy is first reduced, a special provision should be made for older retirees, who are least able to adjust to new financial circumstances by generating new income. For example, the income threshold for beginning to reduce the subsidy could be increased by \$1,000 for each year of age beyond 65. Thus, a retiree who is 85 when the income-tested subsidy reduction goes into effect would not lose any benefits until

his or her individual income reached \$45,000, and would not lose the subsidy entirely until the income level reached \$145,000.

A more fundamental equity problem with the Medicare subsidy is one that affects all future beneficiaries: eligibility for full benefits at age 65. As life expectancy has increased, new retirees have received an ever-increasing amount of benefits. To keep benefit levels constant, Medicare's eligibility age must be regularly increased. Specifically, since today's retirees are projected to live two years longer than the original Medicare beneficiaries,²⁰ the current retirement age should be gradually increased to age 67 by adding two months each year to the retirement age. An increase in the Social Security retirement age has already been enacted so that someone who is now 35 won't receive full benefits until age 67, and someone who is now over age 56 will not be affected. Additional increases to age 70 are warranted by the projected growth in life expectancy and the long-term financing needs of both Social Security and Medicare. These steps should be taken only as subsidies are enacted for all the poor, including older Americans nearing retirement, so that the number of uninsured does not increase.

Reforming Medicaid

Medicaid differs from Medicare in several crucial respects that influence the proper strategy for competitive reform.

First and most obviously, Medicaid is partly financed, and wholly administered, by the states, subject to federal rules. Thus, short of an abandonment of the federal-state partnership, Congress cannot create a uniform competitive system for Medicaid. Conversely, if Congress arbitrarily limits the federal government's financial contribution to Medicaid in a way that neither guarantees adequate resources nor encourages competitive reforms—as in block grants—then the country has no assurance that Medicaid will operate in an efficient or equitable way in any given state.

Second, Medicaid is already an income-based program. With the partial exception of long-term care (discussed immediately below), the primary concern in subjecting Medicaid to market discipline is not that the government's subsidy may be excessive, but that it may be inadequate, which would affect both the efficiency and equity of the system.

Third, Medicaid has two key components, acute care and long-term care, with very different characteristics and problems. Medicaid's long-term care program has become in effect a middle-class entitlement to nursing home care, which undermines alternative and more cost-effective options for ensuring custodial care in cases of long-term disability. Limiting use of the nursing home entitlement is probably the most crucial step in strengthening market forces in long-term care.

Thus, federal Medicaid policy must focus on encouraging states to adopt competitive reforms; it must take into account the special characteristics of the Medicaid-eligible population; and it must distinguish between acute and long-term care.

Medicaid Acute Care: Cap Per Capita Spending and Allow States to Adopt Competitive Reforms. As President Clinton proposed in his revised federal budget proposal for FY 1996, federal payments to states should be capped on a per person basis and states should have much greater flexibility to administer the program, within the context of broad accountability for results.

Unlike the aggregate cap on Medicaid spending implied in the block grant concept, a per capita cap would fairly reflect variable future trends in state populations (and in the percentage of population in poverty), and would not discriminate in favor of states that have in the past been excessively generous in offering services or egregiously inefficient in delivering them.

The inefficiency (and resulting inequity) of Medicaid's open-ended subsidy to states is illustrated by the extraordinary disparity of costs among the states. The variation was fourfold in 1993, from a high of \$9,700 per beneficiary in New Hampshire to a low of \$2,381 in Mississippi.²¹ Focused quite naturally on their own expenditures, some states have sought to hold down Medicaid costs, while others have adopted the strategy of maximizing federal payments: Federal Medicaid policy encourages the latter approach as much as the former.

The per capita cap would initially be set at current per capita spending for each state, including both acute care and DSH payments. The goal would be to adjust the caps so that within five years, all state caps would be at the national average, adjusted for cost-of-living differences. During this five-year period, the annual rate of increase for Medicaid would be limited to the same growth as for private plans operating under Medicare. Since the cap would apply to total federal and state Medicaid expenditures, it would not affect match rates. The goal would be achieved by lower-than-average increases in the cap for high-spending states.

Existing federal laws governing eligibility for Medicaid and mandated optional services for Medicaid beneficiaries would initially remain in place, with two key exceptions: (1) All legal restrictions on state use of managed care strategies would be repealed, and (2) the Boren Amendment, intended to force adequate provider reimbursements, would also be repealed for states that adopted a competitive system. States could in theory remain within their per capita cap by improving efficiency, eliminating optional services, or some combination of the two.

Congress should begin as quickly as possible to develop a new minimum benefit package for Medicaid that is consistent with the evolving delivery system for medical services, similar to the Medicare HMO benefit package. More generally, federal and state officials should work together to develop a set of outcome measurements for state

Medicaid programs similar to the report cards increasingly used by employers to rate the quality of health plans.

To reflect the Medicare reform proposals discussed earlier, the cash value of the supplemental coverage that states now provide for low-income Medicare beneficiaries would be contributed to a health purchasing account at the beneficiaries' request. That way they could use these funds to supplement the cost-sharing requirements of the benchmark benefits package.

Unlike a Medicaid block grant, this proposal would keep states accountable for the use of federal funds, while giving them the flexibility to improve efficiency. States would be strongly encouraged to save money by using competition rather than by reducing health care coverage or restricting eligibility.

In five years, all states will be operating under a national per capita cap. Furthermore, under current trends, reinforced by federal flexibility and cost containment measures, most Medicaid beneficiaries will be enrolled in private health care plans. In fact, many states will probably be operating a competitive system similar to the one proposed earlier for Medicare.

Since the system of competing plans and private consumer cooperatives for Medicare will be up and running within five years, Medicare cost inflation from that point on is the most appropriate peg for future adjustments in the Medicaid per capita cap.

If, contrary to logical expectations, any state is unable or unwilling to meet national outcome standards for Medicaid within the financial constraints of the per capita cap, then at this juncture Congress should impose the same competitive system operating for Medicare, with appropriate adjustment to reflect the different needs of the Medicaid population.

All states will have the option of enrolling their Medicaid beneficiaries in the private regional co-op system. States would essentially serve the same limited function—establishing minimum coverage, ensuring fair competition, and offering a fixed-sum subsidy—in the co-op system that will be performed by the proposed Office of Competition for Medicare beneficiaries.

Medicaid Long-Term Care Step 1: Cap Per Capita Spending and Promote Alternative Sources for Care. In contrast to Medicaid acute care, the problem with Medicaid long-term care is not simply one of excessive per capita costs but of excessive enrollment, since its availability on a fee-for-service basis has undermined alternatives that most middle-class families could afford, such as private long-term care insurance. As the average age of the U.S. population continues to rise, the potential costs associated with Medicaid long-term care are ominous.

There is no readily available strategy to reduce per capita costs for long-term care, comparable to the well-tested forms of managed care used for other health services. Furthermore, there is no more than a small (if growing) private market for spreading the risk of long-term disability costs through insurance policies.

Congress should immediately adopt four reforms to begin restructuring the delivery and financing of long-term care, while holding down public costs.

First, Congress should impose the same type of per capita cap on long-term care spending as was proposed earlier for Medicaid acute care: A cap that over five years adjusts each state's cap to the national average.²² Annual increases during this five-year period would be limited to the cost growth of similar nursing home and home health care services offered under Medicare.

Second, Congress should allow states significant new flexibility to determine the right mix of long-term care services (e.g., home health care and intermediate care, along with skilled nursing care) for their populations. With such authority, states could establish either public or private managers to coordinate long-term care services.

Third, in a key exception to the general rule of state flexibility, Congress should require states to allow every Medicaid beneficiary who is enrolled in a Medicare HMO to receive both long-term care and acute care through the same organization. HMOs that offer such services are called social HMOs. At the request of the beneficiary, the state Medicaid program would be required to pay a social HMO a fixed monthly amount equal to what the state would have otherwise spent.

Fourth, Congress should promote greater use of private long-term care insurance, as follows:

- ▶ Allow states to establish partnerships with private insurers to limit Medicaid's share of long-term care costs, as several states have already begun to do on an experimental basis.²³
- ▶ Authorize states to use Medicaid administrative funds to initiate an educational campaign to promote the use of private long-term care insurance. The message of this campaign, aimed at both young and old, would be: "You will not be able to rely on Medicaid for long-term care unless you lose your savings and assets first. If you want to keep your savings and assets for yourself and your family, buy private long-term care insurance."
- ▶ Make minor changes in current tax law to permit the sale of innovative long-term care insurance products. For example, if life insurance policies can pay long-term care benefits, which would otherwise be taxable income,

insurers will be able to offer a more attractive product because of its multiple purposes.

We should reject the proposal to encourage long-term care insurance through the tax code included in the Contract with America: extending the current exclusion from taxable income applied to employer health insurance contributions to long-term care policies. While well-intentioned, this proposal is poorly targeted, because it would subsidize at taxpayer expense the purchase of long-term care insurance by people who will never qualify for Medicaid under any circumstances. Thus, the massive potential loss of tax revenue would not be offset by Medicaid savings.

Finally, both public and private experts need to immediately begin addressing the poorly developed state of the art in assessing long-term care needs and measuring the performance of various long-term care services. A model for such an effort might be the Foundation for Accountability, recently formed by the Jackson Hole Group, a health policy research organization. This foundation will set outcome measures for the quality of medical care that can be used by consumers and providers alike. A similar initiative in the long-term care field would give policymakers tools to evaluate the effectiveness and efficiency of state programs and lead to a performance basis for federal payments to states.

Medicaid Long-Term Care Step 2: Impose a Broad Funding Limit and Adopt New Standards. After five years of federal and state efforts to promote alternatives to the current Medicaid long-term care system, Congress should squarely address the oversubscription problem by limiting total expenditures by state.²⁴ States would then have the choice of covering a larger number of beneficiaries at a lower cost, or a smaller number at existing costs. In addition, states would be allowed to make total family income (i.e., including the income of children) the key factor in determining eligibility for long-term care services under Medicaid, which could both restrict eligibility and promote family responsibility.

As soon as a consensus has developed on standards for assessing long-term care needs and measuring the performance of services, Congress should adopt them as a means of holding states accountable for use of federal funds, either through positive incentives or negative sanctions, or both.

The Health Net

Within five years, this proposal creates a system of government-authorized, privately operated health consumer cooperatives offering competing menus of competing private health plans, required for Medicare beneficiaries and strongly encouraged for Medicaid beneficiaries. This system represents much more than a cost containment strategy for public health care entitlements. In fact, it could and should operate as an infrastructure to maximize competition and consumer choice for a broad array of public and private health care services.

In effect, this "web" of competition and information is, to use a computer concept, a "switch": A common frame of reference that allows different systems to communicate and interact.

The federal government can radically intensify the usefulness of this switch—this health net—by creating electronic links with all the elements of the competitive system: beneficiaries (who would have on-line access to purchasing account information and transactions), co-ops, and private health plans. Existing technology is more than sufficient to make this possible, and by the time the system has been implemented, improvements in telecommunications and in user-friendly computer software are expected to spread the use of on-line services to a large percentage of the American population, including the elderly.

This step would create pathways whereby all these players in the system could communicate with each other (e.g., plan and co-op price and enrollment information, or providers compiling or transmitting medical records) and with those offering related services or information (e.g., medigap policy underwriters, prescription drug suppliers, researchers evaluating the performance of plans and medical practices, or even private providers billing their patients). As with the best-known "network of networks," the Internet, confidential information could be encrypted, while general access could be virtually universal. Further, the creation of this huge new market will undoubtedly stimulate the development of new products to expand the usefulness of the health net (for example: software to use information from the Health Purchasing Account to create a personal or family health care budget).

Dee W. Hock, who created the decentralized but nearly universal VISA credit card system, was the first to envision the application of similar principles to health care information and transactions. According to Hock, the key is a system in which "the whole does not control the parts and none of the parts control the whole."²⁵

Ultimately, the health net could produce a radically decentralized "virtual marketplace" for health care information and transactions—enabled by government action, but privately operated and owned by no one but open to all. As a universal "clearing system," the health net could greatly improve the efficiency of health care markets generally, not just those involving Medicare or Medicaid beneficiaries.

From Entitlement Reform to Health Care Reform

Aside from creating a health net, the Medicare and Medicaid reforms proposed above would represent a fundamental transformation of the government's role in financing, regulating, and delivering health services.

Today, the United States operates a balkanized system in which some citizens obtain health insurance in the private marketplace, some enjoy an entitlement to government-sponsored insurance, and some go without insurance at all.

If the proposed reforms are implemented, we would have a single, private, competitive system for purchasing health insurance. Some citizens would receive a direct subsidy in the form of a payment by Medicare or Medicaid. Many others would receive a subsidy in the form of the current exclusion from taxable income of employer contributions to health care benefits.

Two anomalies will remain: First, while the Medicare/Medicaid subsidy will be fixed by market competition, the tax subsidy for employer health benefits is still open-ended.

Second, millions of Americans—the uninsured—receive no subsidy, even though they need it most, and even though as taxpayers they help subsidize everyone else.

Capping the Tax Subsidy. The first anomaly should be tackled head-on, by capping the tax subsidy for employer-sponsored health benefits at the current per person average. Future adjustments to the cap could be linked to increases in the Medicare subsidy, once the competitive system is in place.

In fact, aside from its equity features, a cap on the tax subsidy for private employer benefits is essential to the overall efficiency of a market-based system. An open-ended tax subsidy helps push up medical inflation in the same manner as the current open-ended subsidy for Medicare and Medicaid insurance. Both should be capped and linked to market prices.

The Uninsured. Once we have limited the Medicare/Medicaid subsidy through a competitive system, and limited the tax subsidy through a market-based cap, we should have the resources and the clear direction to deal with the last great anomaly of the current system, the uninsured.

Ironically, while we have failed so far to agree on a limited subsidy to ensure that everyone has health insurance, the system provides an unlimited, and often hidden subsidy for most of the uninsured, through uncompensated care. Hospitals cannot legally deny emergency care to the sick or injured even when they do not have a way to pay for it. Public and nonprofit facilities provide uncompensated non-emergency services, as do many individual providers. These costs are absorbed elsewhere in the system, sometimes through cost-shifting, sometimes through budgets for public facilities, and sometimes through such indirect methods as Medicaid's DSH payments.

It is time to make the subsidy for the uninsured explicit, rational, and fair, especially as we move toward a more efficient overall system in which markets allocate resources and their costs. Indeed, as more and more providers begin to compete on the basis of price and quality of care, they will have less and less opportunity to absorb or shift the cost of uncompensated care.

Furthermore, subsidies for the uninsured are the only way to assure the success of basic private insurance reform, which is probably the health care initiative with the strongest public support. Without broad subsidies, banning exclusions for pre-existing conditions or experience-rating by underwriters will disrupt insurance risk pools by encouraging high-risk individuals to enter the market without an offsetting increase in insurance purchases by low-risk individuals. The effect would be to increase insurance premiums for everyone.

Congress could take the first step toward addressing the problem of the uninsured by dedicating the revenue it will raise through capping the tax subsidy for employer-provided health benefits to a federally funded expansion of Medicaid eligibility to cover all Americans below the poverty line. This step would cover nearly one-third of those currently without health insurance. Partial subsidies for those above the poverty line, and a mandate that everyone purchase insurance coverage, are both necessary steps to make sure all young and healthy individuals contribute to insurance pools that pay for the care of older and sicker individuals.

Once all the anomalies in a competitive system have been addressed, the superficial differences between various public subsidies—hidden tax expenditures and explicit subsidies—will become transparent. At that point, it should be possible to rationalize the obsolete programmatic structure of Medicare and Medicaid, along with other subsidies, to reflect the emerging reality of a unitary system.

Democratic and Republican Alternatives

Medicare—Variations on an Old Theme

As noted in the introduction to this paper, neither party has proposed in 1995 the kind of system change for Medicare which PPI proposes—much less a path to comprehensive health care reform.

For the most part, congressional Democrats have supported the status quo approach to health care entitlements in the face of conservative demands for deep budget cuts. Some Democrats oppose any significant reductions in spending on health care entitlements, while others support substantial reductions, but less than those called for in the Fiscal Year 1996 Republican budget plan: \$270 billion for Medicare over seven years, and \$183 billion for Medicaid, using Congressional Budget Office (CBO) estimates.

The President's Medicare proposal claims seven-year savings of \$124 billion (using the Administration's estimates) with most of the savings coming from reductions in provider payments. His plan also proposes more extensive and effective experimentation with managed care, avoiding the current system's self-defeating use of fee-for-service prices to fix a uniform formula for payments to HMOs.

Clearly, the President's proposal moves in a direction that lays the groundwork for a truly competitive system in which market forces set the price for Medicare services. But so long as the system maintains an entitlement to a government-run fee-for-service plan that insulates beneficiaries from its real costs, it imposes an artificial limit on the cost savings that competition can produce.

On September 14, 1995, House Republicans unveiled a broad outline of their long-awaited Medicare reform proposal, entitled *The Medicare Preservation Act*. Senate Republicans indicated their proposal would differ only in minor respects.

In this new proposal, Republicans all but abandoned any effort to achieve Medicare savings through a competitive system, opting instead for regulatory measures to squeeze savings from beneficiaries and providers.

Roughly \$70 billion of the \$270 billion the Republicans claim to save over seven years would come directly from increases in the premium beneficiaries pay to participate in Medicare Part B (payments to doctors). Remarkably enough, the plan raises money through the one kind of beneficiary contribution that does not—unlike copayments and deductibles—generate additional savings by discouraging over-utilization of services.

The remaining savings would have to come from some combination of efficiency savings and reductions in payments to providers.

GOP leaders claim their proposal will save unspecified billions for taxpayers through efficiency improvements. In fact, the plan does little or nothing to encourage market efficiencies in Medicare. Furthermore, savings produced by expanded enrollment in private health plans are retained by beneficiaries, and thus cannot reduce government spending.

The so-called "Medicare Plus" feature of the Republican proposal, which allegedly aims at promoting much greater enrollment in private health plans, is really no different than the current Medicare HMO option, and shares its crucial shortcomings.

Like the existing system, it promotes limited privatization, but without the competition that can produce real savings. Private plans certified in the Medicare Plus system would be paid a fixed amount by the federal government based on the average cost of fee-for-service Medicare coverage. Plans that can produce equivalent coverage at a lower cost could not offer the government a lower price. Instead, they are required to offer beneficiaries additional coverage.

The one significant innovation in Medicare Plus is the availability of a Medical Savings Account option. Styled as "Medisave," this option would allow Medicare beneficiaries to buy a high-deductible, catastrophic insurance policy. Any difference between the cost of this policy and the amount Medicare pays to private health plans

under Medicare Plus could be retained by the beneficiary in a Medical Savings Account for routine medical expenses.

As critics have often noted, the high-deductible policy made available in this option will be most attractive to the healthiest of Medicare beneficiaries. If such beneficiaries leave the traditional Medicare program in great numbers, the cost to the government of insuring the rest of the Medicare population will go up. That is why our proposal urges caution and careful monitoring in experimentations with high-deductible policies, while the GOP plan makes it an immediate option for all Medicare beneficiaries.

In addition, the Medisave option will further undermine the already weak incentives the proposal provides for enrollment in a managed care plan, reducing still further the already marginal savings they can produce.

Overall, there is no reason to believe that Medicare Plus will produce any efficiency savings at all, and in fact, the Medisave wrinkle could force costs up.

Thus, the GOP plan relies decisively on government-imposed reductions in payments to providers to achieve its fiscal goals—to an extent never before proposed by either party. In fact, the proposal anticipates the need for additional rounds of provider cuts in the future by including a so-called "fail-safe" provision, which would automatically reduce provider payments in any year where costs exceeded the budget.

As noted earlier, excessive regulatory control of provider payments has in the past produced a variety of perverse results, including cost-shifting to private payers and reduced participation by providers. Since the magnitude of provider cuts contemplated in this proposal exceeds all precedent, it is reasonable to ask whether Republicans are risking previously unimagined levels of cost-shifting, or a massive exodus of providers from the system.

Conversely, the backlash against excessive provider cuts could lead Congress in a different direction to keep Medicare on budget—perhaps through even higher contributions by beneficiaries, or perhaps through reductions in the value of their benefits. Indeed, the impossible fiscal arithmetic of the Republican budget plan led most observers to expect voucherized benefits—a popular conservative reform strategy—as part of the Medicare proposal.

Instead, the plan outline goes out of its way on two occasions to emphasize that it does not include vouchers, does not require beneficiaries to make choices on the price of private health plans, and does not modify the current relationship between the government, the beneficiary, and the private insurer.

A brief discussion of the "Medicare Voucher" approach is helpful, because Republicans may return to the concept in the future if their plan is rejected or if it predictably fails to generate the budget savings it claims.

The basic thrust of various voucher proposals is to allow beneficiaries to individually purchase health insurance (and/or to cover out-of-pocket medical expenses) in an amount roughly equal to current per capita Medicare spending.

In its purest form, as proposed by the Cato Institute and the National Center for Policy Analysis, Medicare vouchers would represent a radical deregulation of publicly financed health care for the elderly.²⁶ The federal government's role would be limited to financing the voucher; its actual value in terms of health insurance would be set by the marketplace. Vouchers would eliminate all the current system's inefficiencies in terms of encouraging undisciplined demand, offering open-ended subsidies for providers, and setting arbitrary prices. But they would substitute the inequities of an unregulated private insurance market, such as exclusions for pre-existing conditions, prohibitively high premiums for the chronically ill, and "risk skimming" by insurance plans.

By dismantling Medicare's collective purchasing power, vouchers would also expose many Medicare recipients to higher prices. Currently, 40 percent of the price of private insurance policies purchased by individuals goes towards administrative costs, compared with 5 percent for participants in large employer plans.²⁷

In effect, Medicare vouchers would constitute a limited federal subsidy for private health insurance—a sort of personal block grant. Assuming the voucher amount is fixed or otherwise arbitrarily limited, this approach would "save" Medicare's financial solvency, but at the expense of beneficiary health care: individually, because the price of insurance would depend on each beneficiary's risk analysis, and collectively, because beneficiaries would not have the advantage of Medicare's buying power.

In sum, Medicare vouchers would create a seller's market, not a buyer's market.

Medicaid—Caps and Block Grants

The President's FY 1996 budget proposes a per capita limitation on Medicaid expenditures similar to the cap proposed in this paper. In addition, the President has proposed to repeal laws restricting use of managed care and other cost-containment strategies in state Medicaid programs.

While the per capita limitation in the President's budget would also apply to Medicaid long-term care, neither the President nor congressional Democrats have addressed over-enrollment in long-term care or the need for private long-term care insurance.

On several occasions in the spring and summer of 1995, Republican congressional leaders and some Republican governors signalled their strong interest in changing the federal-state Medicaid entitlement program into a block grant, in conjunction with a

broad GOP block grant agenda that has already included welfare and crime legislation enacted by the House.

In sharp contrast to the game-day jitters Republicans succumbed to in pursuing the conservative agenda for reforming Medicare, it appears the GOP will go full-tilt towards Medicaid block grants, perhaps reflecting the relatively low number of reliable Republican voters among the Medicaid population.

In its most straightforward form, a Medicaid block grant would abolish all national eligibility rules for the program, along with any state responsibility to serve a specific population or appropriate its own funds, and would then give each state a fixed sum for indigent health care based on recent federal match payments.

The GOP's focus on insulating the federal budget from health care cost increases at the expense of beneficiaries is especially well-illustrated by the popularity of the Medicaid block grant concept. By converting federal Medicaid payments to the states to a discretionary account, Congress could and undoubtedly would limit future increases in funding to the amount necessary to achieve its budgetary targets, and let states sort out the implications in terms of eligibility, services, and costs. In fact, that is the most benign possible outcome from the point of view of the states and Medicaid beneficiaries: Some conservative theorists suggest that block grants for Medicaid and other social services areas would simply operate as a temporary "way station" on the road to total abandonment of federal responsibility.

Aside from the issue of the aggregate federal contribution to Medicaid, the distribution of federal funds to the states creates a host of technical problems and potential inequities. Since federal payments would be based not on the future number of eligible beneficiaries but on past distributions, states with rising populations (total and indigent) would be placed most at risk, and states with superior cost-management records would be penalized. For example, New York's Medicaid per beneficiary expenditures are two-thirds more than those of California, in part because California has aggressively promoted use of managed care strategies that New York has historically resisted.²⁸

The wrangle over a funding formula for welfare block grants, which has helped stall progress on welfare reform legislation in the Senate, is but a playground quarrel compared to the fight that is likely to emerge over distribution of Medicaid block grant funds, given the enormous share of state budgets that Medicaid represents, compounded by the complexity of the factors that will determine future state costs. At the July 1995 annual meeting of the National Governors' Association, Senate Majority Leader Bob Dole asked the governors to come up with their own proposal for a Medicaid block grant funding formula, to avoid a struggle in Congress.

The impact of a Medicaid block grant on beneficiaries and providers is obviously impossible to calculate, since the complex array of decisions affecting benefits and prices

made each year by Congress and the Administration would have to be played out in 50 states. Indeed, that is one of the proposal's political advantages for Congress: a block grant would insulate federal officials from the tough decisions involved in holding down Medicaid costs, which will inevitably affect powerful groups of providers and beneficiaries alike. Many state officials are publicly expressing concerns that the process of creating state Medicaid programs under a block grant would transform state politics in an unpredictable and potentially dangerous direction, with providers and advocates for the elderly demanding expanded resources at the expense of such critical state responsibilities as public education.

Indeed, the willingness of GOP leaders to demand that states re-create our most complex domestic program virtually overnight (in the House welfare block grant, states are given six months to move to the new system, but must reimburse the federal government for any spending that exceeds the block grant allocations) is another indication of the budgetary motives involved. Financing indigent health care has never been a responsibility that federalism advocates or state officials considered the natural or logical province of the states. It should be recalled that in 1982, President Ronald Reagan proposed to entirely federalize Medicaid as part of his "New Federalism" agenda. As recently as 1994, many Republican members of Congress supported a significant expansion of the federal entitlement to means-tested health care benefits.

Block grant supporters argue quite correctly that states could help hold down Medicaid costs if given greater flexibility to manage the program. But enhanced flexibility does not require the complete elimination of national eligibility standards or of the current federal-state cost-sharing system.

Furthermore, block grants provide flexibility in a way that sacrifices accountability for results. States will receive the same federal dollars whether they run efficient or inefficient Medicaid programs, and will not even have the political accountability that risking their own funds tends to supply.

In summary, block grants attack the wrong elements of Medicaid. The feature of the current system that feeds excessive cost increases is not national eligibility standards or a federal formula based on eligibility; the real problem, rather, is the open-ended subsidy for state spending, compounded by restrictions on the ability of states to fully use competition to restrain costs.

If that open-ended subsidy is limited by arbitrary aggregate caps on federal payments to states, rather than competitive forces, then federal Medicaid funding will inevitably become a political exercise far removed from a framework of genuine reform.

Market-Based Budgeting and Real Choices

The current debate over Medicare and Medicaid budgets is a fun-house mirror distortion of the real choices the country faces.

The much-discussed differences between the President's proposed reductions in health care entitlement spending and those enshrined in the Republican-sponsored FY 1996 budget resolution are grossly exaggerated by both sides, mainly due to differing economic assumptions.

If the two budget plans are placed on the same economic assumptions, half of the alleged seven-year difference vanishes (a disparity of \$146 billion for Medicare drops to \$75 billion, while a disparity of \$129 billion for Medicaid drops to \$60 billion).²⁹

Both parties are relying primarily on provider cuts to reach their budget targets, *without any clear knowledge about the ability of the system to absorb these cuts without major disruptions.*

In other words, whether the seven-year savings goal is \$270 billion, \$124 billion, or some other figure, the specific means of achieving the goal is almost entirely speculative. It is entirely possible, even probable, that under *either party's* plan Congress will have to take a fresh look at the Medicare budget in the near future.

Neither party has even begun to deal with the long-term health entitlement budget problem, which will mushroom for both Medicare and Medicaid when the baby boom generation reaches age 65 in 2011. And obviously, neither party is currently thinking about how to make the resources available to create universal health care coverage.

The proposal we have outlined in this paper creates a much more realistic guide for health care budgeting. It does not include specific budget projections because we acknowledge we do not know exactly how much or how fast a competitive system will generate savings, just as Democrats and Republicans should acknowledge their inability to calculate the savings—or the consequences—of Medicare provider cuts. Our proposal, however, can rely on provider cuts to supplement efficiency savings where necessary—for example, to keep the Medicare trust fund solvent. But the Democratic and Republican proposals cannot supplement provider cuts with efficiency savings, because they do not propose the necessary system change.

Unlike Medicare provider cuts or Medicaid block grants, the buyer's market system we propose *does* implement reforms that will permanently improve the efficiency of both programs, and of the private sector health care system as well.

Our proposal ensures the maximum savings achievable through efficiency measures, and thus makes it possible to focus on the real policy choices the country faces about how much health insurance we can afford to subsidize, and for whom.

Fully implemented, our proposal will make all public subsidies for health insurance explicit, measurable, and subject to market forces. In effect, we will have a true national health care budget, with the cost of all subsidies capped by market competition. Only the actual competition will determine whether the tax resources supporting these subsidies are adequate. If not, Americans will have to decide whether to cut back on subsidies or pay more for them.

In the complex morass of public health care policy, with its incomprehensible budget numbers and conflicting partisan claims, a series of reforms that creates clear public choices about the costs and benefits of health care subsidies would be a revolutionary achievement. Aside from the new clarity this would give the health care debate, it would also treat Americans not as beneficiaries or taxpayers alone, but as citizens sharing a common responsibility for our common health—and commonwealth.

Americans are entitled to this kind of health care reform.

*David B. Kendall is senior analyst for health policy
for the Progressive Policy Institute.*

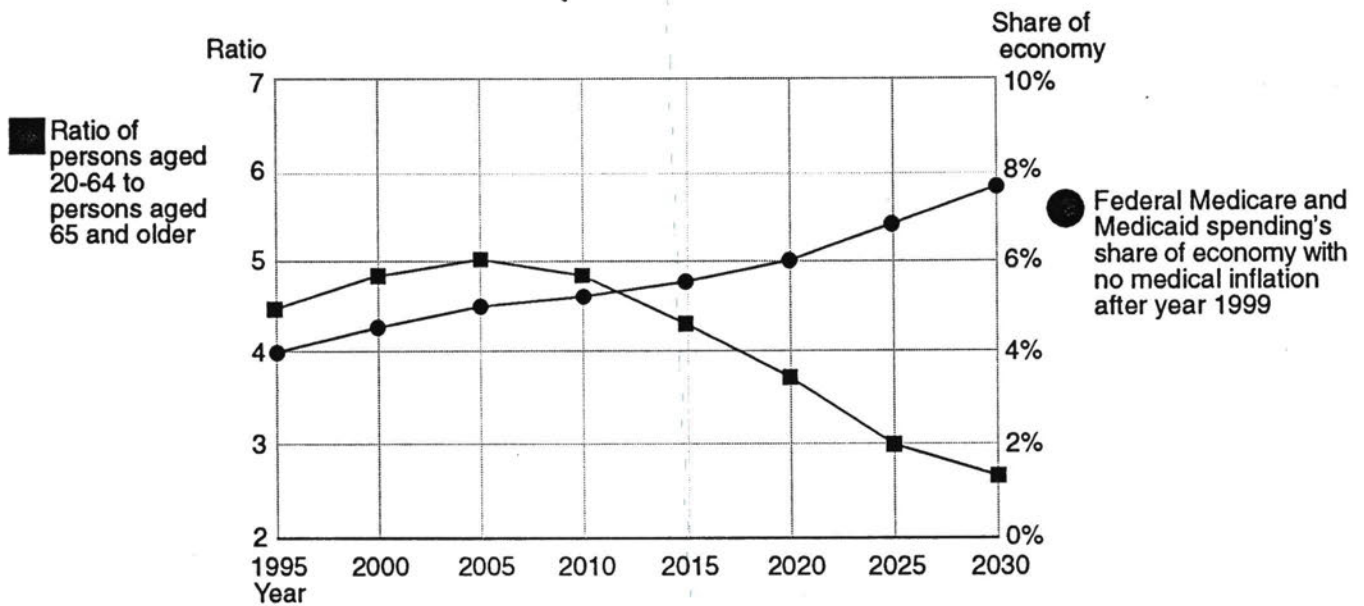
Acknowledgements

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The wisdom and advice of many others informed this work: Paul Ellwood, Alain Enthoven, Lynn Etheredge, Heidi Kendall, Graham Rich, and Sara Singer to name a few. Any errors remaining are my own.

Fewer Workers to Support Retirees Will Drive Up Federal Health Care Spending Even if Medical Inflation is Controlled



Source: Bipartisan Commission on Entitlement and Tax Reform, August 1994, *Interim Report to the President*, pp. 14-15.

Summary of Reforms

1995-98

Medicare: Privatize insurance for Medicare beneficiaries and limit Medicare spending to an individual, fixed-sum subsidy tied to competition in the marketplace.

Medicaid: Cap federal per capita payments, allow states flexibility to adopt competitive reforms, and promote alternative sources for long-term care.

Private Sector: Cap the tax subsidy for employer-provided health care and dedicate the revenue to provide a fixed-sum, individual subsidy for all Americans living in poverty.

1998-2000

Medicare: Create a system of voluntary consumer purchasing cooperatives, which would compete by negotiating the best price with health plans and by setting a benchmark benefits package.

Medicaid: Link the Medicaid per capita cap to a competitive system.

Private Sector: Complete coverage for the uninsured by guaranteeing a fixed-sum, market-based subsidy to all Americans based on their ability to pay for private coverage.

2000

Medicare: Means-test the Medicare subsidy and increase the eligibility age.

Medicaid: Impose a broad funding limit on Medicaid long-term care and adopt performance standards.

Private Sector: Enact an individual mandate to cover any remaining "free-riders" who continue to forgo coverage despite the universal subsidy.

For All Health Spending: Create a "bottom-up" national health budget from the universal, market-based subsidy in order to make explicit choices about the costs and benefits of the levels of subsidies.

Endnotes

1. Calculated from the following sources: historical data (for Medicare) from the Office of the Actuary, Health Care Financing Administration, U.S. Department of Health and Human Services, and (for Medicaid) *Medicaid Source Book: Background Data and Analysis (A 1993 Update)*, a report prepared by the Congressional Research Service for the use of the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives, 83; projections of Medicare and Medicaid spending from the Congressional Budget Office, March 1995 baseline; and for gross domestic product data from "Historical Tables: Budget of the U.S. Government, Fiscal Year 1996," (Executive Office of the President, Office of Management and Budget), 17-18.
2. Paul N. Van de Water, Assistant Director for Budget Analysis, Congressional Budget Office, statement before the Committee on the Budget, U.S. Senate, February 1, 1995, 6-10.
3. Bipartisan Commission on Entitlement and Tax Reform, *Interim Report to the President*, August, 1994, 15.
4. Physician Payment Review Commission, *Annual Report to Congress*, 1993, 232.
5. Michael A. Morrissey, *Cost Shifting in Health Care: Separating Evidence from Rhetoric* (Washington, DC: AEI Press, 1994), 85.
6. David Liska, Karen Obermaier, Barbara Lyons, and Peter Long, *Medicaid Expenditures and Beneficiaries: National and State Profiles & Trends, 1984-1993*, (Washington, DC: Kaiser Commission on the Future of Medicaid, July 1995), 94.
7. Paul M. Ellwood and Alain C. Enthoven, "'Responsible Choices': The Jackson Hole Group Plan for Health Reform," *Health Affairs* (Summer 1995): 24-39.
8. Dennis Murray, "Why Three out of Four Doctors Participate in Managed Care," *Medical Economics* (November 21, 1994).
9. Vicky J. Keston and Alain Enthoven, *Total Hip Replacement: A History of Innovations to Improve Quality While Reducing Costs*, unpublished article (August 1995).
10. As an interim step before the competitive basis for paying health plans is put in place, the existing HMO payment system should be revised to reflect the current rates of increase in the private sector. The Jackson Hole Group recommends a 5 percent annual increase instead of the 10 percent increase that Medicare HMOs will likely receive this year. Even lower rates of increase would be appropriate in areas of the country where HMO payments have been inflated by fee-for-service practices that are more costly than the national average.
11. The simple average of bids would not be adequate to determine the government's payment rate to health plans because some plans might try to drive up the average by submitting a higher priced option that they had no intention of promoting. Thus, it would be better to "weight" the average of bids according to each plan's enrollment during the previous year so that plans with no enrollment would not influence the average. For a thorough discussion and thoughtful proposal on setting the government's contribution in a competitive system, see Bryan Dowd, Roger Feldman, Jon Christianson, and Janet Shapiro, "Development of the Competitive Pricing Proposal for Medicare: Final Report," (Institute for Health Services Research, University of Minnesota, February 1993).
12. Lynn Etheredge, *Reengineering Medicare: From Bill-Paying Insurer to Accountable Purchaser* (Health Insurance Reform Project, George Washington University, Washington, DC: June 1995), 8.

13. A Health Purchasing Account would pay for both insurance premiums and out-of-pocket costs (for deductibles and copayments) unlike a Medical Savings Account, which covers only the latter type of expense. In other words, a Health Purchasing Account is a *consumption* account for all health care expenses as opposed to a *savings* account for only a particular type of expense.
14. Holcombe B. Noble, "Quality is Focus for Health Plans," *The New York Times* (July 3, 1995).
15. Mark V. Pauly, Patricia Danzon, Paul J. Feldstein, and John Hoff, *Responsible National Health Insurance* (Washington, DC: American Enterprise Institute, 1992), 14.
16. Frank B. McArdle and Kenneth L. Sperling, *Designing a Health Care Benefit Package*, testimony before the Committee on Finance, U.S. Senate, March 3, 1994.
17. *Sources of Health Insurance and Characteristics of the Uninsured* (Washington, DC: Employee Benefit Research Institute, January 1994), 30.
18. It is important to note that Medicare is progressive from the point of view of an individual's lifetime payments and benefits. Although the benefits are the same for rich and poor, low-income workers pay less in taxes before they retire. See C. Eugene Steuerle and Jon M. Bakija, *Retooling Social Security for the 21st Century*, (Washington, DC: The Urban Institute Press, 1994). Thus, in reality, Medicare is very much a "welfare program" that redistributes wealth from the rich to the poor as well as from the young to the old. That is just one more reason to move beyond the obsolete view that Medicare benefits should be the same regardless of income.
19. *Sources of Health Insurance*, 30.
20. Steuerle and Bakija, *Retooling Social Security*, 41.
21. Liska et al., *Medicaid Expenditures*, 50.
22. The per capita cap for the long-term care of the chronically and severely disabled should be calculated separately because their greater needs cost significantly more than the average older American.
23. The states' ability to experiment with private long-term care insurers partnerships under Medicaid was restricted in 1993 by Congress, in part, for budgetary reasons. The problem is that the partnerships allow an unlimited number of people to qualify for Medicaid assistance once they have exhausted coverage under a private insurance policy, and thereby might undermine the government's long-term savings from increased use of private coverage. The broad funding limit in PPI's proposal avoids this budgetary problem by limiting the portion of the population eligible for assistance.
24. The broad funding limit for Medicaid long term care would be based on both a state's per capita cap and a limit on the portion of its population participating in Medicaid. The only states affected by the broad funding limit would be those with both high per capita costs and high participation rates especially if the participation limit were set at today's highest state level, which would not reduce current spending levels but rather prevent future program growth. In addition, the participation limit would have to be adjusted for each state's poverty rate to prevent overly-restrictive limits in poor states.
25. Dee W. Hock, *Chaordic Health-Care System*, addendum to an address to Salt Lake Valley Hospitals Division of Intermountain Health Care, December 13, 1994.
26. Doug Bandow and Michael Tanner, *The Wrong and Right Ways to Reform Medicare* (Washington, DC: CATO Institute, June 8, 1995); Peter Ferrara, *Solving the Medicare Crisis*, (Dallas, TX: National Center for Policy Analysis, May 5, 1995).

27. Congressional Research Service, *Costs and Effects of Extending Health Insurance Coverage*, Committees on Education and Labor and on Energy and Commerce, U.S. House of Representatives, October 1988, 46.

28. Liska et al., *Medicaid Expenditures*, 58.

29. Under the health care spending projections of the Congressional Budget Office, the President's budget would have to cut Medicare by \$195 billion and Medicaid by \$123 billion in order to achieve the same spending levels in 2002 that the Administration has projected using more optimistic assumptions about health care inflation. Calculated from the following sources: Conference Agreement on the Budget for Fiscal Year 1996; letter of Alice Rivlin, Director of the Office of Management and Budget to Senator Pete Domenici, Chairman of the Committee on the Budget, June 22, 1995; and the Congressional Budget Office's March 1995 baseline.

THE PRESIDENT HAS SEEN
9-26-95

This needs to be
more efficient put in
message + attach + file

Immigrants With Skills

THERE ARE TWO ways to view the impact on the national interest of allowing skilled workers and professionals to come to the United States as immigrants. One camp has it that welcoming these foreigners is an unmixed blessing. They are highly trained, either at the professional level or with skills acquired over a number of years. They are eminently employable, will be no drain on the welfare system and will make a real contribution to the country. All of this is true. Others reply that there are plenty of highly trained Americans—many of them college graduates—who could and should be filling those job slots. They point out that without foreign competition, Americans would compete for and perform well in these jobs. This is also true. In the coming months, Congress will try to find some middle ground.

The total number of immigrants and refugees admitted into this country (now 800,000 a year) will almost certainly be reduced by Congress. The final figure will be somewhere between 400,000 and 550,000 a year. The mix will also shift, with peripheral relatives such as married siblings excluded and the percentage of available places allotted to skilled workers rising. But because the total will be smaller, the actual number of spots for skilled workers will go down

from the present 140,000 a year to something in the 75,000 to 100,000 range.

American manufacturers are complaining. They like the system as it is: fairly simple to get a temporary visa for a worker (permission from the Labor Department is not needed) and five years later to get a permanent visa. The system works so well for them, in fact, that there is no backlog of visa applicants in this category, and the authorized 140,000 places are not filled.

Immigration of those with skills should be encouraged, and the restructuring now being considered gives added weight to this priority. But it is also important to put the needs of American workers first. The Commission on Immigration Reform, chaired by former representative Barbara Jordan, has recommended, for example, that employers bringing in foreign skilled workers be required to pay a substantial fee—perhaps one-third of the first year's salary—to a designated private-sector initiative dedicated to developing a well-trained American work force. More to the point, they should also be required to conduct a nationwide search for workers here, offering 105 percent of the prevailing wage, before being allowed to hire foreigners. These suggestions are worth exploring.

THE WASHINGTON POST
SATURDAY, SEPTEMBER 16, 1995

Rahm
D. BAER
Leon

1 New Senator, Special Del...

THE WHITE HOUSE
WASHINGTON

95 SEP 28 A10:41

September 28, 1995

MEMORANDUM FOR THE PRESIDENT

FROM: RAHM EMANUEL *R.E.*
SUBJECT: IMMIGRATION MESSAGE

I have advised Commissioner Meissner and Secretary Reich to incorporate putting American workers first into their message at the Senate immigration hearings. They will be testifying today at Senate hearings on legal non-immigrant visas.

Should be put
to priority now

✓

We have also received the following information items:

⑦

- **Immigration Message.** An editorial in the September 16 *Washington Post* on "Immigrants With Skills" talked of the need to put American workers first and cited some suggestions from Barbara Jordan on this subject. You noted that this message "needs to become a more explicit part of our message." In response, Rahm reports that he advised Commissioner Meisner and Secretary Reich to incorporate this message into their testimony at Senate immigration hearings on September 28.

Rebekah
would
be at
the
DOJ
on 9/28
containing

- **9th Circuit decision on religion in schools.** From Steve Neuwirth. On Friday, the court ruled that a public high school receiving federal funds could not prohibit a student religious club from meeting on high school premises during the lunch period, when other extracurricular student clubs are permitted to meet. The court's decision was based on the Equal Access Act and confirmed a key principle in Secretary Riley's guidance to schools; DOJ filed an amicus brief in the case supporting the position the court took. The Christian Legal Society issued a statement praising the Administration's participation in the case stating, "[t]his was teamwork at its best, religious advocates and the White House successfully fighting the pervasive discrimination against free religious expression."

✓

- **Vesco extradition from Cuba.** From Richard Nuccio via Harold. Cuba never offered to extradite Vesco. When our government indicated an interest in having him, Cuba backed off. Castro has publicly stated that it would be "immoral" to extradite him. While we are still interested in Vesco, we would not back off our embargo to secure his return.

✓

- **Return of Hope, Arkansas Pilot's Remains.** From Tony Lake. The remains of Lieutenant Commander John F. Barr, USN, from Hope were among those of 18 servicemen from Vietnam and Laos returned to Travis AFB in California on September 27 from the processing center in Hawaii (which you have visited). Barr was previously unaccounted for after his aircraft was lost during a strike over North Vietnam on October 18, 1967. Barr's remains were returned to Hawaii in 1988 and recently positively identified based on a match of blood-samples from his mother and sister. He will be interred with full military honors October 18 at National Cemetery in Houston, where his family lives. Also, a set of group remains to be buried at Arlington October 12 includes those of Captain Earl R. Michles, USA, of Pocahontas, Arkansas. He was in a helicopter shot down on June 13, 1968.

⑨

cc: Mr. St. Mach
Mr. St. Mach
The families of the
9th Circuit - Barr
successful extradition

taxpayers claiming the EITC would still have to file returns. Compliance costs, while reduced for individual taxpayers, would shift to employers, financial institutions and the IRS. The tax system generally would be less able to promote social goals. The U.K. system, developed when the typical taxpayer was a male head of household who held his job for life, is becoming more difficult and time-consuming for U.K. authorities to administer.

Tyson
Gandy
(E) **CFTC regulatory authority.** In response to your note on *Wall Street Journal* op-ed. Article alleged that a CFTC ruling was too broad, serving to micro-manage the off-exchange swaps market and create uncertainty. CFTC feels strongly that this company engaged in core illegal activity and almost inflicted serious damage on the futures market. But, while the settlement is only binding on this company, CFTC acknowledges that some of the language in the agreement may have been over-broad. More importantly, CFTC feels that basic statutory scheme of the Commodities Exchange Act simply doesn't work with respect to new financial instruments. Mary Schapiro, CFTC chair, has therefore started a complete review of the statute with the goal of developing some alternative legislative "roadmaps." An interagency group on financial markets, chaired by Secretary Rubin, will be involved.

(F) **Follow-up to Wyoming oil and gas industry meeting.** From Bob Armstrong at Interior via Bruce. Bob defends Interior's record and says he shouldn't be viewed as anti-drilling. Key issues: Interest on Overpayments and Statute of Limitations -- legislation would be required to allow government to pay interest on royalty overpayments and the Minerals Management Service is working on possible language. A six-year time limit on audits and collection actions could be established by Executive Order; internally, Interior issued a directive in July to complete such actions within six years of the due date. Access to Federal Lands -- this Administration has made more acreage available and approved more Applications for Permit to Drill (APDs) than the Bush Administration, while avoiding the environmental litigation that has shut the leasing program down in the past. BLM is currently reviewing the issue of special and seasonal stipulations, which are designed to allow oil and gas activities while protecting the environment and can impose delays on lease operators up to 9 months.

Interior has proposed a Federal Advisory Committee (government, industry, environmental community) to address all these issues in the context of the Greater Green River Basin. Industry is split on the idea.

(G) **COPS program.** Rahm forwards a state-by-state listing of the number of police officers funded by the Crime Bill.

(H) **Congressional correspondence.** 1) Senator Leahy: thanks you for invitation to Cal Ripken game and praises Hillary's trip to China; 2) Senator Inouye: commends you and the military for the VJ-Day celebrations -- great press coverage in Hawaii; 3) Rep. Ray Thornton: forwards a letter of encouragement of you from Parkview High student in Little Rock whose art work is on display in the Capitol; 4) Rep. Gary Condit: commends Wendy Smith, Dan Tate, Regan Burke and Mary Kaems for their work on your trip to California.

(I) **Clips.** From your trip to California.

THE PRESIDENT HAS SEEN
10/2/95

THE WHITE HOUSE

WASHINGTON

September 11, 1995

95 SEP 18 P6:04

MEMORANDUM FOR THE PRESIDENT

THROUGH:

LAURA D'ANDREA TYSON *Laura D. Tyson*

FROM:

Ellen Seidman *Ellen Seidman*

SUBJECT:

Response to Merton Miller piece concerning CFTC

You asked that we look into allegations about over-regulation by the Commodity Futures Trading Commission (CFTC) made by Merton Miller and Christopher Culp in a Wall Street Journal op-ed piece. The original op-ed is at Tab A.

Messrs. Miller and Culp argue that the language in a settlement agreement between the CFTC and MG Refining & Marketing is overbroad, and suggests the CFTC intends to micromanage firms and destroy the off-exchange swaps market. At Tab B are two responses to that piece: one from Mary Schapiro, the CFTC Chairman, and another from Jack Sandner and William Brodsky of the Chicago Mercantile Exchange.

The CFTC's response to Miller's particular charge is four-fold: (i) the MG case is an absolutely core case of illegal, unregulated retail sale of off-exchange futures, of a type similar to what the CFTC brings regularly against Florida bucket shops; (ii) the magnitude of the damage MG almost inflicted on the market as well as participants (which goes far beyond what the bucket shops accomplish) justifies the parts of the agreement concerning internal controls to prevent the illegal activities from happening again; (iii) MG itself recognized the instruments at issue were not swaps and didn't even raise the defense that they might therefore have been legal under the CFTC's "swaps exemption"; and (iv) the settlement agreement is binding only on MG.

On a broader basis, however, the CFTC recognizes that some of the language in the settlement agreement may have been over-broad, and, more importantly, that the basic statutory scheme of the Commodities Exchange Act (CEA) simply doesn't work with respect to new financial instruments. Chairman Schapiro believes it is critical that firms offering new financial products know for certain the regulatory scheme they are under and that regulators -- whether the CFTC, the SEC or the banking or insurance regulators -- be certain of the scope of their authority. In her opinion, the CEA, with its blanket prohibition against off-exchange futures trading and its long list of exemptions and exceptions, doesn't provide that certainty, on either side.

Chairman Schapiro has therefore started a complete review of the statute, with the goal of developing some alternative legislative "roadmaps." The process will include all market participants, as well as other regulators. The Interagency Working Group on Financial Markets, chaired by Secretary Rubin, will be involved. You should be aware that any expansion of exemptions from the CEA or of CFTC exemptive authority (which appears to be what Messrs. Merton and Culp desire) will be strongly opposed by the Chicago futures exchanges.

THE PRESIDENT HAS SEEN
8-23-95

Enrich
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BC

Laura
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to the 1st
John G
122

Rein In the CFTC

By MERTON H. MILLER
AND CHRISTOPHER L. CULP

A recent enforcement action by the Commodity Futures Trading Commission against MG Refining & Marketing Inc. and MG Futures Inc. renders uncertain the enforceability of an important class of commercial derivatives transactions. Based on the ruling, which held certain MG Refining & Marketing contracts to be "illegal off-exchange futures," losing counterparties on numerous similar contracts—and remember, every derivatives contract must have a loser—may have a choice: pay up and eat the loss, or refuse to pay, claiming their contracts are illegal, too.

In calling attention to the CFTC's July 27 action, our purpose is not to defend or attack MG Refining & Marketing itself. Our concern, rather, is with the egregious overreaching that the ruling represents. The time has come for Congress to rein in an agency seemingly more concerned with establishing turf than with the damage it may be doing to the markets.

A Doomed Quest

Because futures contracts have no specific economic attributes of their own other than exchange trading to distinguish them from ordinary forward contracts or swaps (a forward contract is any contract for the future purchase of a commodity at a fixed price, and a "swap" is merely a package of forwards), the quest for any objective definition of "off-exchange futures" among contracts not already exchange-traded is doomed from the start. An overzealous regulator fishing for "illegal off-exchange futures" thus confronts a virtually unlimited supply of possibilities.

To lawyers, the seeming oxymoron of "off-exchange futures" has legal meaning thanks to the Commodity Exchange Act of 1936. That law, designed in the main to protect exchanges from competition by free-riding "bucket shops," requires all "futures" to trade on an organized and regulated exchange. The term "futures contract," needless to say, is not explicitly

defined in statute law. Nevertheless, a determination by the CFTC that a financial contract is a "futures contract" immediately renders that contract illegal unless it is traded on a regulated exchange or specifically exempted.

Congress has attempted several times to remedy the inevitable legal uncertainties in the act over what is a "futures contract" by limiting the jurisdiction of the CFTC. Ordinary commercial forward contracts, for example, are specifically excluded from the act. In 1992, Congress also urged the CFTC promptly to exempt certain off-exchange transactions, including some swaps, from most regulation under the act. The agency did so in 1993.

The action against MG Refining & Marketing by the CFTC ruled some of the

derivatives are not used either to speculate or hedge, what are they used for?

Exclusions and exemptions from the act may ensure the continued legality of some existing products. But the applicability of such exemptions—covering certain forward, swap, hybrid, energy and trade option contracts—was not analyzed by the CFTC in its written ruling, suggesting that it may be signaling its intention to narrow some exemptions.

For other products not clearly covered by an exemption, of course, the consequences of the MG Refining & Marketing settlement may be even worse. Swaps on equities and certain swaps on securities, for example, are not covered by the swaps exemption and hence are not protected from the CFTC's new three-point acid test. MG Refining & Marketing's firm-flexible

Its extremely broad definition of futures calls into question the legality of numerous financial transactions.

firm's privately negotiated oil derivatives contracts—called "firm-flexible" contracts—illegal futures. In support of its position, the CFTC argued that those commercial marketing contracts met "all the essential elements of a futures contract." In almost total disregard of its previous rulings and statements, the CFTC defines a future as any financial contract that: (1) calls for future delivery at a price or formula set at the contract's inception, (2) can be satisfied either by physical delivery or an offsetting transaction, and (3) is used either to speculate or hedge rather than to take delivery.

The CFTC's extremely broad definition of "all the essential elements" of futures inevitably calls into question the legality of numerous financial transactions. After all, every derivatives contract contains some reference price or formula. Because the terms of many derivatives allow some form of cash settlement, they may also meet the second part of the test. And if de-

contracts, moreover, are essentially the same as many other agreements commonly negotiated by oil and gas companies, sometimes called "take-or-pay" contracts. Are these, too, now illegal?

The CFTC denies that the settlement sets any sweeping precedents for the regulation and legality of swaps—what else would you expect it to say?—but "in-the-money" counterparties everywhere are, and should be, worried that some losers will now refuse to pay up. The CFTC's repeated public denials of wider applicability, after all, carry no probative weight when a private lawsuit is filed on the basis of a ruling already on the record for all to see (and cite).

In the settlement, the CFTC also raised its micromanagement of "futures commission merchants" to a new level. The CFTC required MG Futures, a futures commission merchant, to submit its risk management systems to review by a new "Special Oversight Committee" comprising com-

pany representatives. In defining that committee's responsibilities, the CFTC spelled out in some detail what might constitute an "adequate" risk management process for a futures commission merchant, including the obligations for keeping its parent informed. Despite the CFTC's pious pronouncements, few would regard this agency sufficiently qualified to pass such specific risk management judgments.

Muscling In

Nor are futures commission merchants the only companies on which the CFTC has set its micromanagement sights. The MG Refining & Marketing settlement follows the Bankers Trust settlement last fall, in which the CFTC used Bankers Trust's presumed status as a "commodity trading adviser" to get its regulatory foot in the company's door. As in the MG Refining & Marketing case, once inside, the CFTC applied its regulatory muscle to Bankers Trust's other internal management activities as well. More important, by relying in both cases on its police authority, the CFTC establishes what are, in effect, industry standards, while circumventing the usual regulatory safeguard in which comments from the public, other agencies and Congress are solicited before rules are promulgated.

Last November, Americans elected a Congress that promised to rein in regulatory agencies whose actions far exceed their public mandates. The MG Refining & Marketing ruling and the uncertainties it has caused clearly put the CFTC in this category. Congress must limit even further the jurisdiction of the CFTC before this bull in the china shop does irreparable damage to our financial markets and their participants.

Mr. Miller, a professor emeritus at the University of Chicago's Graduate School of Business, won the 1990 Nobel Prize in economics. Mr. Culp is senior fellow in financial regulation with the Competitive Enterprise Institute in Washington.

THE WALL STREET JOURNAL FRIDAY, AUGUST 25, 1995

A Prescription for Disaster

A9

On Aug. 17, you published an editorial-page article by Merton Miller and Christopher Culp ("Rein in the CFTC") and an editorial ("Swaps in Danger"), each of which criticized the Commodity Futures Trading Commission for instituting an enforcement action against MG Refining & Marketing Inc. and MG Futures Inc. Purportedly, the CFTC's action constituted "egregious overreaching" (Miller and Culp), which "tightened the screws on the swaps market" (editorial). The authors of both editorial-page entries, with great disgust and hyperbolic rhetoric, accuse the CFTC of micromanagement, creating market uncertainty, exceeding its mandate and changing its interpretation of the law. To the contrary, the CFTC, in a settled action that applies only to these parties, acted well within its authority in addressing actions by a registered entity that threatened the stability and integrity of the markets. Editorial predictions of doom and gloom conveniently ignore the facts of the case and misstate the law the CFTC is charged to administer and enforce.

The salient facts are these: By the end of September 1993, both the U.S. subsidiary of MG that sold energy contracts to gas station owners, and the registered affiliated brokerage entity that carried massive related futures positions, had exhausted all funding sources available to them in the U.S., including credit lines of some \$900 million, and become wholly dependent upon a guarantee of their German parent. The parent's top management was not aware of the guarantee and lacked material information about size and ability to finance the futures and related positions. This disconnect was a Baringsesque prescription for disaster, and, as this newspaper noted, led experts to fear that an MG collapse might not only cause "an international credit crisis, but also seriously damage financial markets and economies world-wide."

Merton Miller and the editorial-page staff argue that the losses suffered in such cases are solely the concern of the imprudently managed firm and do not implicate either the public interest or the regulatory safeguards designed to protect that interest. It is one thing for a company to fail and thereby injure its shareholders, with whom rests the ultimate control and thus responsibility, for the corporation's management practices. It is quite another matter to jeopardize the well-being of other participants in the futures markets, and the countless others who might be trapped in the fallout of the collapse of a major international conglomerate such as MG.

Fortunately, our financial markets are protected by regulatory safeguards that are designed to prevent brokerage firms entrusted with the property of others from jeopardizing the integrity of the marketplace as a whole by undertaking commitments they cannot keep. The CFTC administers and enforces those safeguards with respect to futures brokers—including a long-standing rule designed to provide regulators with an early warning of the type of internal controls failure that occurred at MG. To enforce and to underscore the importance of compliance with these safeguards, on July 27, the CFTC instituted and simultaneously settled this case. The commission found that the registered broker had failed to report material inadequacies in its internal controls. Considering that in January 1994, as reported by this newspaper, MG increased its reported losses for its prior fiscal year by about 1.5 billion marks, largely losses from the derivatives activity of the U.S. trading firm, there would seem to be little question that MG's managers were not appropriately apprised of key aspects of the trading firm's operations. And there was a direct, indeed inevitable, link to the regulated brokerage firm, which stood first in line to pay the losses on the trading firm's futures positions and was dependent on liquidity arrangements with its parent, as its capital (some \$20 million) was but a fraction of the trading firm's approximately \$300 million in losses in 1993 alone.

By bringing this case, the commission has been accused of signaling a change in its view of what constitutes an unlawful off-exchange futures contract or a permissible swap agreement. Nothing, however, could be further from the truth.

A brief review of the Commodity Exchange Act is sufficient to refute the authors' contention that the CFTC's jurisdiction is limited to products traded on established exchanges. The core of that legislation, which the CFTC administers, is a statutory prohibition of trading futures contracts off-exchange. Indeed, it was only in 1992 that Congress gave the CFTC authority to modify that prohibition by exempting specified contracts from the exchange-trading and other requirements. If the commission regulated only on-exchange products, as Prof. Miller and Mr.

Culp claim, both the statutory prohibition and the CFTC's exemptive authority would be meaningless.

Equally fantastic is the editorial-page staff's claim that the CFTC has usurped authority by improperly "adopt[ing] a markedly expansive interpretation of the meaning of 'futures,'" in contrast to the "narrow definition" that the agency "argued for and won" in the early 1990s. This is simply incorrect; this decade's futures legislation did not define the term "futures contract."

Turning to swaps, the editorial-page staff chose to apply that label to MG's contracts, but MG did not. In marketing this product, MG did not analyze whether the gas station operators to whom it sold its contract were "appropriate" participants in the swaps markets. Nor did it seek to apply other applicable criteria. It is this newspaper, not the commission, that creates uncertainty by suggesting that, as a result of the MG case, the legitimate swaps markets are now in jeopardy. Further, the so-called Main Street angle highlighted by the editorial-page staff misses the key point that the commission's order affects the violator's ability to enforce those contracts, not the rights of innocent counterparties.

The CFTC has long been sensitive—and responsive—to the need to provide legal certainty to the evolving swaps markets. In 1989, it issued a policy statement to make clear that, while most swap transactions at that time possessed elements of commodity futures or options contracts, the commission would not regulate them as such provided that the swaps met certain specified criteria. In January 1993 it acted expeditiously to use its new power to exempt swap transactions from all but the antifraud provisions of the Commodity Exchange Act.

Innovation and evolution inevitably create the potential for legal uncertainty, which can disrupt or retard the growth of financial markets. The CFTC understands this and consistently has acted to reduce uncertainty, and remains committed to this purpose. The antipathy expressed by a few to actions such as the settlement with MG may be based less on the specter of market disruption than hostility to financial regulation generally. The real market disruptions involving Barings, MG, and others in recent years reinforce the need for regulatory agencies to pay attention to how the risks of large market participants are managed and how new products are marketed and sold, or else the statutory mandates we all operate under mean very little indeed, and the public interest we are charged to protect will be disserved.

MARY L. SCHATTO
Chairman

Commodity Futures Trading Commission

Washington

2/1

A9

CFTC Must Protect Individual Investors

The appropriate scope of CFTC regulation has long been subject to debate. As Merton Miller and Christopher Culp point out in their Aug. 17 piece, the recent enforcement action against MG Refining & Marketing Inc. and MG Futures Inc. has created uncertainty in the market and added to the confusion surrounding the legal status of derivatives negotiated off a registered futures exchange.

Whether one agrees with Messrs. Miller and Culp's criticism of the CFTC rule of the MG contracts, or sides with the CFTC, it should be obvious that there is a strong temptation to avoid the heavy regulatory burden placed on exchange-traded derivatives. This is usually done by cloaking off-exchange futures in different names or slightly different forms.

The evolution of the Commodity Exchange Act has sometimes added to the ambiguity. For example, some believe the Treasury Amendment gives them the right to sell currency futures to the public with no regulation at all. However, Congress's intent is very clear. Off-exchange futures peddled to the general public either through seedy bucket shops or respectable broker-dealers cannot be tolerated by the CFTC.

Care must be taken to avoid overregulation of legitimate commercial business, but it is absolutely appropriate and essential that the CFTC exercise its authority to ensure that individual investors are not being deprived of their rights and protections.

JOHN F. SANDNER
Chairman

WILLIAM J. BRODSKY
President

Chicago Mercantile Exchange
Chicago

THE PRESIDENT HAS SEEN
10/21/95

THE WHITE HOUSE
WASHINGTON
October 1, 1995

MEMORANDUM FOR THE PRESIDENT

FROM: TODD STERN
PHIL CAPLAN

SUBJECT: Recent Information Items

We are forwarding the following recent information items:

(A) **Tobacco update.** From Harold and Jennifer O'Connor. Highlights: Ford introduced his bill (some regulation of advertising and vending machines, but no FDA regulation), but it received little press attention; Rep. Baesler is working on a bill to require an FTC license to sell tobacco but remove FDA jurisdiction; Canadian Supreme Court struck down Canada's total ban on advertising, but would allow restrictions on images or ads aimed at kids; Southern Baptists, National Association of Evangelicals, United Jewish Appeal and Future Farmers of America all want to help; WH staff is drafting a model legislative resolution for states; your schedule for October and November will include a Nickelodeon TV special, an East Wing event with supportive groups and a possible event in Connecticut next month.

(B) **Community Crime Prevention Plan.** Working paper from Amitai Etzioni (forwarded by Rahm) entitled "It Takes a Whole Village to Prevent a Crime." Core idea is to offer communities that organize crime prevention efforts a share in the savings that result from those efforts. Example: if a state and city spent \$9 million/year on public safety in a community and that amount was reduced to \$8 million through the community's own efforts, the community would get \$500,000 back for its own use.

(C) **Pension simplification for small business.** In response to your note, an upbeat report from Ellen Seidman on the prospects for the Administration's pension reform proposal. Much of the plan you announced at the WH Conference on Small Business is included in the Ways and Means tax bill, though the bill contains many provisions the Administration opposes. Ellen says our initiative "is well-positioned to pay off for small business, and we are well-positioned to take credit for the action."

(D) **Les Samuels note on eliminating need to file tax return.** In response to your question. A pay-as-you-earn (PAYE) system of the kind used in the U.K. could eliminate filing requirements for one half to two thirds of U.S. taxpayers, but it would require very large changes to the tax system and would include substantial downsides. For example, we would have to eliminate many itemized deductions, expand withholding to cover non-wage income sources, change the tax treatment of social security benefits and capital gains. Those

Eushin
see my notes

① in WH summering
want to help
rel. groups - Muslim
Christian challenge
support coalition
② Mr. Baesler on legislation
to Ford Baesler

John

THE WHITE HOUSE
WASHINGTON

THE PRESIDENT HAS SEEN
10/2/95

95 SEP 25 P6:04

25 September 1995

MEMORANDUM FOR THE PRESIDENT
VICE PRESIDENT
LEON PANETTA
ERSKINE BOWLES

CC: MAGGIE WILLIAMS
JACK QUINN
CAROL RASCO

FROM: HAROLD ICKES
JENNIFER O'CONNOR

SUBJECT: TOBACCO UPDATE

Attached is an update from Jennifer O'Connor on tobacco initiative activities for last week. It includes a weekly report from Andrew Hyman, Special Assistant to the General Counsel at the Department of Health and Human Services, which describes the Hill legislation introduced by Senator Ford and reports on media, public outreach, intergovernmental outreach, and legal issues.

THE WHITE HOUSE
WASHINGTON

September 23, 1995

MEMORANDUM FOR HAROLD ICKES

FROM: JENNIFER O'CONNOR
SUBJECT: TOBACCO UPDATE

Attached is Andy Hyman's weekly report on our tobacco initiative. It describes the Hill legislation introduced by Senator Ford and reports on media, public outreach, intergovernmental outreach and legal issues.

Highlights of the attached memorandum, and other activity this week include:

- Ford bill was introduced and received little press attention.
- Rep. Baesler is working on a bill that will require retailers to have an FTC license in order to sell tobacco products, and that will remove FDA jurisdiction.
- This week Canadian Supreme Court struck down Canada's total ban on all tobacco advertising. The court's opinion in Canada, however, says that it would have upheld restrictions on ads aimed at kids, or restrictions on images. It held merely that a total ban was too broad. In this way, this decision makes our rule seem reasonable.
- The Southern Baptists, National Association of Evangelicals and the United Jewish Appeal each indicated in meetings this week that they want to help with our initiative.
- Future Farmers of America met with the Department of Agriculture this week and indicated that they want to be supportive and involved in our initiative.
- At a meeting with Pat Griffin, Marcia Hale, Chris Cerf and myself, we agreed that the intergovernmental shops should draft a model resolution supporting the President's initiative. Marcia will then ask various state and local elective bodies to pass the resolution. Pat is convinced this will not stir up any trouble on the Hill.
- The Short Term Scheduling meeting agreed to put three events on the President's

schedule in October and November: a children's event to be aired by the Nickolodeon cable channel and hosted by Linda Ellerbee; an East Wing event with the groups that support the initiative (the Future Farmers, Southern Baptists, retailers, anti-smoking groups, PTAs, etc.), and an event with parents and teachers.

- The American Academy of Pediatrics is meeting on October 16. Marilyn Yager is requesting that either the Vice President attend the meeting, or the President do a satellite address to it. This request has not yet been approved.
- In mid-October, the President is travelling to Connecticut. The Communications planners are searching for a tobacco event for him to do while there. This event has not yet been addressed by Short Term Scheduling. In addition, I have given HHS a list of cities to which our principals might travel, so that they can point out any great tobacco events that could potentially be worked into their schedules.
- November 9 is shaping up as another potentially huge "Tobacco Day." The American Academy of Physicians is asking all their members across the country to go to a 7th or 8th grade class to discuss smoking on that day. On the same day, the Future Farmers of America are meeting in Kansas City with 40,000 kids. Marilyn Yager is putting together a proposal that the President accompany a physician to a class that day and also satellite in to the Future Farmers to address the kids on tobacco. These requests have not yet been considered by Short Term Scheduling.

Finally, our next meeting is scheduled for Tuesday, September 26. Many staff who attend the meeting will be away for Rosh Hashana on Tuesday. I think it may make sense to skip the meeting and meet as scheduled on Friday. What do you think?

September 22, 1995

MEMORANDUM

TO: Harold Ickes

FROM: Andrew D. Hyman *July*
Special Assistant to the General Counsel

SUBJECT: Tobacco Report 3

LEGISLATIVE

- On September 20, Senator Wendell Ford (D-KY) introduced the Tobacco Products Control Act of 1995 (S. 1262). Its principal provisions are:
 - ♦ Billboard advertisements for tobacco products must be more than 500 feet away from any school.
 - ♦ If at least 15 percent of a publication's readership is younger than 18, the publication cannot accept advertisements for tobacco products.
 - ♦ Cigarette vending machines are allowed if they are in the constant view of the retailer or if they are in settings that restrict the presence of those younger than 18, such as bars or employee lounges.
 - ♦ The penalties for a state's noncompliance is reduction of federal grants for drug prevention and control activities.
 - ♦ FDA is expressly prohibited from regulating tobacco products.
- Rep. Scotty Baesler (D-KY) is reportedly drafting a bill requiring that retailers have an FTC-issued license in order to sell or distribute tobacco products, and expressly prohibiting FDA from regulating tobacco products. This bill should be ready for introduction within the week.
- On September 20, the Senate completed work on the Agriculture appropriations bill without including any legislative language affecting FDA's proposed regulation.

MEDIA

- Introduction of the Ford bill received minimal national attention (AP, Wall Street Journal) and even low-key local attention (inside story in Courier-Journal).
- The Canadian Supreme Court ruling invalidating the Tobacco Products Control Act's advertising/promotion ban (see below) also received low-key national attention (wire stories).
- Researchers at Columbia-Presbyterian Medical Center in a study funded in part by the tobacco industry (the Council for Tobacco Research), made significant discoveries about the physiological effects of nicotine. The finding, reported in the September 22 issue of Science, could help explain the addictive qualities of nicotine.

The story is receiving moderate attention (AP, Washington Post, Wall Street Journal, USA Today).

- Shalala roundtable with women's magazines in New York City on September 27 has been set up by HHS public affairs.
- Mitch Zeller (FDA) met with the Christian Science Monitor editorial board in Boston and is doing other local media in both Boston and Denver.
- Kessler interview with CBS's popular Sunday Morning on September 22 for broadcast on September 24.

LEGAL

On Thursday, September 21, the Canadian Supreme Court struck down sections of the Tobacco Products Control Act (TPCA), a 1988 law which banned all advertising of tobacco products in the Canadian media and required health warnings on packages. The suit was brought by RJR MacDonald Inc. and Imperial Tobacco Ltd. Specifically, the Court rejected sections dealing with advertising, trademarks and labelling as being "inconsistent with the right of freedom of expression."

OUTREACH

The White House Office of the Public Liaison met this week with representatives of the National Association of Evangelicals, the Southern Baptist Church, and the United Jewish Appeal to discuss the initiative.

On September 22, USDA staff met with representatives from Future Farmers of America, who expressed interested in supporting the

initiative.

Staff from Veterans Affairs, USDA, Labor, Education, SBA, HHS, and Transportation met on Tuesday. The agencies are identifying their Department's constituencies and, once given a script and background material, will begin calling the groups to provide them with information about the tobacco initiative. The Coalition on Smoking OR Health will contact the groups interested in actively supporting the initiative.

INTERGOVERNMENTAL

A resolution supporting the tobacco initiative (or its goals) is being drafted which will be passed by state and local governments. The White House and HHS Intergovernmental Affairs offices will meet next week to discuss how this should be accomplished.

LAW OFFICES
BOYETT, MORGAN AND KILLOUGH, P.A.
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SEARCY, ARKANSAS 72145-0806

September 22, 1995

The President of the United States
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500-2000

Dear Mr. President:

If you feel like you have been put in the pillory, take heart. I am sending you under separate cover a little book titled "The Book of Insults" and I think you will get a real kick out of reading it. The particular section on political insults should give you some succor and lighten your life somewhat to know that others in office had somewhat similar problems. It does seem extremely strange and most difficult to justify the attacks on you. The economy is in good shape, folks are prosperous and foreign affairs appear to be in reasonably good shape considering the fact that you are always going to have national interests at loggerheads on many issues.

We are seeing an attempt to project as a main stream philosophy that only candidates of certain religious persuasions are acceptable candidates for public office. Whether one is morally fit is the criteria rather than the ability to adequately perform the duties of office. These sort of sentiments have been around for a long time but have not assumed the mainstream perceptions which certain groups are now trying to achieve with repetitive television, radio and other communications. It is bad enough to have somebody judging you from the pulpit but then to have to have a second life also subjected to judgment by some self appointed wizard seems almost too much for an ordinary elected official to have to bear. This is not to condone abuse of office powers such as Senator Packwood got into but people should realize if they want to elect a Pope they go to Rome, if they want to elect an official they go to the ballot box.

Some areas which would seem to be critical to bring about a re-election victory for you might include labor unions. Surely, they have now awakened to the fact that they are going to have to do something about the labor movement to strengthen it; to have new leadership, new blood and to support Democratic candidates. I get the sense that, that movement might be coming to the surface.

Additionally, the poor and the uneducated have also got to have a wake up call and realize that they are going to have to do something to protect their own interest by the ballots; they are going to have to get out and vote, they are going to have to persuade other to get out and vote or otherwise a Republican congress is going to strip all or most of all the programs which would provide assistance for them to help themselves and those programs will become a thing of the past.

I know you are deeply involved in the Medicaid and Medicare programs but there might be a couple of issues which could be addressed which will give the American people an alternative to think about rather than grinding away on the entitlements. Why not come out, as a budget balancing measure, a proposal to impose a surtax on income of recipients of federal educational funds after their graduation. This would eliminate all of the problems of attempting to collect on promissory notes or other agreements which the recipients have signed and would give a strong note that these funds are going to be collected and would reduce the deficit spending over the long haul. While the amount of money in actuality is small, the public perception of physicians driving off in BMWs after graduation and never repaying the loans is a little piece of sand in the craw.

With reference to the foreign affairs why not have the opportunity for United States military ground forces to volunteer to be assigned to either NATO or the United Nations. This would be a voluntary act on the part of the military person and there are several advantages. This way we can keep the theory that the United Nations/NATO as a world wide peace group and the United States as not the only one trying to keep peace. By the same token it should satisfy the United States citizens that any group of land forces which we furnished would have been on a voluntary basis by United States military personnel who volunteer their services in the first place. There may be some need for financial inducements in that regard but I don't think the American public would have any objection to that.

There are many challenges but there are always solutions and think how boring life would be without challenges.

Respectfully yours.


Comer Boyett, Jr.
W.A.S.P.

CB,Jr.:kl
45.c88

THE CHURCH OF JESUS CHRIST OF LATTER-DAY SAINTS
47 EAST SOUTH TEMPLE STREET
SALT LAKE CITY, UTAH 84150

GORDON B. HINCKLEY

THE PRESIDENT HAS SEEN
10/22/95

September 13, 1995

JD has original

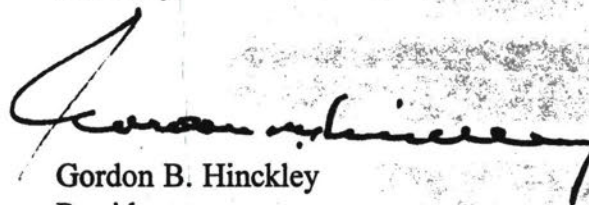
President William Jefferson Clinton
The White House
Washington, D.C. 20500

Dear President Clinton:

I was advised of your invitation to have breakfast with you last Monday morning at the White House. I regret that I had to excuse myself because of a very heavy cold. I just completed a very extensive series of meetings in England and Ireland and apparently picked up a virus somewhere along the way.

It was most gracious of you to extend this invitation. I want you to know that I deeply appreciate this kindness and would have enjoyed being with you.

Sincerely,



Gordon B. Hinckley
President

CLINTON ⁹⁶ GORE

9.22.95

Dear Nancy,

Jim Harman, the Co Chair for the
New York Gala on November 6th
has asked us to forward this letter
from the President of the Mormon
Church, Mr. Hinckley to President
Clinton. Thank you so much. Jenni³ Jamie

Paid for by the Clinton/Gore '96 Primary Committee, Inc. Contributions to Clinton/Gore '96 are not Tax Deductible

EE me
Dan Burchett
Original to Douglas
2 letters
Kenny
Schlesinger
letters
JAP



CAROLINE AND JOHN KENNEDY
WOULD LIKE YOU TO HAVE
THIS SPECIAL TRIBUTE
IN MEMORY OF THEIR MOTHER

THE WHITE HOUSE
WASHINGTON

September 27, 1995

Ms. Caroline Kennedy Schlossberg
Apartment 11B
888 Park Avenue
New York, New York 10021

Dear Caroline:

Thank you for the copy of the tribute to your mother. She was a remarkable woman whose life touched people around the world. Hillary and I are honored that you chose to share this special gift with us.

We deeply appreciate your thoughtfulness and send our best wishes to you, Ed, and your children.

Sincerely,

Bill



THE WHITE HOUSE
WASHINGTON

September 27, 1995

Mr. John F. Kennedy, Jr.
P.R. New York
17th Floor
220 Fifth Avenue
New York, New York 10001

Dear John:

Thank you for sharing with Hillary and me the book commemorating your mother's memorial service. We are moved by this tribute, which is a fitting testament to a woman who was revered by so many.

We deeply appreciate this thoughtful gesture and send our best wishes.

Sincerely,

Bill

White House Gift Record

Presented: 08/31/95
Arrival : 08/31/95
Entered : 08/31/95

Gift ID: 375275/lkk

Donor Information

Mr. John F. Kennedy, Jr.
20-26 North Moore Street
New York, NY 10013

Acknowledged By: Pending BC Gift Draft

Ms. Caroline Kennedy
888 Park Avenue
#11B
New York, NY 10021

Acknowledged By: Pending BC Gift Draft

Comments:

Arrived in regular mail. Gift is given in tribute to the donors' mother.

Gift Information

Intended: President and First Lady

Disposition: Archives

Description:
Hardcover. "In Memoriam - Jacqueline
Bouvier Kennedy Onassis."

Location of Gift:
The gift is in Archives.

Total Gift Value: \$25

THE PRESIDENT HAS SEEN WHITE HOUSE
10/2/95 WASHINGTON

10-1-95

Leon → See me in
Thurs -

See, Fountain call

① China WTO
Thurs
will be going

② Mex → meo Thers
to go after
fubert. for,
gangs →

③ Dinner w/ Dick, Hqs

BS

DAILY NEWS

 THE PRESIDENT HAS SEEN
10/2/95

40c

NEW YORK'S HOMETOWN NEWSPAPER

Wednesday, December 8, 1993

36

Law firm with Latin beat Client list reads like rainbow coalition

By SONIA REYES

Daily News Business Writer

The image of Queen Isabella, successfully launching an expedition to the New World, tugs like a talisman on the hearts of Carmen Pacheco and Betty Lugo.

Pacheco and Lugo embarked on their own journey through uncharted territories to open an international Wall Street law firm in 1992, the year of the 500th Quincentennial, with offices at 1 World Trade Center.

The two *Puertorriquetas* pooled their life-savings to start up the first-ever — and only — Latina principal law firm in the city.

And yet this ground-breaking significance is just starting to dawn on them: They say they're just two 30ish women friends, with similar educational and cultural backgrounds, who met in college and decided to start a law firm.

"In college, Carmen would draw sketches of an imaginary building, with a promenade in the lobby and a place for helicopters to land. She'd say, 'This will be our law firm someday.' And I'd tell her she was crazy," recalled Lugo.

They credit a strong family life with an emphasis on education and self-reliance for much of their success.

"My mother always told never to roll over, never to give up and to study hard," said Lugo, who was raised in the Williamsburg section of Brooklyn.

A sumptuous painting of 18th Century women at leisure and a stately Chippendale desk welcomes a diverse array of clients to the 29th floor law firm of Pacheco & Lugo.

Antique furniture dominates the decor, creating

a comfort zone for the Wall Street types they represent.

Pacheco's previous experience includes a stint at the Wall Street firm of Carter, Ledyard & Milburn, where former president Franklin D. Roosevelt served an apprenticeship.

Lugo worked as an assistant district attorney in Nassau County.

Clients come in all shapes and sizes. The prestigious list includes Chemical and Citibank, N.A., along with the Mexican, Peruvian and Paraguayan Consulates. It also lists Chinatown businesses, the largest tortilla manufacturer, and the second largest trucking firm in the city.

The list includes many women and minority-owned small businesses, as well as various city agencies.

They say they wanted to fill the void for high-quality legal services at reasonable fees and, in particular, to help the Latino community to thrive economically.

The journey isn't without its bumps, says Pacheco.

"But we're here. And we made it," she smiles.



TWIN POWERS: Carmen Pacheco (left) and Betty Lugo at law offices at 1 World Trade Center. C.J. ZUMWALT DAILY NEWS



PACHECO & LUGO
ATTORNEYS AT LAW

ONE WORLD TRADE CENTER
SUITE 2961
NEW YORK, N.Y. 10048

TELEPHONE: (212) 432-9200
FACSIMILE: (212) 432-9332

*2 summaries
of the
story
by
Sonia Reyes*

THE PRESIDENT HAS SEEN
THE WHITE HOUSE
WASHINGTON
10/2/95

Leon

10/2

Bro Miller says
thanks for fighting
Yucca Flats provision
of Energy Bill

But says we
haven't threatened to
 veto - we we keep will
help us a lot then -

Advice -

Bx

THE PRESIDENT HAS SEEN
10/2/95

Lyndon
Very interesting
experience

If It Ain't Broke...

Don't Try to Fix a Tax System That Is Doing What America Wants

By Herbert Stein

THE COSTS and difficulties imposed upon taxpayers in complying with the federal income tax are commonly used as reasons for a radical change in the federal tax system. They lead Rep. Bill Archer, chairman of the House Ways and Means Committee, to say that we need to tear the income tax out by its roots. We are offered as simpler replacements the Armer flat tax, the Gephardt 10 percent tax, the value-added tax and a national sales tax.

I believe that all this discussion is seriously mistaken, and possibly intentionally misleading, for two reasons. First, it implies an erroneous notion of the purpose of the tax system, and second, it reflects an exaggerated impression of the costs of compliance.

One can ask whether a pencil is a simpler writing instrument than a word processor. The answer obviously depends upon the purpose for which the instrument is to be used. If the object is to do a crossword puzzle, the pencil is simpler. If the object is to write a long document, revise it along the way, check the spelling, insert charts and footnotes, make a clean copy and store the work in a small space—the computer is much the simpler instrument, even though it comes with a thick instruction manual.

Moaning about the complexity of the income tax assumes that the object is simply to raise about \$600 billion of annual revenue. If that is the object there surely are simpler systems than the federal income tax. But suppose that the object is to raise that much money in such a way that the higher the taxpayer's income is, the higher the proportion he pays in tax. Most of the radical alternatives to the income tax that are now being proposed gain much of their simplicity by giving up the attempt to do that, or to do it to the degree that it can be done by the present tax system.

The difficulty of filing an individual income tax return does not result from the existence of a schedule of five different tax rates. The IRS provides a table that relieves most taxpayers of doing the simple arithmetic involved in that. The difficulty arises from requiring the taxpayer to list all his deductions and sources of income. The deductions problem can be solved by eliminating deductions—for taxes paid, for charitable contributions, for medical expenses, for mortgage interest and so on. Minority Leader Richard Gephardt's proposal would do that, except for that most sacred of sacred cows—the mortgage interest deduction. The ideal of eliminating the deductions raises howls from the expected sources, but it is a route to simplification, if that is the main objective.

The basic difficulty is the requirement that individuals list all their sources of income—not only wages and salaries but also interest, dividends, capital gains, self-employment income, business income, rental income, pension distributions and anything else they have. A sales tax would bypass this problem by making it unnecessary for individual taxpayers to file any returns at all. But that would also eliminate any possibility of progressivity except in a crude and

limited form by exempting from the sales tax some kinds of purchases believed to bulk largest in low-income budgets.

Sens. Sam Nunn (D-Ga.) and Pete Domenici (R-N.M.) have a plan that they say preserves progressivity while promoting savings. But their proposal also shows that taxing consumption is no way to achieve simplification. The taxation of consumption at a progressive rate—i.e., the more the consumption, the higher the rate—requires a more complicated return from the taxpayer than the taxation of income does, because it requires a calculation of savings that can be deducted from income to arrive at consumption.

The Armer flat tax achieves a high degree of simplification by not requiring the individual taxpayer to report and pay tax on any income other than wages and salaries. All other income, which is essentially the quarter of the national income that is a return to capital, would be taxed only at the business level and at a flat rate. Thus, a dollar of dividends would be taxed at the same rate whether the dollar accrued to a person with \$10,000 of income or to a person with \$1 million of income. Gephardt cannot achieve the same degree of simplification because he wants the individual to pay tax on

is an aspect of a highly developed economy. We no longer grind our own flour, cut our own hair or repair our own automobiles. There is no more reason to expect that everyone should do his own tax return than that everyone should be his own cardiologist.

Of the 35 million people who file form 1040 and do not take the standard deduction, probably about 10 million do not feel the need for help from a paid tax-preparer. I will give myself as an example. My return for 1994 came to 34 pages of schedules, not because my income is so large but because I have a large variety of income sources, expenses and deductions. I encountered some problems in filling out the forms, but I found the answers in a few paragraphs of a book that I bought for under \$15 and that is smaller and clearer than the manual for my computer. Then I used a computer program costing around \$30 that guided me step-by-step through my entries, called attention to any discrepancies, did all the calculations and printed out the results. When I was through I felt that I had met a challenge and had learned something about my own finances as well as about the income tax.

ILLUSTRATIONS BY DAVID MCLIMANS FOR THE WASHINGTON POST

that kind of income at the same rate as on wages and salaries, which requires that he report all that income.

The question before the American people is not whether they would like a simpler tax system. Of course they would. The question is how much of the ability to levy taxes progressively they are willing to give up in order to achieve greater simplicity. Or, to put the question more crassly, how much additional tax are middle-income people willing to pay in order to achieve greater simplicity, for themselves and, especially, for the higher-income taxpayers who have more complex tax returns.

So how complicated is compliance with the federal individual income tax? Some people like to frighten us by pointing to a 10-foot shelf of impenetrable language that constitutes the federal tax code. But, in fact, few taxpayers have anything to do with that.

In 1993, 114 million individual income tax returns were filed. Of these 21 million were filed on 1040EZ and 28 million on 1040A, both very simple forms. The basic form, 1040, was filed by 65 million taxpayers, but of these half took the standard deduction rather than itemizing their deductions. These were probably also very simple returns. Almost two-thirds of all the taxpayers filing the basic return—1040—used the assistance of a paid tax-preparer. This fact is sometimes cited as evidence that the tax must be very complicated. But specialization

I may be unusual, but not extremely so. (People think that because I am an economist I have exceptional ability to forecast interest rates and the stock market and to understand the income tax. Unfortunately, that is not so.) Over one-fourth of all households now have computers, and the proportion must be higher in households that have complex tax returns. We are raising a generation of children who have been using computers since kindergarten and who will wonder why we found the income tax difficult. By their time the postcard, of which the flat-taxers are so proud, will be obsolete, as will the post office.

The flat-taxers have come along too late. In another generation, in Newt Gingrich's brave new world of high tech technology, all economic transactions will be electronically recorded in financial institutions, whence they will be electronically transmitted to the IRS computer that will calculate the tax liability of each individual taxpayer and instantly debit his or her bank account. Some people will miss the fun of doing their own income tax, but I suppose they will find other amusement. For the present, compliance with the income tax is burdensome to some. But so are other responsibilities of membership in this society, like jury duty, voting and, if necessary, serving in the armed forces. If, as I think, progressive taxation is a feature of a good society, the compliance costs are not too great.

Herbert Stein is a senior fellow at the American Enterprise Institute. His latest book, written with Murray Foss, is "The New Illustrated Guide to the American Economy" (AEI Press).

THE PROBLEM HAS BEEN
10/2/95

26 Clayton

THE PRESENT HAS SEEN
10/2/95

Laura
Fyfe Bx

10/2/95

WHO WILL FACE THE MUSIC?

When it comes to the nearly broke Social Security system, virtually nobody.

BY ELIZABETH KOLBERT

AMA SUTRA IS STILL WARMING UP WHEN THE FIRST students approach the ticket table. It is a Wednesday night a few weeks before finals at the College of William and Mary and everyone seems to be wearing the same half-sullen, half-somnolent look that is Generation X's answer to stress. Upon learning that it's going to cost them \$3 to hear the band's generic grunge sound, some are about to amble off when Brady Gintert goes into his spiel.

Gintert, a big, burly 22-year-old with a little Ethan Hawke beard, is clutching a stack of fliers in one hand and gesticulating broadly with the other. The fliers are filled with dire predictions about the fiscal future, and Gintert is clearly making an effort to deliver them in a suitably grave tone. Unless current laws are changed, he warns the students, who have started surreptitiously to finger their wallets, their generation will be totally shut out of the Social Security system. So much is being spent on current retirees that entitlements and interest on the national debt will consume the entire Federal budget by the year 2012. A few years later, Social Security will start eating up its reserves.

"And, in the year 2029 — these are Government numbers," he continues, "the system will go bankrupt. So it's foremost in our generation's dire interest to reform the system. Because we will have nothing, and our kids will have even less."

If any of the students are moved by Gintert's exhortations, they don't show it; as he talks, their sullenness seems to harden into something solid, like plaster of Paris. Still, almost all of them cough up the \$3, either because they are convinced the cause is worthy or, more likely, because they really want to hear the music.

The money is going to PAC 20/20, which bills itself as the nation's first political action committee dedicated to protecting young Americans' stake in Social Security. (Its motto: "Foresight is 20/20.") The PAC was founded earlier this year by three recent William and Mary graduates, one of whom, Christian Klein, is collecting cash behind the ticket table. By anyone's standards, this PAC is peanuts; it operates out of Klein's bedroom and considers a successful fund-raising event one like tonight's, which nets \$300. (By contrast, the American Association of Retired Persons has an annual budget of more than \$300 million.)

America, it is often lamented, is an increasingly polarized nation in which one group is all too ready to assume that its interests are being trampled by another. Over the last few years, fierce battles have been waged over affirmative action, the right to pray in school and the treatment of illegal immigrants. And yet in this profoundly contentious period, there has hardly been even a skirmish

Elizabeth Kolbert reports on media and politics for *The New York Times*.

over a huge and growing generational inequity. Not only through Social Security and Medicare, but also through veterans' pensions and a score of other programs for the elderly, the Federal Government has, over the last several decades, effected an immense transfer of wealth from one group of citizens to another, from young working Americans to retirees.

Politicians on both sides of the aisle, who are usually quick to exploit any potential "wedge" issue, have been extremely wary about even acknowledging this one. In fact, they have done their best to avoid it altogether. Even in the current debate over cutting Medicare, both sides have effectively conspired to obscure the truth about the issue, which is that the Republicans' proposals, which Democrats call cruel impositions on the old, would make only a marginal difference in what the system already costs the young.

It is this pattern of evasiveness that the founders of PAC 20/20, with their awkward if well-intended amateurism, are trying to challenge. They are not, they insist, interested in generational warfare — "my grandmother's a big supporter," Klein points out — and even if they were, it's doubtful their elders would notice. But though they are now a straggly group serving a special interest that doesn't seem especially interested, time, in a morbid sort of way, is on their side. The same fiscal policies that have favored the elderly at the expense of the young have also brought the nation's social insurance system to the verge of ruin. The numbers can be juggled for a few more years — 5, maybe 10 — but the system is going to have to be reconstructed, and at enormous cost. And when the country does finally get around to reckoning it, our sense of what the 1980's and 90's were about is likely to change. They will no longer seem to have been the decades in which we fought bitterly over affirmative action, school prayer and illegal immigrants, but the decades in which we ignored — out of fear, inattention and just plain selfishness — the real risks posed to the nation's future.

WRITING IN NEWSWEEK IN 1967, PAUL SAMUELSON, THE NOBEL PRIZE winner and textbook author, declared: "The beauty about social insurance is that it is actuarially unsound. Everyone who reaches retirement age is given benefit privileges that far exceed anything he has paid in." This kind of beneficence is possible, he went on, because "the national product is growing at compound interest and can be expected to do so for as far ahead as the eye cannot see. . . . A growing nation is the greatest Ponzi game ever contrived."

When Samuelson was writing, the United States was just coming to the end of two decades of postwar prosperity. Social Security was 32 years old and on the verge of an enormous expansion. Medicare was only 2.

Both Social Security and Medicare were conceived in the same spirit of optimism that infused Samuelson's oft-mocked prose: the economy and the number of young people would keep growing, so there would always be more workers to pick up the tab for those who had retired. It was fine to take a little more than you put in; in fact, it was O.K. to take a lot.

This assumption is fundamental to the current system, but has apparently

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2/4



A grunge band is the draw at a fund-raising event for PAC 20/20, which is dedicated to protecting the younger generation's stake in Social Security. If we don't reform the system, says one member, "we will have nothing."

been forgotten or suppressed in the intervening years. Until recently at least, programs for the poor like welfare or food stamps were called entitlements, but few Americans thought they were really owed to their recipients. In contrast, programs for the elderly tend to be viewed as genuine entitlements, benefits people have earned during their working lives and are entitled to get back when they retire, just as one is "entitled" to money one has put in the bank. A recent survey for the American Hospital Association shows that 72 percent of all Americans believe that retirees collect Social Security as "benefits their taxes have already paid for," and that 53 percent believe the same about Medicare.

But the windfall the average senior citizen gets from Social Security and Medicare is so substantial, it makes the money received by, say, your average welfare mother hardly seem worth fighting over. According to the latest calculations by economists at the Urban Institute, many retirees have received enough benefits above what they paid into the system to purchase a house and car and still have something left over. For instance, a couple with one earner who made the maximum wage taxed under Social Security — \$61,200 in 1995 — and who retired this year can expect to get about \$240,000 more in benefits than the earner paid in. A couple whose breadwinner was making an average income — about \$25,000 — can expect an even larger net gain, about \$250,000.

This kind of return might be fine if the Ponzi scheme were working as Samuelson and others had imagined, but, as most Americans are by now aware, it is not, because of several unforeseen developments. First, older Americans started living longer and consuming more benefits. Then, real wages began to stagnate. And finally, instead of reproducing at a rate sufficient to provide an ever-growing number of workers, Americans stopped having children; the baby boom gave way to the baby bust. Together, these factors have shifted the equation dramatically. In 1950, there were 100 workers paying into Social Security for every 6 beneficiaries; by 1990, there were 27 beneficiaries. By 2030, there will be 43 beneficiaries.

By 1983, just 16 years after Samuelson's rosy prediction, the Social Security system was already in serious enough trouble to prompt a much-publicized crisis. Months of negotiations on Capitol Hill produced a "compromise" to save it, which included a stiff increase in the payroll tax. This compromise was supposed to keep the Social Security system solvent for at least 75 years, or until 2058. The

of children. Today, those figures are reversed: 12 percent of the elderly are considered poor, compared with 20 percent of the nation's children.

LARRY KOTLIKOFF HAS SPENT THE LAST SEVERAL YEARS WORKING full time over the inequities of America's pay-as-you-go social insurance system. A slight, earnest man, Kotlikoff teaches economics at Boston University. He tends to speak in the dry, abstract terms of his profession, except when he talks about politics. "What's going on down there in Washington," he says, "constitutes reckless endangerment of the next generation."

I met Kotlikoff in his office, which overlooks the Charles River and is decorated with drawings by his 5-year-old son, Alex. I had come across his work in a volume published in 1993 by A.A.R.P., "Justice Across Generations: What Does It Mean?" Most of the contributors — historians, philosophers and clergymen — argued that "justice across generations" was difficult to define, but, to the extent it could be defined, existed. Kotlikoff, on the other hand, argued that in economic terms at least the phrase was simple to define, and that in those terms "justice across generations" definitely was not being done. There needs to be, he wrote, "a frank recognition of the zero-sum nature of generational policy, namely that helping one generation is likely to require hurting some other."

At the root of Kotlikoff's anxiety is a matter of accounting. America may currently be obsessed with balancing the budget, but such an obsession, Kotlikoff insists, distracts us from the real problem. It's not that he is a free spender — far from it — rather, he is convinced that the budget deficit is a grossly inadequate indicator of America's real economic woes. The deficit measures spending on a year-by-year basis, when what is needed is a long-term measure that takes into account the spending commitments the Government has made far into the future. When these commitments are tallied up, the deficit, estimated at some \$160 billion this year, starts to look like small change. For Social Security alone, the "unfunded liability" — the difference between the benefits the Government expects to pay out and the taxes it expects to take in — is estimated at more than \$7 trillion.

To focus attention on the problem, Kotlikoff and his colleagues have come up with their own method of accounting — "generational accounting." By this method, the budget would be in balance if each generation took out of

THE NEW YORK TIMES, SUNDAY, AUGUST 27, 1995

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A.A.R.P.'s council sets its legislative agenda, which, though largely reflecting the concerns of the over-65 set, also targets education and children's health. Meeting those goals could cost the Government an extra \$800 billion a year.

the system no more than it put in. It has won a fairly wide following in economic circles, and even some small renown in Washington. For three years, the White House included a section on generational accounting in its budget. This year, however, when the President proposed a budget that did virtually nothing to remedy the generational imbalance, the section was dropped. Members of Congress have also expressed interest in Kotlikoff's method, but when he runs the numbers for their proposals, as he did for the Senate Republicans' plan this spring, their interest, too, tends to wane.

"We had this whole balanced budget debate," he says in a voice choked with frustration, "and there was a lot of reference to the next generation. You might ask these guys, Why is it if they're concerned about the next generation, they don't want to measure how we're treating the next generation?"

Kotlikoff's numbers are indeed frightening. For retired Americans, generational balance is virtually impossible to achieve, since they have already paid most of their taxes. But even for the youngest Americans, achieving generational balance would require truly drastic action — either an immediate Federal income tax hike of 52 percent, or a 70 percent increase in payroll taxes, or a 95 percent cut in Social Security payments, or some combination of these. Every year that goes by without such changes adds to the generational deficit and makes balance that much tougher to achieve. If, for example, we wait until 2001 to make the necessary fixes, Kotlikoff calculates that income tax rates will have to go up 63 percent, or payroll taxes will have to rise 79 percent, or Social Security will have to be eliminated altogether.

IN THE BASEMENT OF THE WILLARD HOTEL, ONE OF WASHINGTON'S PIN-est, A.A.R.P. is holding its 1995 legislative conference. The group has taken over the ballroom, and members of the council, which formulates A.A.R.P.'s legislative agenda, are sitting at tables that form an enormous rectangle with a podium at one of the places. The arrangement makes the invited speakers seem less like outsiders and more like A.A.R.P. members, a presumption of intimacy that most of the speakers seem only too happy to indulge.

With the exception of Senator Bob Kerrey, who occupies a prominent place on A.A.R.P.'s enemies' list, the speakers all either play down or sidestep the increasingly awkward question of what the group's agenda means for younger generations. Richard Gephardt, the House minority leader, takes up the issue only long enough to dismiss it. "You get all this argument about intergenerational fighting — can we continue to pay these bills if

we've got all these other needs?" he says.

"Well, I think that's a crazy discussion," Gephardt's words are exactly what council members like to hear. Not because they are ruthlessly self-interested, indifferent to future generations, but precisely the opposite.

Eugene Lehmann, 78, a kindly man with a white buzz cut, has spent the last year and a half as A.A.R.P.'s president and describes himself as a typical member. A retired teacher, Lehmann speaks disparagingly of groups like PAC 20/20 that "organize on a generational line," and he seems sincerely disturbed that some people might accuse A.A.R.P. of being just such a group. A.A.R.P.'s membership may be older, he says, but that does not mean it is insensitive to the concerns of the young. Recently, he tells me during a break in the conference's packed schedule, he volunteered to serve on a committee working to pass the school budget in his hometown, Madison, Wis. "I signed on because I want to demonstrate that I support a strong educational system," he says. "I support taking care of our children and older people, and I think you'd find there's universal support for that."

With more than 30 million members, A.A.R.P. is one of the nation's largest lobbying organizations and, after the Catholic Church, the largest organized group of any kind. Almost by definition, it is a mainstream organization, and as such embraces all the contradictions of being elderly in America today.

Membership in A.A.R.P. is open to anyone over 50 — all it takes is an \$8 annual membership fee — but the group's agenda largely reflects the concerns of those over 65. This is the generation that lived through the Depression, ushered in the New Deal, fought World War II and built the country's postwar prosperity, themes that come up frequently in conversation with members. "I was there during the Depression on a farm when finding shelter and enough to eat was a problem," Lehmann tells me. "I saw neighbors take a horse and cart and drive to the poor house." They believe, and with good reason, that they have already sacrificed and suffered a great deal; it doesn't square with anyone's vision of them, and certainly not with their vision of themselves, to think that they are now receiving benefits far in excess of what they contributed. Thus, it is not surprising that few politicians have the heart to ask them to give up some benefits, or even to introduce the notion that those benefits are being paid out at the expense of those who are younger. Young or old, most of us would prefer to believe, with Gephardt, that all generations can be taken care of.

This belief runs implicitly through A.A.R.P.'s legislative goals, which are printed up each year after the conference in a phone-book-size volume. Its pages are full of talk about increasing spending on Medicare and on education, on long-term care and on children's health. In 1993, the National Taxpayers Union Foundation, a fiscally conservative watchdog group, priced out A.A.R.P.'s goals and estimated that their fulfillment would eventually cost the Federal Government an extra \$800 billion a year.

IN AUGUST 1993, WHEN BILL CLINTON'S FIRST BUDGET SEEMED HEADED for defeat, Senator Bob Kerrey cast the vote that saved it. At the same time, the Nebraska Democrat extracted a curious commitment: the President would appoint a commission to examine entitlement spending; Kerrey would be the head. The whole performance, which at one point included an invitation from the Senator to the President to join him at the movies, was typical Kerrey — that is to say, inexplicable by conventional political logic. While everyone else was running away from the problem of entitlements, Kerrey was running after it.

The commission was made up of current and former Government officials, as well as a handful of business and union leaders. By the end of last summer, its 32 members were able to reach a broad consensus that current spending patterns would bankrupt future generations. In mid-December, the commission produced

4/4

a lengthy final report containing five separate proposals for reform. Kerrey's proposal called for, among other things, raising the retirement age and reducing benefits for affluent retirees. Sensing no political advantage to be gained, most of the commission's members declined to sign on to any of them. By now, bound volumes of the report, filled with glossy, full-color charts prophesying doom, have doubtless made their way into landfills all across the D.C. area.

Kerrey is famous for his detachment — during the last Presidential campaign, his aloofness earned him the nickname "Cosmic Bob" — but he is blunt when he talks about his colleagues' reluctance to face what they know to be a looming crisis. "They do not want to deal with it politically," he says. "Any problem that can be postponed till tomorrow by a politician will be postponed. And this is a problem that we can still postpone."

Kerrey, 52, has just returned to his office after speaking to A.A.R.P. at the Willard. Although it is hard to say exactly what has brought him to play the Cassandra of the United States Senate, the role does seem to satisfy his contrarian streak. This morning, Kerrey seems downright pleased to have been able, once again, to sound the warning before a crowd of resistant retirees.

The Senator and A.A.R.P. have been at odds ever since the entitlement commission was established, and in a state of open warfare since its final report was issued. At that point, the group said it was "appalled" that Kerrey continued "to use seniors as the scapegoat for our nation's deficit problems." It concluded, somewhat incongruously, "Our children deserve better." Kerrey's willingness to take on A.A.R.P. has made him a local hero among the small but growing number of 20-somethings entering political consciousness. The leaders of PAC 20/20 wanted to give Kerrey its first campaign contribution until they realized he had already been re-elected. And the co-founders of Lead... Or Leave, a second, nearly defunct lobby for Generation X, describe Kerrey as the secular version of a martyr to the cause. (The pair congratulated the Senator on having the courage to dive "on

benefits to the elderly. When Americans found out about this side of the equation, the response was immediate — and negative. And so within days, the Republicans were backpedaling, trying to explain that they were not really cutting Medicare to balance the budget and to provide the wealthy with tax breaks.

The first argument they came up with was that the cuts in Medicare shouldn't be called "cuts" — the very term disturbs voters — they should be called "slower increases in the rate of growth." Their second argument was more daring, if also more disingenuous. Pollsters discovered that if voters were told that Medicare was in danger of going broke by 2002, they were much more likely to believe some changes were acceptable. Republican lawmakers suddenly developed a passionate interest in saving the system. All at once, they began to insist they weren't interested in cost-cutting at all, they were interested in protecting Medicare from itself. "We're going to make sure the program survives," Newt Gingrich told interviewers from A.A.R.P. this summer.

Medicare and, by extension, Social Security are among the few issues Democrats believe they can win on in 1996. This is why they were so ticked off when, in June, President Clinton announced his own balanced budget plan. While the President's proposed Medicare cuts are roughly half the size of those proposed by the Republicans, many Democrats felt that all Clinton did was muddy the waters, making it that much more difficult for them to campaign as defenders of the elderly.

The reason Democrats are so eager to campaign on Medicare is not just that the elderly vote in larger proportions than any other age group, or even that the elderly are one of the party's most loyal constituencies. It is that support for Medicare and Social Security actually plays well with all generations. People over 65 are concerned about the benefits they are already receiving. People in their 50's are concerned about the benefits they will soon be receiving. And people in their 30's and 40's are worried about their aging parents' benefits, and nervous that they might have to help out.

Senator Bob Kerrey is blunt about his colleagues' reluctance to face what they know to be a looming crisis: 'They do not want to deal with it politically.'

the grenade of entitlements" — not necessarily the best metaphor to use in connection with Kerrey.)

Since the commission disbanded in January, Kerrey has continued to go his separate, if not so merry, way. In May, he was one of three Senate Democrats to vote for the Republican budget plan, all the while denouncing it as too timid.

One of Kerrey's few allies, indeed perhaps his only ally in the Senate, is Alan K. Simpson, the Wyoming Republican. If Kerrey is A.A.R.P.'s Grant, Simpson is its Sherman. In an obvious effort to blunt the group's influence, Simpson, 63, held hearings this summer on A.A.R.P.'s nonprofit tax status, which, he argues, is incompatible with its lucrative arrangements with various insurance companies. Simpson was among the few members of the entitlements commission to sign on to a detailed proposal, and this spring he and Kerrey jointly introduced Social Security legislation to raise the retirement age and limit cost-of-living increases. The chances of the bill's getting anywhere soon, with a crucial election approaching, are approximately zero. "Our colleagues are solidly in back of us," Simpson says, "way, way back."

FOR DEMOCRATS ON CAPITOL HILL, THE WINTER OF 1995 WAS THE darkest anyone could remember. It wasn't just that the Republicans had captured both houses of Congress or that the Clinton Presidency looked so weak. It was that they didn't have a clue what to do in response. The Republicans were trumpeting their plans to balance the budget and getting tremendous press. Should the Democrats come out against the idea, or should they come up with their own plan, or should they just passively play along?

Then the Republicans made their plan public, with its proposed cuts in Medicare, and the Democrats' mood brightened perceptibly.

During the campaign, the Republicans had stressed balancing the budget and lowering taxes, but had neglected to mention that this would entail cutting

Even the 20-something crowd is sympathetic. ("You don't want to stab your grandparents in the back" was how Brady Gintert of PAC 20/20 put it.) Polls show that even as younger Americans grow more pessimistic about their own chances of collecting retirement benefits, they continue to believe the benefits their grandparents are getting today are too meager. In fact, a majority of young people believe that the old are not even getting out of the system what they put in.

The broad support enjoyed by programs for the elderly is clearly a product of the family connections among generations that make age a different kind of social category from, say, race or ethnicity. It reflects the widespread recognition that programs for the old are, indirectly at least, also programs for the middle-aged and the young, who in the absence of Government benefits would have to take care of elderly relatives themselves. But this support also reflects an uncritical faith in the endless bounty of the system.

Sometime in the next year, PAC 20/20 hopes to make its first campaign contribution to a candidate who is speaking out against the system's unfairness. There won't be many to choose from. As they gear up for the next election, politicians at all levels of government once again can be heard declaiming on issues like affirmative action, school prayer and illegal immigrants. The issues of concern to PAC 20/20 rarely even get mentioned.

Most of the wedge issues that are so popular in American politics feature an "other" who can be comfortably pictured as outside the mainstream, as too poor, too rich, too liberal, too conservative, too dark or too white. The grand design of America's social insurance system was to bring everyone in. This is the beauty of the system and also, it turns out, the greatest barrier to its survival. Because the system embraces everyone, its problems can't be foisted off on any of the usual culprits. They aren't caused by right-wing zealots or welfare cheats, but rather by millions of ordinary middle-class Americans who are simply collecting benefits they haven't paid for. ■

THE PRESIDENT HAS SEEN
10/21/95

Burn/Welcoming

This is my goal
but we need to discuss
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qualifies + we'll be that
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up on on
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spousal improvement
etc.

Rehabilitation Needed, Not Surgery



The trust fund's crisis isn't new; the President offered a solution to insolvency.

By ROBERT E. RUBIN, DONNA E. SHALALA, ROBERT B. REICH and SHIRLEY S. CHATER

Our nation is involved in a serious examination of the status and future of Medicare. Congressional Republicans have called for \$270 billion in cuts over the next seven years, claiming that Medicare is facing a sudden and unprecedented financial crisis that President Clinton has not dealt with, and that all of the majority's cuts are necessary to avert it.

While there is a need to address the financial stability of Medicare, the congressional majority's claims are simply mistaken. As trustees of the Part A Medicare Trust Fund, which is the subject of the current debate, and authors of an annual report that regrettably has been used to distort the facts, we would like to set the record straight.

Concerns about the solvency of the Medicare Part A Trust Fund are not new. The solvency of the trust fund is of utmost concern to us all. Each year, the Medicare trustees undertake an

examination to determine its short-term and long-term financial health. The most recent report notes that the trust fund is expected to run dry by 2002. While everyone agrees that we must take action to make sure that the fund has adequate resources, the claim that it is in a sudden crisis is unfounded.

The Medicare trustees have nine times warned that the trust fund would be insolvent within seven years. On each of those occasions, the sitting President and members of Congress from both political parties took appropriate action to strengthen the fund.

Far from being a sudden crisis, the situation has improved over the past few years. When President Clinton took office in 1993, the Medicare trustees predicted the fund would be exhausted in six years. The President offered a package of reforms to push back that date by three years and the Democrats in Congress passed the plan. In 1994, the President proposed a health reform plan that would have strengthened the fund for an additional five years.

So what has caused some members of Congress to become concerned about the fund? Certainly not the facts in this year's trustees report that these members continually cite. The report found that predictions about the solvency of the fund had improved by a year. The only thing that has really changed is the political needs of those who are hoping to use major Medicare cuts for other purposes.

President Clinton has presented a plan to extend the fund's life. Remarkably, some in Congress have said that the President has no plan to address the Medicare Trust Fund issue. But he most certainly does. Under the President's balanced budget plan, payments from the trust fund would be reduced by \$89 billion over the next seven years to ensure that Medicare benefits would be covered through October 2008—11 years from now.

The congressional majority's Medicare cuts are excessive; it is not necessary to cut benefits to ensure the fund's solvency. The congressional majority says that all of its proposed \$270 billion in Medicare cuts

over seven years are necessary. Certainly, some of those savings would help shore up the fund, just as in the President's plan. But a substantial part of the cuts the Republicans seek—at least \$100 billion—would seriously hurt senior citizens without contributing one penny to the fund. None of those savings (taken out of what is called Medicare Part B, which basically covers visits to the doctor) would go to the Part A Trust Fund (which mostly covers hospital stays). As a result, those cuts would not extend the life of the trust fund by one day.

And those Part B cuts would come out of the pockets of Medicare beneficiaries, who might have to pay an average of \$1,650 per person or \$3,300 per couple more over seven years in premiums alone. Total out-of-pocket costs could increase by an average of \$2,825 per person or \$5,650 per couple over seven years. According to a new study by the Department of Health and Human Services, these increases would effectively push at least half a million senior citizens into poverty and dramatically increase the health care burden on all older and disabled Americans and their families. The President's plan, by contrast, protects Medicare beneficiaries from any new cost increases.

As Medicare trustees, we are responsible for making sure that the program continues to be there for our parents and grandparents as well as for our children and grandchildren. The President's balanced budget plan shows that we can address the short-term problems without taking thousands of dollars out of peoples' pockets; that would give us a chance to work on a long-term plan to preserve Medicare's financial health as the baby boom generation ages. By doing that, we can preserve the Medicare Trust Fund without losing the trust of older Americans.

Robert E. Rubin is secretary of the Treasury. Donna E. Shalala is secretary of health and human services. Robert B. Reich is secretary of labor. Shirley S. Chater is commissioner of Social Security.

and in the houses of the rich. On cross-examination, Prosecutor Christopher Darden asked if Lopez could tell time. To some this seemed insulting—an allusion to the stereotype of Hispanic *manaña* or an implication that Lopez, who read English

consequent naming patterns are among the most variable of cultural variables. Many cultures, including some Latin American ones, use both the paternal and maternal surnames; that Lopez used a singular surname may have been an accommodation to

is to seek not a conviction but truth, know enough of the cultures of those questioned, accused and charged to ensure that cultural difference is not redefined as crime? Should not defenders be aware of cultural mitigations and motivations? In a state as diverse

Move Over, Ross Perot

Describing the 4,000 people who attended the recent Ross Perot conference in Dallas as representatives of the "radical middle," David Broder in his Aug. 15 op-ed column concluded that they are "probably the next wave in American politics."

I take exception to Broder's conclusions for two reasons:

There is much more to the middle ground of politics in America today than those who are speaking out angrily with radical views.

And while it is not attending conferences presided over by leaders adept at gaining

Taking Exception

national publicity, this other segment of the electorate is gathering force and could alter the political situation significantly in its own way.

This other portion of the "middle" is taking a less-polarized, more inclusive approach to public decision-making than we have been seeing for years. Its alternative political style is a grass-roots phenomenon, hard to spot from inside the Beltway.

The trend is emerging in dozens of communities, local environmental organizations and small groups discussing some of the society's most volatile issues. "I sense a hunger for less conflict and more communication," says Laura Chasin, director of the Public Conversations Project in Watertown, Mass.

It may not be long before this new style makes its way into national politics, producing leadership that attempts to communicate with people rather than talk at them in sound bites. We might even see some congressional and presidential candidates in 1996 attempting to listen to a broad range of public opinion, seeking public suggestions and feedback rather than advancing simplistic programs in response to polls.

At the heart of the alternative politics is the notion of a more civil public discourse. Almost all the other characteristics of this approach—greater individual participation, concern for the community and an openness to partnerships with diverse interests—flow from this core idea.

Two examples of the emphasis on reasoned discussion and cooperative efforts come to mind:

■ In Madison, Wis., a group of seven people, six from pro-life and pro-choice groups around the state, met with a mediator for 13 months beginning in late 1991, talking together for several hours once every four to six weeks. One result was that "we came to see each other as people first, and as people with opinions second," says Maggi Cage, who participated in the meetings. Another result was a mutually agreed-on approach to sex education in schools, which the group presented to state legislators for their consideration. Such discussions don't need to be large; a few people can plant seeds that spread change.

■ In Charlottesville, Va., a "sustainability council" arising in 1994 from a planning commission project had by June established 14 discussion groups involving hundreds of people. Many people have stuck with the project through two conferences, with a third planned in November. The goal is a region-wide partnership among citizens, business, public interest groups and government, striving for strong local markets, clean technologies and durable housing construction.

THE WASHINGTON POST
SUNDAY, AUGUST 27, 1995

THE PRESIDENT HAS SEEN

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How could something so apparently simple as people talking together in a cooperative spirit bring about a change in the nation's political style? To answer, we may need to recall that especially since World War II, the American public has been losing—or giving up—its communal voice. Propelled by the forces of the modern age, including television and sprawling suburban development, we have separated ourselves from each other. As writers such as Robert D. Putnam have observed, people aren't joining the PTA or women's clubs. They aren't helping out at the Red Cross or the scouts, and they are turning away from the Lions, the Shriners and the Masons.

In a troubling statistic for the health of politics, six out of 10 eligible people didn't vote in last fall's elections. That left a vacuum to be filled by some of the angriest among us, those who have tended to make the government a scapegoat for their frustrations. With recent congressional actions as an example, there has seemed to be little room for the moderate—the person with opinions but also with some concerns that may be shared by the “opposition,” making compromise and joint efforts possible.

The meetings and conversations now taking place in growing numbers nationwide may be a cause of many of the turned-off and disenfranchised finding opportunities to reclaim their voices and affect public affairs without relying on highly publicized, outspoken gatherings or forming new movements with narrow agendas.

One can imagine many ways that this grassroots, participatory democracy may make itself felt in the national policy-making process. In addition to influencing the style of election campaigns, discussion groups could address contentious issues that face the whole society, interact with newspapers, which are themselves seeking ways to increase public involvement and communicate with computers, community antenna television and even the TV networks. The challenge will be to use products of the information age to help humanize politics rather than further depersonalize it.

Other routes to involvement might include greater grass-roots input to public interest organizations, nonpartisan citizen groups working locally and nationally, engagement with elected officials from mayors to senators, participation in congressional and agency hearings, and that old, time-honored method, visiting the voting booth, where this active "moderate middle" could influence the election of the next Congress and the nation's choice for president.

It wouldn't be good political thinking to dismiss the potential impact of the Perot followers and others unhappy with "politics-as-usual." But neither would it be wise to overlook the clout of this civic-minded force that is also in the political "middle." In the long run, its hallmark, more dialogue and less rancorous debate, may improve the way the nation makes its public policy decisions and also the quality of those decisions.

John Heritage is a Washington writer.

THE PRESIDENT HAS SEEN

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Colin Powell's Doctrine on Use of Military Force Is Now Being Questioned by Senior U.S. Officers

By THOMAS E. RICKS

Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON — America may be on the verge of Powellmania, but there is one place that is immune to the hype: the retired general's old haunt, the Pentagon.

Some senior U.S. officers, reviewing the military's handling of crises in Somalia, Rwanda, Haiti and Bosnia, are growing uneasy with Colin Powell's key legacy, the Powell doctrine. That doctrine holds that the armed forces should act only with decisive force and with the clear support of the American people.

Especially in the services that compete with Gen. Powell's old service, the Army, there is a sense that his risk-averse approach to the use of force was shaped too much by the Army's snake-bit experience in the Vietnam War. And even in the Army these days, the new buzz word is "minimum footprint," jargon for getting the job done with as few troops as possible — a far cry from the half-million soldiers Gen. Powell sent to take on Saddam Hussein in the Gulf War.

To be sure, the Powell doctrine is only being questioned, not replaced or even challenged directly in public. It still holds sway over much of the U.S. military, especially the Joint Staff, which has dominated American military planning since Gen. Powell's tenure as chairman of the Joint Chiefs from 1989 to 1993. What's more, the general's opinions about two other crucial questions — keeping the U.S. military out of Bosnia, and cutting its size after the end of the Cold War — still prevail in Pentagon circles.

But in the Navy, Marines and Air Force, senior officers are asking whether the Powell approach effectively ties the hands of the president by entertaining only all-or-nothing options for using military force. "Why is it," asks one skeptical Marine officer, "that whatever the question is — enforcing a peace agreement in Bosnia, evacuating the U.N. from Bosnia, or invading Haiti — the answer is always 25,000 Army troops?"

One unhappy admiral labels the Powell view "the Never-Again Club," referring to the Army's fear of repeating Vietnam in Bosnia or somewhere else. That doctrine, he contends, won't consider a military engagement unless Congress supports it and total victory is the almost certain outcome. This formulation, the admiral

argues, forecloses consideration of limited uses of force. Those lesser sorts of military engagement to support diplomacy historically have been specialties of the Navy and the Marines, services that became comfortable with "gunboat diplomacy" and "banana wars."

Even in retirement, Gen. Powell remains influential at the Pentagon. Not one of the dozens of officers outside the Joint Staff who were interviewed on this subject would speak for attribution. (Also, catching wind of this story, Air Force Lt. Gen. Walter Kross, the director of the Joint Staff, called around the Pentagon to urge some of those officers to soft-pedal their criticisms.) Nor would Gen. Powell agree to be interviewed for this article.

The revisionists aren't tackling Gen. Powell directly, but instead are taking aim at a proxy target, the Joint Staff, which reports only to the chairman of the Joint Chiefs. Under Gen. Powell's tenure as chairman, the Joint Staff moved to the center of power in the U.S. military establishment. It coordinates the activities of the regional commanders who oversee U.S. forces in Europe, the Pacific, Latin America and the Mideast.

'The Imperial Staff'

For months, the services have been nipping privately at the heels of the Joint Staff, or, as some generals call it, "the imperial staff." The Navy, for example, was outraged last October when the Joint Staff overruled its wish to move the USS Kitty Hawk, an aircraft carrier, from East Asia to the Persian Gulf to counter Saddam Hussein's brief new threat against Kuwait. Then, in the spring, outgoing Marine Commandant Carl Mundy, in a personal letter to Gen. Powell's successor, Gen. John Shalikashvili, questioned the competence of the Joint Staff's planners. Gen. Shalikashvili scheduled two meetings of the Joint Chiefs to discuss the letter, but both were postponed.

Lately, the services have become bolder in challenging the Joint Staff. That may be because this summer, for the first time, the Joint Chiefs became entirely "post-Powell" — with turnover at the top of the Army and Marines, not one of the chiefs of the services held that position during Gen. Powell's chairmanship. Perhaps because they never had their arms twisted in the hallways before meetings, as Gen. Powell was famous for doing, the new set of chiefs seems less inclined to take marching orders from the Joint Staff.

Signal From Marines

The services' new boldness in questioning the Powell way of doing business was signaled by the Marine Corps Gazette, which, using military insiders' code, called

for a discussion of "the limits of jointness."

Simultaneously, the Air Force, which has had bad blood with Gen. Powell ever since a series of incidents during the Gulf War, went ballistic over the Joint Staff's handling of Bosnia policy. The downing of an American F-16 by a Serb surface-to-air missile, and the lack of any U.S. military response, sent the Air Force into opposition.

The shoot-down also seems to have inspired the Air Force to stop grumbling that the Joint Staff didn't know how to use air power, and instead devise a plan of its own. That new plan is now the stick that U.S. diplomats are using to bring the Bosnian Serbs to the negotiating table: If the Bosnian Serbs don't start talking soon, the U.S. is threatening to bomb them while it arms the Muslims. Limited in its scope, intensity and duration, the Air Force's approach is essentially an updated version of the Navy's old gunboat diplomacy, more Wilsonian than Powellian.

Army Reconsiders

Even in the Army, the service most comfortable with Powellian doctrine, there has been some reconsideration lately of the general's tenets. After Somalia, some officers argued that always putting in large numbers of troops invites congressional second-guessing, and lays the groundwork for expanding the military mission — the dreaded "mission creep," in military jargon — as commanders find tasks to keep soldiers busy.

Also, some in the Army now suggest that the Powell doctrine's admonition to act only with the clear support of Congress and the people may be outdated in the post-Cold War world. In the absence of superpower tensions, it is much easier to send U.S. troops where they have never been before. That means the Army probably will be pulled into situations whether or not it, or the Congress, likes it.

Officers who participated say the Army's top priority in its Rwanda relief mission last summer was limiting its involvement, not being overwhelming. Out of that experience came the "minimum footprint" notion. That new model probably will get its first major test in Bosnia sometime over the next year, as U.S. troops go in either to monitor a peace agreement or evacuate United Nations peacekeepers.



Colin Powell



EXECUTIVE OFFICE OF THE PRESIDENT
COUNCIL ON ENVIRONMENTAL QUALITY
WASHINGTON, D.C. 20503

THE PRESIDENT HAS SEEN
10/2/95

Kathleen A. McGinty
Chair

95 SEP 29 P8:11

September 29, 1995

MEMORANDUM FOR THE PRESIDENT

FROM: KATHLEEN MCGINTY

CC: LEON PANETTA

RE: CEQ WEEKLY REPORT

Handwritten notes:
Sept 29
10/2/95
11:00

INTERIOR APPROPRIATIONS

In a stunning defeat of public land grabbing, the House passed a motion to recommit the 1996 Interior Appropriations to the conference committee to fix the egregious language associated with mining. Led by Representative Sidney Yates (D-IL), the Democrats prevailed 277-147, with 91 Republicans joining the motion to recommit. CEQ and OMB will meet early next week to discuss next steps.

VA, HUD AND INDEPENDENT AGENCIES APPROPRIATIONS

The Senate passed its version on Wednesday. The Senate version reduces your request for the EPA by 23%. In addition, CEQ's budget is slashed by 54%. The VA-HUD bill now heads to conference with riders attached to both the House and Senate bills.

GOP FAITHFUL BREAKING RANKS ON ENVIRONMENT

Some Republican faithful are breaking with the party on the issue of the environment. The story is attached.

TIMBER

Headwaters Forest

CEQ met with representatives from two groups which are urging the Administration to negotiate a debt-for-nature swap for the Headwaters Forest in Northern California. The Headwaters, a private forest, contains approximately 3,000 acres of redwood. The forest is controlled by Charles Hurwitz, who owns Maxaam Corporation, and used junk bonds for leverage in a 1985 hostile takeover of the Pacific Lumber Company (PLC). PLC was

logging in Headwaters but logging was suspended for years due to environmental litigation. The Federal Deposit Insurance Corporation has sued Hurwitz for \$1.6 billion for allegedly filing false claims against the government. The debt-for-nature swap would allow Hurwitz to pay off some or all of his debt in exchange for federal government title to the Headwaters forest. CEQ is now in the process of setting up a meeting of all relevant federal agencies to discuss the issue.

318 (Green) Sales

The U.S. Forest Service will be announcing the release of an additional number of "318 sales" today in Oregon and Washington (the total volume will be some 40 million board feet). These are sales that we have determined we must release under the timber provisions of the rescissions bill. They are not salvage sales and some involve serious environmental problems (particularly impacts on fish). These are some of the sales that are the subject of a pending motion for contempt against Administration officials. Because of the potential environmental impacts, we looked closely at our ability to withhold or modify the sales, but ultimately determined we are unable to do so. We are working on a process to ask the companies and individuals who are buying the timber to work with the federal agencies to make voluntary modifications to their logging plans to address environmental problems. We expect a loud and adverse public reaction to the release of these sales. Our hands are tied, however, under the rescissions bill.

Thunderbolt

The Forest Service will announce its decision today to proceed with the Thunderbolt salvage sale in Idaho. The National Marine Fisheries Service has registered strong concerns that this action will endanger fish. We expect loud protests from environmentalists.

BONNEVILLE

Bonneville Power Administration (BPA) will conclude contracts with a significant number of its direct service customers tomorrow. These contracts give BPA certainty that they will hold these customers, rather than lose them to increasing competition in the region. The Administration has been strongly criticized for this move, however. Environmentalists say that BPA is giving these customers such a cut-rate deal that they will then complain they can't afford fish protection expenditures (see attached Sierra Club release). BPA competitors will say this amounts to very unfair competition and that the only way BPA can get away with it is because U.S. taxpayers subsidize them.

PACIFIC NORTHWEST, OVERALL

Section 318 sales, Thunderbolt and Bonneville add up to very bad press for us in the Pacific Northwest for this weekend.

CONFIRMATION HEARING

The Senate Environment and Public Works Committee held a hearing to consider my nomination earlier this week. Overall the hearing went very well and given the multitude of items on the Senate agenda, turnout was fairly light. Senators Chafee, Baucus, Reid, Inhofe, Kempthorne and Lieberman attended. Senator Kempthorne chaired the bulk of the hearing and asked a long series of questions. The committee did not vote although action on the nomination is expected as soon as any supplementary questions they submit are answered. Senator Chafee has told me that he believes I will be successfully voted out of committee.

BUDGET ACTIVITIES

CEQ and EPA co-chair a working group on Environment, Health and Safety in the Budget Task Force headed by Erskine Bowles which meets daily. There are numerous proposals pending for opportunities for you to speak out on environmental issues.

WETLANDS LEGISLATION WILL RESULT IN SUBSTANTIAL LOSSES

Legislation passed by the House and proposed by the Senate would, if enacted, reduce the protection of wetlands by approximately 75 percent. The most problematic issue is a proposed new definition of wetlands. This definition has no scientific basis and is completely inconsistent with a recent National Academy of Sciences report on wetlands. This past June, the Army Corps of Engineers led teams in all fifty states to evaluate the new definition. The teams, which included other Federal agencies, states, and private sector consultants determined that the definition alone would reduce wetlands protection by 60 to 75 percent (approximately 70 percent in Arkansas). The value of wetlands has been clearly demonstrated, for both economic and environmental reasons. Congressional attempts to gut wetlands programs is a big issue with the environmental community. Through your August 1993 wetlands plan the Administration has made substantial progress in addressing the legitimate problems with federal wetlands programs. For example, the Corps recently issued a new general permit for the construction of single-family homes. Landowners no longer have to get individual wetland permits if they are building or expanding a home. Attached is a scorecard highlighting the two-year anniversary of your plan.

FDA

CEQ met with representatives from the Food and Drug Administration to discuss the timetable for release of FDA's streamlined regulations for implementing the National Environmental Policy Act. The regulations, which would ensure that the pharmaceutical industry would not have to prepare unnecessary environmental analyses are expected to be released in draft form near the end of October. We've worked hard on this and it's another great example of our Reinvention efforts. If successful, we will categorically exempt new drug applications from environmental analysis requirements.

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REGULATORY REFORM

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Lead 2/15/87
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^AM-FL- Environmental Republicans,460

^Some GOP Faithful Breaking Ranks On Environment

^d611jmtamp

JACKSONVILLE, Fla. (AP) Some Republican faithful are breaking with the party on the issue of the environment.

They call themselves Republicans for Environmental Protection. They say they're angry that their party is systematically dismantling many of the environmental protections built over the past 25 years.

Bob Stoll, member of the group in Ponte Vedra Beach near Jacksonville, said he considers himself a loyal Republican. He even campaigned for conservative icon Barry Goldwater in the 1960s.

"We, as an organization, want to remind the people in Washington that maybe they're shooting themselves in the foot that we are out here," said Stoll.

He believes most Americans, regardless of party affiliation, want strong protections.

Martha Marks, a Republican county commissioner in Lake County, Ill., said the group got its start last spring when environmental activists gathered in Washington for a meeting of the Endangered Species Coalition. Republicans at the meeting were "kind of the oddballs in that group."

"An environmentalist Republican is not quite the oxymoron you might think," Marks said. "There are actually quite a lot of us, but there is no real network for us."

Marks said the GOP is going overboard in its fervor to strip regulations. "There seems to be this feeling in Congress that the public is angry about regulations and that the public is clamoring for relief," Marks said. "Frankly, I don't see that. I think the public very much understands we need protection from the polluters. If we don't protect what we have, we'll go back to the bad old days where we had dirty air and dirty water." Environmentalists have accused the GOP-controlled House of a "stealth attack" on environmental regulations.

The House, for instance, voted to slash the U.S. Environmental Protection Agency's budget by one-third and attach 17 provisions that would prohibit the agency from enforcing certain regulations.

The House also voted to rewrite the Clean Water Act to eliminate protection for more than half of the nation's wetlands and halt the cleanup of polluted runoff. And it passed a bill that would open new avenues for industry to block regulations.

The Senate, which has yet to act on much of the legislation, is expected to take a more moderate approach.

Kim O'Keefe-Wilkins, a Jacksonville financial consultant and member of the group, said Florida has too much to lose in the current environmental debate to remain silent.

"We've got to get back to where we have respect for living things," she said. "We've got so many things in this country that we need to work real hard to protect."

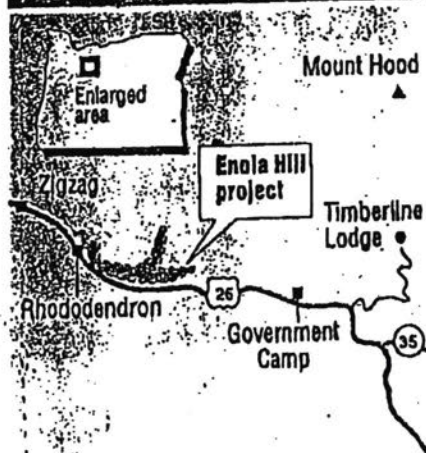
ANNUAL REPORT OF THE WHITE HOUSE
INTERAGENCY WETLANDS WORKING GROUP

**TWO YEARS OF PROGRESS
MEETING OUR COMMITMENT FOR
WETLANDS REFORM**

Protecting America's Wetlands: A Fair, Flexible and Effective Approach
• August 1993 - August 1995 •

- ✓ **Exempt Prior Converted Cropland**
All USDA Designated Prior Converted Cropland Exempt From Clean Water Act - Final Rule Published 8/24/93
- ✓ **Increase Certainty and Flexibility for Identifying Wetlands**
USDA Identifies Wetlands on All Farm Lands - Agency Agreement - Effective 1/4/94
Increase Reliance on State and Private Wetlands Identifications - Proposed 3/14/95
Develop Appeals Procedure for Wetlands Identifications on Private Property - Proposal Published 7/19/95
- ✓ **Provide Relief for Homeowners Nationwide**
Home-Related Construction in Wetlands Approved by Nationwide Permit - Issued 7/19/95
- ✓ **Streamline Processing for Private Landowners**
Streamlined Permit Review for Home, Farm, and Small Business Construction in Wetlands - Issued 3/6/95
Increased Flexibility for All Projects with Minor Environmental Impacts - Issued 8/24/95
- ✓ **Increase Incentives for Farmers**
Wetland Reserve Program Expanded to 50 States
- ✓ **Simplify Mitigation Through "Banking"**
Encourage Expanded Use of "Mitigation Banking" - Issued 8/24/93
Number of Banks has Doubled to 200 since 8/93
- ✓ **Clarify Regulated Activities**
Final "Excavation Rule" - Published 8/25/93
- ✓ **Empower State and Local Governments**
New Jersey Assumption - Approved 3/2/94
EPA Grants Program Increased to \$15 million
14 States Adopted Programmatic General Permits (PGPs) to Reduce Federal/State Overlap
Two-Day Workshop on PGPs With the States
- ✓ **Improve Efficiency of Permitting**
40,000 Activities Approved by General Permit in Average of 16 Days
4,000 Individual Permits Issued in Average of 127 days - More than 90% Approved
Only 358 Permits Denied (0.4%)
Number of Permits Pending Longer than Two Years Reduced by 70% to just 41
- ✓ **Improve Environmental Protection**
Current Estimate of Wetlands Loss is 80-90,000 Acres/Year vs. 290,000 Acres/Year in the Mid-1970s

TIMBER SALE



ANALYSIS

CLINTON'S



■ The rhetoric and the issues sound familiar as environmentalists and the industry appear ready to replay their conflict

By ROB EURE
of The Oregonian staff

9-24

After five years of uneasy truce at the bargaining table, the Northwest timber warriors seem to be back where they started with no real improvement.

Protesters have returned to Western Oregon's woods, promising to weather this fall and winter as they try to block harvests. Many have been arrested.

The Oregonian

And timber industry voices once again are decrying environmental terrorism as the industry resumes limited logging of some of the state's remaining old trees.

In between them, beleaguered federal land managers are pleading for a sympathetic ear — while their lawyers scurry from court to court facing a spate of new lawsuits.

Sound familiar?

It should. The conflict centers on many of the same faces, the same timber sales and much of the same rhetoric.

President Clinton forged a forest compromise in

Please turn to
TIMBER, Page A22

A22

METRO/NORTH

Timber: Despite their differences, both sides complain in similar tone

■ Continued from Page One

1992 as an effort to keep peace in the woods. It reduces federal timber harvest to about one-fifth of the high volumes of the late 1980s in search of a plan that would avoid crisis shutdowns like the one that followed protection of the northern spotted owl as a threatened species. But the fragile peace Clinton crafted was never popular with either side.

Environmentalists already are planning more protests, including one at a timber sale in the Mount Hood National Forest just outside Rhododendron at Enola Hill — an area controversial as an American Indian cultural site, embarrassingly visible from U.S. 26 and close to the Portland metropolitan area.

On Monday, chain saws are set to start harvesting at Roman Dunn, another timber sale left over from the earlier fights. Environmentalists claim it is loaded with treasures. They even have film of a spotted owl taken this month at the site between Eugene and Florence.

"Have we moved back to square one? We've moved below square one," says Tim Hermack of the Native Forest Council in Eugene, a hard-line timber war veteran. "They've taken our rights to court action and comment. Our only course is to have a Boston Tea Party."

The timber industry complains in similar tones, or different reasons.

"Five, eight years ago, the fight was over old-growth forests," says Mike Miller of Associated Oregon Loggers. "Today, they are against cutting any trees, period. Alive or dead."

Both sides agree that in strategic terms, the war between loggers and environmentalists looks and sounds the way it did at its height in the late 1980s.

When fallout from the spotted owl landed on the timber industry in 1990, it virtually shut down harvest from federal lands. Left hanging were scores of individual sales at various stages of preparation.

Last summer, Congress passed and President Clinton reluctantly signed the so-called salvage logging measure. It included a provision to fast-track logging on a number of sales caught in the shutdown. The provision bypasses many of the nation's environmental laws by shielding some sales from administrative appeals and lawsuit.

Environmentalists felt betrayed. They argue that they are worse off with an ally in the White House and an unfriendly Congress than they were when the reverse was true.

The action in Washington, D.C., came at the same time Clinton's forest plan began to turn out green timber sales.

But beside the new style of timber sales — designed to protect much of the old-growth forest, animal habitat and sensitive fish-bearing streams — the specter of old-style clear-cuts from the old sales under old rules added to the insult.

"It's all about what we're doing with the last of the old sales," said Tom Tuchmann, Clinton's point-man on forest issues in Portland.

Tuchmann argues that without congressional intervention, the president's plan would have maintained the uneasy truce.

"You cannot compare the timber sale program of eight years ago with the timber sale program of today," Tuchmann said.

This brings up one of the more ironic outcomes of the new logging law: Rather than reduce lawsuits, it has spawned several. At least four suits have been filed over the new law by environmentalists and the industry, and more are on the way.

The renewed war also has begun to unravel support for the timber plan.

Hermack never signed on to Clinton's plan, but says more environmentalists who did are joining him.

"I hate to think that the worst predictions I made are going to come true, but here we are, back to defending the best of what's left," he said.

Loggers counter that the environmentalists won a stunning victory over their industry with the Clinton plan but won't accept their win.

"Suddenly, it has become morally wrong to cut green trees," lamented Howard Sohn, president of Sun Studs mill in Roseburg. "I was optimistic about the Clinton plan, but the fact is that the plan turns out to be extreme and went beyond what was required. Because they went for overkill, they are seeing a reaction from Congress."

Sohn said he believed Congress might be overreacting as well, but he would not excuse the protesters' return to civil disobedience.

"I think you make your best case in politics and the legal forum, and then you accept the results," Sohn said. "We should be a little better losers than that."

So far, the main actions have come in Southern Oregon, a familiar battle ground between the industry and conservationists.

The Sugarloaf timber sale in the Siskiyou National Forest is not far from Bald Mountain, one of the most bitter battle sites in the 1980s. At Bald Mountain, Earth First — the environmentalist's most radical arm — got its start.

Warner Creek, another flashpoint sale outside Eugene, is a salvage sale on an area burned by arson in 1992. It has emerged as a major protest point for environmentalists from across the country as an example of how the new law squelched lawsuits.

In coming weeks, environmentalists are eyeing several other timber sales they may protest.

Several near Portland could provide a chance to draw on the area's large population of environmentalists and heavy media concentration.

The Enola Hill sale is one of those. Located on a hillside above U.S. 26 on the side of Mount Hood, the helicopter logging will be both readily visible from the road and easily accessible by protesters.

The sale, included in the sales the new logging law aims to speed, has been stalled for years by claims that Indians used the slope for religious wanderings called vision quests.

Foresters say the logging plan is an example of new, environmentally conscious harvesting. Loggers will remove between 25 percent and 50 percent of the overhead canopy in a thinning operation. A logging contract has been awarded to Hanel Lumber Co. Inc. of Hood River and could begin as soon as next month.

"We're conscious of spreading ourselves too thin," said Mark Hubbard, conservation director for the Oregon Natural Resources Council. "But we are also conscious that the Forest Service and BLM can only monitor so much activity at one time."

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NEWS

... from the **Sierra Club**



For immediate release: September 29, 1995

For more information, please contact:

Bill Arthur, 206-621-1696

Jim Baker, 509-332-5173

DOE BETRAYS NORTHWEST RATEPAYERS, REVERSES DECISION ON BPA'S POWER SALES CONTRACTS WITH DSIs

"The Clinton administration yesterday set a new speed record for caving in to greedy corporations and political pressure," said Bill Arthur, Northwest Regional Director for the Sierra Club. In a quick about-face performed in less than a business day, the U.S. Department of Energy (DOE) yesterday first cancelled 5-year power sales contracts offered by the federal Bonneville Power Administration (BPA) to the Direct Service Industries (DSIs), and then allowed BPA to sign the contracts.

The Sierra Club today denounced DOE's stunning reversal of its earlier decision to cancel the new DSI contracts. "The DOE has betrayed Northwest ratepayers, and has given BPA the green light to sell the store to the DSIs," Arthur said. "This go-ahead for the DSI power sales contracts is all the more bitter and frustrating because earlier in the same day DOE made the right decision, and then buckled under to political pressure."

The Direct Service Industries are some 15 factories, mainly aluminum smelters, in the Montana, Oregon, and principally Washington State, which receive electricity directly from BPA. Bonneville had offered 5-year power sales contracts to the DSIs at the rate of 2.26 cents per kilowatt-hour. "Under the terms of these contracts, BPA would not recover its costs of generation, WPPSS debt, or fish and wildlife," said Jim Baker, Northwest Salmon Campaign

Sierra Club

Northwest Office • 1516 Melrose Ave. • Seattle, WA 98122 • (206) 621-1696

Columbia Basin Field Office • Route 2, Box 303-A • Pullman, WA 99163 • (509) 332-5173

Coordinator for the Sierra Club. "BPA is paying the DSIs to take a free ride on the federal hydropower system."

In a press release, the Energy Department gave "the threat of a precipitous load loss" as the excuse for its decision reversal. As a result, DOE told Bonneville to commit each DSI to at least 80 percent of its load in signing the new contracts. "This merely adds insult to injury," Baker argued, "because costs go up for Northwest ratepayers when Bonneville serves large DSI loads at below-cost rates with expensive generation especially from the WPPSS-2 nuclear power plant and/or with expensive purchases on the spot market. Moreover, the rest of us must now pay for WPPSS debt, fish and wildlife, and BPA's other financial obligations because the contracts let the DSIs completely off the hook."

DOE's earlier decision yesterday to cancel the DSI power sales contracts came under intense fire from Bonneville and from Capitol Hill, particularly Sens. Mark Hatfield (R-Oregon), Slade Gorton (R-Washington), and Larry Craig (R-Idaho), leading to the Department's reversal. "Apparently the BPA tail wags the DOE dog," Arthur noted. "And sad to say, Republican senators run the Energy Department — not President Clinton."

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THE PRESIDENT HAS SEEN

10/21/95

THE WHITE HOUSE

WASHINGTON

September 28, 1995

95 SEP 28 09:07

RECOMMENDED TELEPHONE CALLS

TO: Senator Barbara Mikulski

DATE: September 28, 1995

RECOMMENDED BY: Pat Griffin
Eli Segal

PURPOSE: Thank her for her leadership on behalf of national service.

BACKGROUND: Senate voted against restoring funding of \$425 million on Tuesday, September 26.

TOPICS OF DISCUSSION: Future of President's national service initiative, AmeriCorps

CONTACT PERSON AND TELEPHONE NUMBER(S): Senator Barbara Mikulski 224-4654

DATE OF SUBMISSION: September 28, 1995

ACTION:

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THE PRESIDENT HAS SEEN

10/2/95

Be

English Only—Let's Go All the Way

As an immigrant disposed to surrender my biculturalism for the sake of unity, I want to jump on the English-only bandwagon. The least that we can do for our children is to make sure they grow up monolingual. But I hope that candidates Bob Dole, Richard Lugar, Pat Buchanan, Pete Wilson and company are ready to go all the way.

The place to start is the official map of the future Unified United States of America. The Indian name of Miami, for example, should be translated into English. It will be in the state of Flowered Land. Out West, we'll have some new state names recovered from the Spanish: Arid Zone, Snowy Land and, north of New Mexico, Red Place (or just plain Red).

A lot of foreign Indian names will

have to be translated or replaced: Mississippi, Michigan, Arkansas, Massachusetts, Connecticut, Idaho, Dakota and so on. Sen. Dole can start by changing the name of his state, Kansas, to a proper English name (as I remember, Topeka has something to do with digging potatoes—that translation may be a delicate matter); then he can call on Phil Gramm to redo Texas, meeting perhaps in Saint Anthony.

California, of course, will need a good going over: The Angels, Saint Francis, Holy Cross, Saint Joseph and all of the other saints. The capital of New Mexico will become Holy Faith. Vermont will turn into Green Mountain, and those French names from the Louisiana Purchase will be properly Anglicized. Finally, winter-weary

northerners will vacation in Saint John, Rich Port.

After awhile, we could consider a campaign like the one Bulgaria conducted to change Turkish family names. Why be a Gonzalez when you can be a Gordon? Why not Kelly instead of Kowalski? Shortening names in the tradition of Ellis Island could come into vogue again. The possibilities are endless, and there's no need to review them now; we can really get down to work in January 1997. But no matter who wins the election, one thing is certain: We'll always remember Bob Dole and his fellow English-only candidates as the men who unified our country.

LUIS E. RUMBAUT
Washington

THE PRESIDENT HAS SEEN
10/2/95

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THE PRESIDENT HAS SEEN
10/2/95

THE PRESIDENT HAS SEEN

10/2/95

THE WHITE HOUSE
WASHINGTON

9/30/95

Mr. President

As we think about
this we should add in
the possible impact on
the Islamic world of
our helping Muslims and
the increased reach
we will have in the
Eastern Mediterranean
and in North Africa
by increasing our
presence so much in
Southern Europe

Newt

E.P.A. Backs Plan to Allow Cleaner Cars In Most States

By MATTHEW L. WALD

WASHINGTON, Sept. 27 — The Administrator of the Environmental Protection Agency today approved specifications for a "clean car" that, if it wins support from auto makers and officials in New York and Massachusetts, could result in emission standards for 49 states far cleaner than Federal rules require but not quite as clean as what some of the states are planning.

Environmental agency officials said the plan, which has been under negotiation for more than a year, was the E.P.A.'s last best hope for a nationwide improvement in controlling car pollution. It is also the auto makers' best hope to avoid a Federal requirement that they sell a fixed quota of cars powered by electricity.

The deal is not yet done, however, because the auto makers' willingness to tighten emission standards depends on the willingness of some states to drop their quota plans for electric cars, which Detroit says it will be unable to meet.

California plans such a quota, and 12 Eastern states have joined in. All 12 have also expressed strong interest in the clean car.

Gov. George E. Pataki of New York and Gov. William F. Weld of Massachusetts have indicated a willingness to compromise on their electric car requirements, but not to drop them. The current plan is that 2 percent of the cars sold in those states in the 1998 model year must be powered by electricity.

The compromise as laid out by the E.P.A. would not require "zero-emission vehicles," as the electric cars are described. Instead, it would require that new cars emit only half as much nitrogen oxides per mile and one-fourth as much hydrocarbons as the Federal standards require in the late 1990's.

The E.P.A. Administrator, Carol M. Browner, signed the agreement late today, said agency officials and others involved in the negotiations. The agency plans to announce the action on Thursday.

The deal would cover every state but California, which has long had the authority to set its own standards for auto pollution performance.

The Clean Air Act amendments of 1990 gave the other 49 states the right to choose between the Federal

Government's standards and California's, and the 12 Eastern states agreed to choose California's standards. Besides New York and Massachusetts, they are Maine, New Hampshire, Vermont, Connecticut, Rhode Island, New Jersey, Pennsylvania, Delaware, Maryland and Virginia.

This decision prompted a compromise offer from Detroit's auto makers. The last few months of intensive negotiations have been mostly free-form, far beyond anything contemplated by Congress when it wrote the 1990 amendments.

Although the 12 states, as represented by their Governors, agreed to adopt the California plan, not all of them actually did so. The auto makers say that the 12 would get cleaner air if all 49 states had cleaner cars, and air blowing in from outside the region would be cleaner, too.

The Clean Air Act also gave the environmental agency the authority to tighten Federal standards early in the next century, but the agency's officials do not believe that Congress will allow them to do so. Instead, they have seized on the aggressive posture of the 12 Eastern states as a way to win nationwide concessions from the auto makers.

One outstanding question is how the compromise will play in the 37 other states. Some have areas that would benefit from cleaner cars; indeed, Missouri, Illinois, Wisconsin, Indiana and Ohio, among other states, have sent letters to the E.P.A. supporting a clean, or "49-state," car. But other states have hardly any air pollution problems.

The cars proposed under the compromise would cost extra; at one point the auto makers said \$400 more. The environmental agency believes the added cost will be \$100 or less and that most cars could meet the standard with only minor changes. Some, though, may need other changes, like catalytic converters that are electrically heated so that they start working almost immediately after the car is started.

While the compromise was offered to the Eastern states, rather than the E.P.A., as a practical matter the agency's concurrence is required. The reason is that the Eastern states, and others that also have air pollution problems, are required to submit plans to Washington for cleaning up their air, a kind of budget-cutting plan for specified pollutants. For the plan to work for the states, the environmental agency has to agree that the cleaner cars are eligible for credit in the states' plans.

*Even/Leon -
A little harder it
is big - we would support
anyway of an agreement in
10/2/95*

THE PRESIDENT HAS SEEN

10/2/95

Leon Lewis
 Also supports
 from medical inflation
 #5 (Columbian
 Bureau)

Health Care Costs Hit Milestone

Premium Increases Are Below Inflation Rate for First Time in 10 Years

By David Segal

Washington Post Staff Writer

Increases in health care premiums have fallen below the rate of inflation for the first time in 10 years, largely because of the growth of managed-care programs, according to a national survey released today by KPMG Peat Marwick LLP, a benefits consulting firm.

The report, which surveyed 1,037 randomly chosen employers, provides both heartening and disheartening news for congressional Republicans who want to curtail Medicare costs by increasing reliance on managed care. Authors of the survey said the ability of managed-care plans to contain costs may be short-lived.

The survey found that health premiums for a variety of plans increased at an average of just 2.1 percent from 1994 to 1995, while consumer prices rose 3.2 percent. The figures continue a two-year trend of moderating prices: In 1994, premiums rose by 4.8 percent and in 1993, by 8 percent.

"Managed care has turned the corner in moderating the rate of health premium increases by pushing it below the consumer price index," said Jim Buckley, partner in charge of health benefits at KPMG Peat Marwick. "But whether or not these savings will continue in the future is the real question."

The slower rate of premium increases generally may reflect one-time savings from the move away from less cost-efficient fee-for-service plans and into streamlined managed-care operations. Additionally, some health care analysts are skeptical that managed care will, in the long run, contain costs at a better rate than other health care delivery approaches.

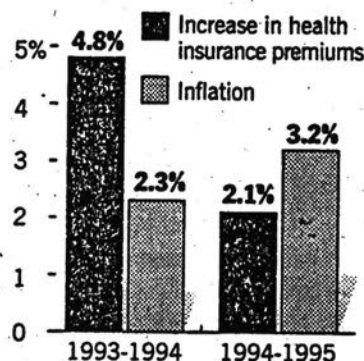
"If I ran [a health maintenance organization], I would be able to squeeze out a fair amount of fat," said Uwe Reinhardt, a health care economist at Princeton University. "But once the doctors' fees have been squeezed to the bare bones, once hospital stays have been reduced, will you then be able to continue the trend? That's an open question now."

As evidence, Reinhardt cites the single-payer Canadian system, which spends less per capita on health care but has seen increases in health care

THE COSTS OF HEALTH CARE

Unlike in 1994, the cost of health insurance premiums this year* has been growing more slowly than inflation overall...

► Health insurance premiums vs. inflation

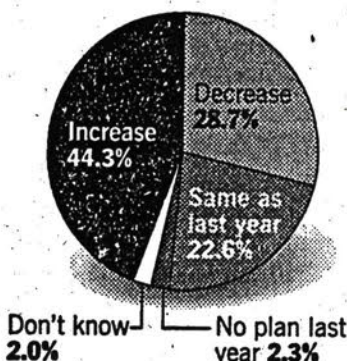


*March 31, 1994-March 31, 1995

SOURCES: KPMG survey of 1,037 employers, Bureau of Labor Statistics

... although premiums for many managed-care firms continued to rise in 1995.

► Premiums for HMO firms, 1995



THE WASHINGTON POST

spending that are similar to those in the United States.

What's limiting the premium increases, the survey found, is the gradual migration of employers to managed care, a catch-all phrase for health plans in which primary-care doctors

The challenge, Buckley said, will be keeping premiums low as advances in technology make health care both better and, paradoxically, more costly.

act as "gatekeepers" to curtail surgical procedures and hospital stays. The survey found that enrollment in all kinds of managed-care plans rose by 4 percent from 1994 to 1995 and now stands at 69 percent of employees in

the companies surveyed. Health maintenance organizations (HMOs) showed the smallest rate of increase in health premiums with just 0.4 percent.

The challenge, Buckley said, will be keeping premiums low as advances in technology make health care both better and, paradoxically, more costly. Unlike other businesses where technological advances reduce costs—computers, for instance, help retailers keep prices down—health care generally gets more expensive as its related technologies improve. A simple X-ray, for example, costs \$80, but will not tell you nearly as much about a broken bone as the results of a \$500 magnetic resonance imaging procedure, which costs about \$500, Buckley said.

Equally vexing is the gradual aging of the population, a trend fueled by low birth rates and the passing into middle age of many baby boomers. For each year that a population ages, Buckley said, its health care spending rises by 2 percent to 3 percent.

These demographic and technological forces are a challenge to Republicans in Congress, who hope to save billions of dollars on health care in coming years by providing vouchers that seniors can use to enroll in managed-care facilities.

Wrangle over pension funds

GOP gets blame
for allowing 'raids'

By David R. Sands
THE WASHINGTON TIMES

A trio of top Clinton administration officials yesterday accused congressional Republicans of trying to foment a corporate raid on retirement savings that will "make the train robberies during the days of Jesse James pale in comparison."

Labor Secretary Robert Reich, Commerce Secretary Ron Brown, and Treasury Secretary Robert Rubin trained their fire on a tax change, approved by the House Ways and Means Committee last week, designed to make it easier for companies to remove "excess" funds that have built up in the defined benefit retirement plans set up for workers and retirees.

Evoking Jesse James, Mr. Reich warned, "This is a pension grab, and there's no excuse for it."

The attack brought immediate and sharp response from Ways and Means Committee Chairman Bill Archer, Texas Republican.

"The administration's attempt to mislead and scare people is deeply regrettable," Mr. Archer said in a statement, adding that the change "will lead to stronger pensions and an increase in the availability of defined pension plans."

Mr. Archer counterattacked, saying a high-profile campaign by Mr. Reich to encourage "socially conscious investing" by private pension fund managers posed a far greater risk to the nation's \$3.5 trillion private pension kitty.

The pension provision was one of more than two dozen tax-code changes approved by the Ways and Means Committee on Sept. 19. Passed over unanimous Democratic opposition, the proposal is expected to raise some \$9.9 billion for the federal coffers and about \$3 billion for the states over five years.

Since 1990, businesses have faced an almost prohibitively high excise tax of up to 50 percent if they take "excess" money, defined as any funds above 125 percent of the plan's current liabilities, from their pension plans. The firms also faced an income tax on the amount removed.

The Ways and Means proposal would create a window of opportunity through July 1, 1996, for companies to tap those funds without paying any excise tax, and then to charge a 6.5 percent tax thereafter. Income taxes on the amount withdrawn would remain.

The Congressional Joint Tax Committee estimates that that provision would induce companies to withdraw between \$30 billion and \$40 billion immediately, money not needed to fund pension



"This is a pension grab, and there's no excuse for it."

— Labor Secretary
Robert Reich

benefits that could be used for investment, construction or new-business creation.

Proponents say the measure affects only well-financed pension plans and will remove the fear companies have now that investments in pension plans will be permanently unavailable for investment or other uses.

"The administration appears to favor a 'mattress' approach to pension savings," said Mark Ugoretz, president of the ERISA Industry Council, a trade group for the 125 largest companies in the country. "Once the money is put in, it's there forever."

Mr. Ugoretz said there are companies who have enough assets in their pension plans that they need not make another contribution for a decade, but are prohibited from putting the excess money to more productive use.

But Karen Ferguson, executive director of the D.C.-based Pension Rights Center, condemned the Ways and Means provision as "a license to loot."

She said the proposed 125 percent cushion did not take into account future increases in worker salaries or benefits, and that companies in the 1980s routinely stripped out "excess" pension assets to pay for hostile takeovers and leveraged buyouts.

The three Clinton Cabinet members serve as trustees of the Pension Benefit Guaranty Corp., the federal agency that backs up the benefits for workers in companies that fail. PBGC analysts released a study yesterday maintaining the GOP provision would leave even nominally "overfunded" pension plans with insufficient assets in case of failure.

Moreover, the study said, easing the rules would be an unwise temptation to place in front of companies that are beginning to get into trouble.

"Companies in financial difficulty may well have an incentive to avail themselves of [the tax change] to strip as many assets as possible out of their pension plans," according to the study.

"We saw what happened when the barn door was open," said Mr. Brown yesterday. "Right now the barn door is closed. This is a proposal to reopen the barn door."

THE PRESIDENT HAS SEEN
10/2/95

The Washington Times
THURSDAY, SEPTEMBER 28, 1995

Laura

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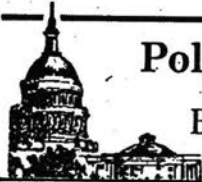
10/2/95

The GOP on the Working Poor: Let Them Eat Cake

The House has approved the Contract for America's call to restore a \$30 billion tax break for more affluent Social Security recipients, while Senate Republicans move to ensure that a \$500-a-child tax credit is available to all families making more than \$200,000.

Simultaneously, the House Ways and Means Committee has endorsed a \$23 billion cut in the earned income tax credit for the working poor—tantamount to a hefty tax hike for that group. Senate Republicans hope to whack these low income families even more, with cutbacks of \$41 billion in the EITC over the next seven years.

Republicans work themselves into a lather when they see Democrats demagoguing against the rich. Bob Dole rants about the Clinton administration's



Politics & People

By Albert R. Hunt

"constant appeal to envy and class warfare." Influential Sen. Don Nickles (R., Okla.) insists any cap on the \$500 child credit is class warfare.

But class warfare is fine to these politicians if it's directed at have-nots who include the working poor. Senate Finance Committee Chairman William Roth, for example, describes the EITC as a "boon for tax cheats and rip-off artists."

This juxtaposition of pushing tax measures, with little economic or social rationale, that benefit small groups of affluent taxpayers while using the working poor as the front line in the battle to balance the budget has prompted White House Chief of Staff Leon Panetta to talk about the GOP's "Marie Antoinette" tax approach.

The two-decade-old EITC, which gives low income workers a credit against taxes—income, payroll or sales—has long

enjoyed Republican support. Many conservatives hail it as far preferable to the minimum wage or other government subsidies; since the EITC goes only to those who work, it is seen as a genuine antidote to welfare. As recently as this February the EITC was praised by House Majority Leader Dick Armey—no bleeding heart—for "rewarding work without destroying jobs."

But the program, which has grown to \$23.3 billion this year, was just too appetizing when congressional Republicans looked for cuts to meet their other promises. To do this and to meet the demands of conservative populists, like John Kasich, to attack corporate welfare, House Ways and Means Committee Chairman Bill Archer vowed to close corporate tax loopholes. The upshot: Of the \$38 billion of net tax revenue gain over the next seven years, 60% of it comes from the working poor by paring back the EITC. Apparently, to Mr. Archer, corporate welfare includes \$17,000-a-year working families.

To justify this hypocrisy, the Republican National Committee recently put out "talking points," charging this is an out-of-control program with skyrocketing costs and widespread fraud.

Bob Greenstein of the liberal but highly reliable Center on Budget and Policy Priorities, picks these charges to pieces.

The contention that this is, as Sen. Nickles says, "the most out of control entitlement we have" is nonsense. Costs have soared because Congress, usually with the support of many GOP members and the past two Republican Presidents, three times in the past decade voted to expand the benefits for this successful program. After these mandated expansions are over, starting next year, the EITC will grow at a 4% clip for the next eight years, or considerably less than the 6.9% projected annual growth for entitlements overall.

This isn't Medicare or Medicaid.

It's undeniable that the EITC was rife with fraud. But the Internal Revenue Service has successfully cracked down on a lot of it and the fraud rate is dropping sharply. Moreover, as Mr. Greenstein notes, only 7% of the proposed cuts in the House and only 4% of those in the Senate are aimed at curbing fraud; the rest—roughly 95%—are real cutbacks affecting more than 10 million working poor families with more than 20 million children.

Other Republicans charge the credit is a disincentive to work; while exaggerated considerably, there's a little to this. But Mr. Greenstein conclusively points out this

more onerous Senate provision, the tax hike would be closer to \$1,700 over the next seven years.

Even some conservatives are dismayed. Rep. Thomas Petri, a Wisconsin Republican and long-time champion of the EITC, favors some reforms like denying the credit to childless couples. But these changes "go too far, especially in the Senate," he claims, and argues that the Republican-prized \$500-a-child tax credit should be made refundable so it benefits working poor families too. Such families have no income tax liability but do pay regressive payroll and sales taxes.

Yet while Sen. Nickles is proposing to

ensure this credit goes to families making more than \$200,000, the GOP backtracked on making it refundable. As a result, one-third of American children would not be covered by this tax credit, hailed by groups like the Christian Coalition as the centerpiece of a pro-family policy.

The GOP legitimately assails some Democrats for playing the class warfare game. Soak-the-rich proposals usually are bad public policy and are dishonest in suggesting that reams of revenue can be gained to pay for other causes.

But today the Republicans are even more shamefully playing a reverse Robin Hood: While Republicans plan a more than \$200 billion tax cut, the latest Treasury distribution figures show that if the EITC is cut back, those making less than \$10,000 a year would actually face a tax hike. As President Clinton said during a luncheon with reporters this week: "I don't believe it's a great idea to raise taxes on working families making \$15,000 a year to lower taxes on me." Any dissenters on that?

Reverse Robin Hood

This is the combined effect that the provisions in the Contract With America and the House Ways and Means Committee-approved Revenue Reconciliation Bill would have on two families of four:

	CURRENT LAW	PROPOSAL	CURRENT LAW	PROPOSAL
Adjusted gross income	\$15,000	\$15,000	\$200,000	\$200,000
Payroll tax:	2,295	2,295	12,017	12,017
Income tax before credits:	0	0	38,333	36,199
\$500 child tax credit:	0	0	0	1,000
EITC:	2,842	2,776	0	0
NET CHANGE		+\$66		-\$3,134

Source: Treasury Dept.'s Office of Tax Analysis

primarily affects wives in two-earner families who, largely because of the EITC, stop working to spend time with their children. Doesn't that promote family values?

To see how this affects real people, take one Bob Greenstein-supplied example. A married couple, with one child, that earns \$18,000 and pays \$200 a month for child care would, under current law, next year have a tax liability, payroll and income, of \$240. If the House Ways and Means Committee-approved cutbacks in the EITC were enacted, that tax bill would climb to \$370; the couple would owe the government almost \$830 more in taxes over the next seven years. Under the

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Robert J. Samuelson

Pouncing on the Working Poor

The Republicans have a split personality. At times, they are principled and bold, striving to make government live within its means even at the risk of being unpopular. They challenge farm spending and Medicare. But at other times, they are simply mean and petty, rewarding friends and punishing anyone else. A case in point is the plan to reduce the Earned Income Tax Credit (EITC), a measure that provides tax relief for the working poor and, until now, had enjoyed wide bipartisan support.

For good reason. Put simply, the EITC makes sense. It mainly allows low-income workers to keep more of what they earn from work. Through income tax refunds, it returns Social Security payroll taxes (now 15.3 percent of wages) and offsets excise and sales taxes. It rewards work and discourages welfare. In 1996 the EITC would cost the government about \$25 billion. Two-thirds of the benefits would go to those with incomes under \$20,000, and most of the rest would go to those with incomes under \$25,000.

To raise taxes on these workers is genuinely hard-hearted. The Republicans are right to reexamine welfare and Medicaid; these programs haven't reduced long-term poverty and dependency. But the EITC ought to be wildly popular with conservatives. It cuts taxes. It

promotes self-sufficiency and self-respect. It doesn't dictate to beneficiaries how to spend their money—whether on food, rent or toys. Politically, it substitutes for misguided increases in the minimum wage.

In fairness, the Republicans wouldn't kill the EITC outright. They would merely make it more stingy. Created in 1975, the EITC was expanded significantly in 1986, 1990 and 1993. The Republicans can cite "policy" reasons for reversing some of this liberalization, but the real reasons are political. First, poor workers aren't Republicans, and the proposed changes are technical and obscure. Who cares? Not Republicans, it seems.

Second, Republicans are desperate to find revenues to balance the budget and provide \$245 billion in tax cuts over seven years (1996-2002). The House Ways and Means Committee would cut the EITC \$23 billion over seven years; the plan now being considered by the Senate Finance Committee involves cuts exceeding \$40 billion. In effect, Republicans are raising taxes for poorer workers so that taxes for higher-income workers can be lowered. Perhaps this is good politics; it is lousy social policy.

True, the EITC isn't perfect; no government program is. One complaint is that it has

spawned widespread fraud. But the worst abuses have been curbed, argues Robert Greenstein, head of the Center on Budget and Policy Priorities, an advocacy group. The most costly scam involved the submission of tax forms with phony Social Security numbers. The IRS is now verifying Social Security numbers before issuing refunds. One sign that the anti-fraud measures are working is that the Congressional Budget Office recently reduced its estimate of the EITC's cost.

Another problem is one that affects many programs for the poor. It involves a question: How fast, as peoples' incomes rise, should benefits be reduced? If the EITC is abruptly ended at a given income level, then recipients are discouraged from earning more money. Most extra earnings are offset by a loss of the tax credit. Consider: In 1996 the maximum tax credit would be \$3,564 for a parent with two children under 18; this credit applies to those with incomes between \$8,910 and \$11,630. If each dollar earned above \$11,630 triggers a dollar's loss of the credit, recipients would face a huge disincentive to work more.

The solution has been to reduce the EITC gradually. No more than 21 cents of each extra dollar of earnings is lost from a lower EITC. But

the phase-out means that, in small amounts, the EITC benefits workers with incomes up to \$28,553 in 1996. Absurd, say Republicans. That's well above any definition of poverty. So, the Republicans would phase out the EITC faster. With other changes, the Senate Finance Committee plan would increase taxes an average of \$372 in 1996 for 7.4 million two-child families, estimates the Clinton administration. By 2005, a fifth of families eligible under present law would lose the EITC.

The Republicans act as if supply-side economics (lower tax rates spur work and investment) is okay for the wealthy but not for the near poor. The Republicans are simply wrong when they say that most of these workers are being subsidized by the EITC. At the very lowest levels, this is true: The refund exceeds income, payroll and excise taxes. But the effect disappears at \$12,000 to \$15,000 of income (depending on the number of children in the family) and, beyond that, the EITC merely reduces the tax burden.

Work is still the best anti-poverty program. Of workers with full-time, year-round jobs, less than 3 percent have incomes below the poverty line. In some ways, the EITC is too narrow even now. It barely applies to workers without

children, and the Republicans would eliminate this part of the credit altogether. It's as if they don't believe single workers can be poor or that, by promoting better work habits among young men, the EITC might foster more stable future marriages.

Naturally, the Republicans deny they're being cruel. In practice, they say, their proposed family income credit of \$500 per child would offset any loss from a stingier EITC. There are two responses to this. First, it's not yet clear whether the credit will actually be enacted; and second, if it is, Republicans shouldn't—relatively speaking—discriminate against low-income families by withdrawing an existing tax benefit.

Of course, people at some point have to pay for government through taxes; and of course, the EITC should constantly be reviewed for flaws and abuses. But trimming it now is the wrong tax increase on the wrong people at the wrong time. Beyond being bad policy, it also strips the Republicans of valuable moral authority—the public perception that they're being "fair" in overhauling government. Once that's gone, Republicans will find it harder to make needed, but unpopular, changes. They are at war with themselves and, all too often, their worst impulses prevail.

Dropping federal regs is an invitation to tragedy

OUR VIEW Everyone has heard the horror stories about the bad old days in nursing homes. Why go back to them?

Eight years ago, after 15 years of argument, Republicans and Democrats in Congress got together to correct a public embarrassment. They passed a law to stop nursing home operators from abusing or neglecting the elderly.

They had ample incentive. Reports of residents lying in excrement, dehydrated, malnourished or overmedicated were commonplace. State regulation was a failure. Public outrage was high.

It should be just as high now. The regulations created by that law are about to be weakened or stripped away — victims of an ideological crusade to curb federal authority, good or bad.

Control would return to the states, despite their history of failure.

Those pushing the new plan, House and Senate Republicans, claim their legislation is not a repeal. They say the law is ineffective. And they say it's hugely expensive.

All three claims are fiction.

Not a repeal? Under existing regulations violators are subject to financial penalties, decertification, denial of payments or takeover by temporary managers if they violate health and safety standards. Proposed changes would weaken enforcement by states that are vulnerable to powerful lobby groups. The Senate wouldn't require in-

spections, nurse staffing or protections against restraints or medication.

Not effective? A government study of 269 homes in 10 states cited impressive results. The study found hospitalization of nursing home residents down 25%, use of restraints down 25%, and detection and punishment of abuses increasing.

Too expensive? Quite the contrary. A study of 9,000 Georgia nursing-home residents reports a monthly \$76,738 savings by curtailing unnecessary drug therapy, thanks to the regulations. And that's not an isolated case. The National Citizens' Coalition for Nursing Home Reform, a resident advocacy group, says the changes saved billions in costs attributed to poor treatment.

Even the American Health Care Association, representing nursing home owners, says costs have not been a problem.

In fact, nursing home owners signed onto the legislation when it passed in 1987. So did consumer groups. So did state officials. So did the Institute of Medicine, research arm of the National Academy of Sciences, whose 1986 report on nursing home conditions led to the reform.

No credible evidence exists to justify reversing course. If changes are necessary they should be based on the same kind of thorough study and public hearings that produced the original regulations.

Seniors are in nursing homes because of advanced age, mental or physical disabilities, to recover from hospitalization or because they have no one to care for them. They are frail and vulnerable. They deserve all the protection the public can provide.

Stop the scare stories

OPPOSING VIEW No one's going to torture grandma. The federal rules just aren't needed.

By Thomas J. Bliley Jr.

The latest, most preposterous "Mediscare" horror story is that our plan to fix Medicaid will allow nursing homes to fire their nurses, tie patients to their beds and sedate them to keep them quiet.

Let's turn on the lights. There's no bogeyman hiding in this closet.

A key component of our "Medigrant" bill is a "Nursing Home Resident Bill of Rights" that includes the right "to be free from abuse, including verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion." Compliance is mandatory, and states are empowered to shut down those facilities in violation.

Rather than weaken protections for nursing home patients, our bill strengthens them by ending an eight-year experiment with "federalization" of standards that by all accounts has been a total failure — a bureaucratic nightmare that is confusing, expensive and counterproductive.

Take the federal requirement that states independently assess the need for nursing home placement. After separately assessing some 81,500 patients placed in nursing

homes in 1989 — at a cost of \$28.5 million — California concluded that only five placements were inappropriate. That works out to \$5.7 million per misplacement. What's more, the federal requirement only duplicated existing California procedures that would have revised those patients' placements anyway.

As governor of Arkansas, even Bill Clinton joined the governors of 47 other states in 1989 to criticize the nursing home regulations as inflexible federal "micromanagement." Our bill does exactly what Clinton and the other governors recommended: require the states (which enforce the rules anyway) to enact their own standards under strict federal guidelines.

Under our proposal, no state will see a penny of federal "Medigrant" assistance unless it first enacts rigorous new nursing home standards including: safety; cleanliness and quality; staffing and employee training; protection of patient records, property and legal rights; and patient grievance procedures.

Nobody wants to go back to the days when nursing homes were unsafe and unsanitary, but we don't need a massive and expensive bureaucracy to protect patients. Let's recognize that all wisdom and compassion does *not* reside in Washington. The states are better suited to do this job.

Rep. Thomas J. Bliley Jr., R-Va., is chairman of the House Commerce Committee.

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Line-item veto crawls into conference

By William M. Welch
USA TODAY

Giving the president power to veto spending on individual government programs has long been a dream of many Republicans — and some Democrats, too.

But with Democrat Bill Clinton in the White House, and Congress' own spending priorities in dispute, last spring's rush toward the line-item veto has slowed to a crawl.

Democrats say Congress is stalling because Republicans don't want to hand Clinton the line-item veto in time to use it against upcoming GOP spending and tax-cut bills.

"The Republicans' double standard on the line-item veto reminds me of the modern-day version of

Saint Augustine's prayer," says Sen. James Exon, D-Neb. "Lord make me good, but not just yet."

The line-item veto was part of the House GOP's Contract with America last fall. The House and Senate approved different versions by big majorities. Clinton said he'd sign it.

But those votes were seven months ago. GOP leaders didn't get around to naming a House-Senate panel to work out differences until earlier this month. The committee didn't meet until Wednesday.

At issue: the timing on transferring Congress' power of the purse.

Fiscal conservatives have long wanted to give the president the power to delete specific items from spending bills Congress approves.

Stop-us-before-we-spend-again is

the idea. Backers argue Congress often is unable to restrain itself.

The job for the conference committee is to resolve differences over how the president can use the veto.

The House plan would give the president power over a broad scope of spending items, even tax loopholes. The more convoluted Senate plan would break spending bills into hundreds of small parts.

But a final version will take time. When the conference committee adjourned Wednesday, the panel instructed its staff to work on it and to report back at the end of October.

No one's betting a compromise will be ready then, either.

"The president has waited for six months to sign it," says Exon. "I hope we don't keep him waiting forever."

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USA TODAY • THURSDAY, SEPTEMBER 28, 1995

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10/2/95

Profiling the Aged: Fat Cats or Hungry Victims?

By CHRISTINA DUFF

Staff Reporter of THE WALL STREET JOURNAL

Just how well off are the nation's elderly?

Endless oratory from debates over Medicare, Social Security and other programs illustrate just how polarized opinions are on this subject. Republican Sen. Alan Simpson of Wyoming calls the 65-plus crowd "greedy geezers" — oldsters in Bermuda shorts teeing off near their second homes in Florida. Old people "care most about themselves — even at the cost of future generations," concluded a study by Third Millennium, a young-adult group that is lobbying for Social Security reform.

On the other side of the debate, older people are seen as helpless victims — frail folks saving coins for what sometimes is the best meal they can buy — dog food. They "live on low incomes and they know where every penny goes," Democratic Rep. Pete Stark of California has said.

"Depending on whom you talk to, [the elderly] are either 'bloodsucking vultures' or 'pathetic creatures,'" says Rebecca Chekouras, a vice president of Age Wave Inc., Emeryville, Calif., which advises companies on how to sell to the aging.

So who's right? "There's some truth in just about everything," says David Wise of the National Bureau of Economic Research in Cambridge, Mass. The elderly's economic status is far more varied than that of any other age group. a slew of research concludes. Timothy Smeeding, a professor of economics at Syracuse University, says the "least interesting statistic for the elderly is the median."

Well above the median, and playing gin rummy at the Columbia Country Club just outside Washington, D.C., 89-year-old Edward Warner says he has invested quite a bit in stocks and has "a good pension, thank God," from his career as an insurance-company executive; Social Security

accounts for only 7% of his income. He nods at plaid-jacketed buddies in the club's Grill Room and confides that "none of these people need" government help.

Overall, today's elderly do have higher living standards than any 65-plus generation in U.S. history. Government-assistance programs like Medicare combined with pension benefits and postwar prosperity to let many own their homes while also

saving for later. They are better educated and healthier than ever, according to a May 1995 Population Reference Bureau study. Nearly one of three golfers is over 65, as are 60% of cruise vacationers, the study says.

One key measure of how people are faring is the poverty level. In 1993, when 23% of all children were below the poverty threshold, a much smaller 12% of elderly

people were considered poor, according to the Census Bureau. (For the elderly, the 1993 poverty level was \$6,930 for a person living alone and \$8,741 for a couple.) The elderly clearly make more money than before; their median income has more than doubled, in 1992 dollars, over the past 35 years, the Census Bureau says.

All of which is heartening — until you look at details. There is still considerable poverty among the elderly, and much depends on their sex, race and marital status. In 1992, for example, elderly white men on average made \$15,276, about 2.5 times more than the older black and Hispanic women at the other end of the spectrum.

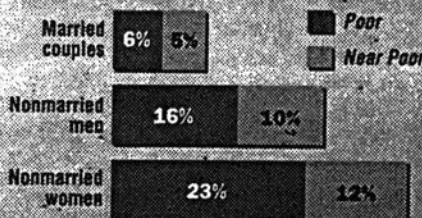
In 1993, 43% of elderly black women living alone were poor. Not far from the Columbia Country Club's well-clipped greens lives one of them, Annie Brown, a 74-year-old widow who survives in Washington mainly on her monthly \$700 Social Security payments. For 75 cents, she gets a chicken or Salisbury steak lunch at a center for the elderly, where she comes

DEMOGRAPHICS

Pictures of the Elderly Poor

The Unmarried Are Hard Hit...

Poverty rates for the elderly by marital status, 1992



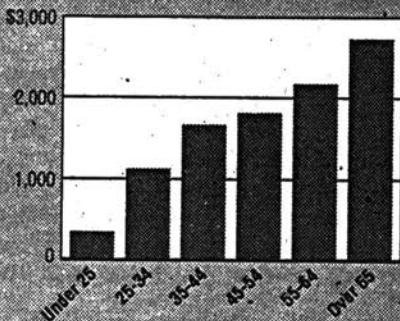
As Are Minority Groups

Poverty rates for the elderly by race, 1992



High Health-Care Costs...

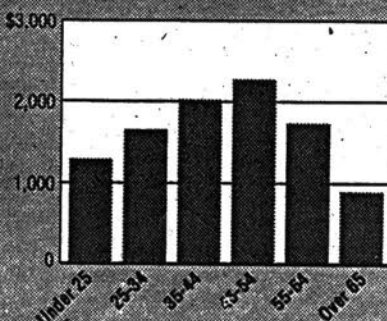
Out-of-pocket average annual health-care expenditures



Source: Census Bureau

Lead to Scrimping on Other Things

Average annual expenditures on food away from home



*Persons of Hispanic origin may be of any race

daily. "I've got barely enough to live on" after 40 years serving cafeteria food and cleaning doctors' offices, Mrs. Brown says.

Worse, while the more youthful destitute may have escape routes — jobs or marriage — the elderly poor "usually have no way out," says Judith Treas, a sociology professor at the University of California, Irvine. And poverty statistics don't reflect the huge numbers of elderly people pushed barely above the threshold by Social Security payments. In fact, 16% of Americans over 65 were considered "near poor," twice the percentage of younger citizens, in a 1991 study by the Department of Health and Human Services. That rose to 20% in 1993 and is even higher for those older than 85 or those who live alone.

"The people who take it in the shorts Please Turn to Page B16, Column 1

an average of \$2,733 a year on health care—\$1,000 more than the average household, according to the Bureau of Labor Statistics. And out-of-pocket costs will increase if Republicans push through Medicare changes.

As they age, Americans generally spend less on the theater, restaurants and the like — even when they can afford it, says Sherman Hanna, a professor of human ecology at Ohio State University. "There's tremendous uncertainty about the future," he says.

Consider 84-year-old Toinette Bachelder. A White House secretary for 34 years, Ms. Bachelder lives comfortably on investments and \$2,300 a month from pensions, and buys supplementary health insurance. But she is trying to pay a \$16,000 hospital bill for a colon tumor, which keeps her from her favorite pastime: catalog shopping.

"It's taken some willpower," she notes with regret, "but I'm ripping out and throwing away those little order forms before they can tempt me."

Continued From Page B1

are the people in between," says Syracuse's Prof. Smeeding. Experts say this middle group is often more vulnerable than the downright poor because they can't qualify for government assistance programs like Medicaid. Nor can they afford someone to fetch groceries or to use air conditioning, like the scores of elderly people who died in Chicago's stifling temperatures this summer.

It's true that the elderly often have more assets and fewer liabilities than their children and grandchildren. The median net worth of Americans 65 and over was \$88,192 in 1991, compared with \$36,623 for all households, according to the Census Bureau. More than 600,000 elderly homeowners with incomes below \$20,000 owned homes valued at more than \$100,000, according to the 1990 census.

But unless rooms are rented out, houses don't generate income, and even the elderly with substantial real-estate assets often lack ready cash. "People can't eat their homes," says Prof. Treas. Mrs. Brown has owned her Washington home for 25 years but has no savings to cover hospital costs if she gets seriously ill.

None of the younger poor have better health-care coverage than grandma and grandpa with their Medicare and Medicaid. Yet because older Americans generally need more health care than the young, the elderly have more out-of-pocket health expenses than other age groups. In 1993, households headed by elderly people spent

Bachelder Lewis Hanna
Smeeding C. Smeeding

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*Alert - He wanted to see
you - would you please call
him? said will talk to you*
Tunstall I. Wilson, Jr. *BE*
Administrative Assistant

THE PRESIDENT HAS SEEN *10/21/95*

Congressman Earl F. Hilliard
7th District of Alabama

1007 Longworth Building
Washington, D.C. 20515
(202) 225-2665

Leah / Sosuich

FYI

THE PRESIDENT HAS SEEN
10/21/95

The Hill ■ Wednesday, September 20, 1995

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cc TO Dick Morris, Ann Lewis, POTUS
Poster Boys? ltrcc

Who are these men... and why are they smiling?



Meet the first family of Big Sugar...

They are Palm Beach corporate farmers, and *FORBES* magazine estimates their worth at half a billion dollars.

Know why they're smiling? Because they are getting a sweetheart of a deal from Congress...

According to the non-partisan Center for Responsive Politics, their interests have contributed \$2.5 million to politicians in Washington...

And some politicians in Washington are cutting a deal to save the federal sugar program, which gives them \$65 million a year — that's right, \$65 million a year.



Even more unbelievable — they aren't even U.S. citizens.

At a time when Congress is making tough choices about Medicare, student loans, environmental protection and other programs that help farmers, the first family of Big Sugar is about to get an even sweeter deal.
Sound like business as usual?

Funding multi-millionaires is not the change we demanded in 1994.
Tell Congress it's time for reform that helps American families.
It's time to end the sugar program.

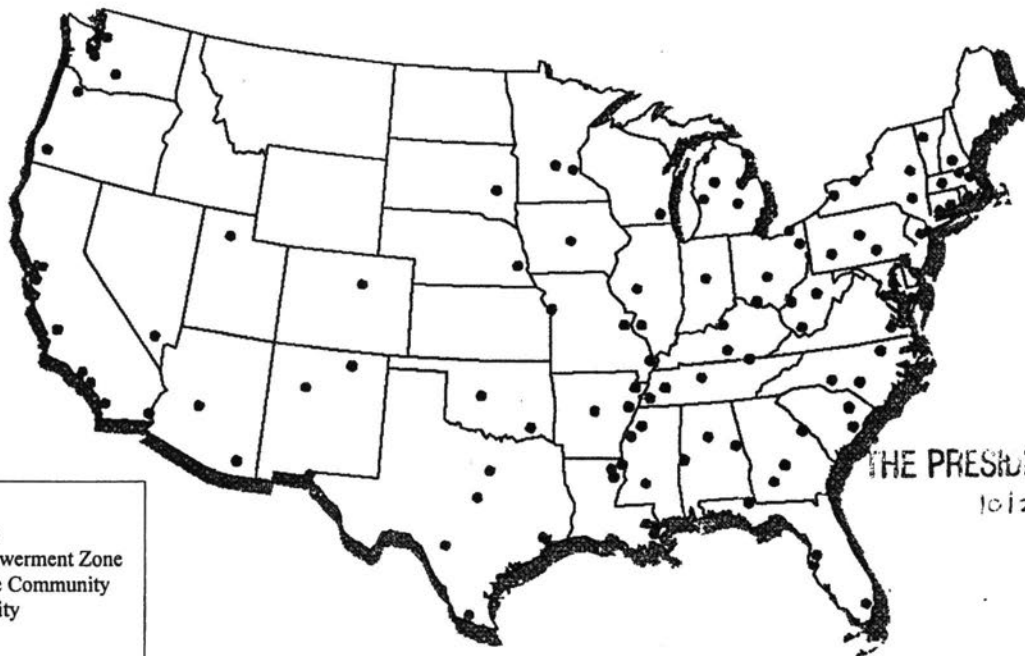
COALITION TO END WELFARE FOR BIG SUGAR

Consumers, businesses, environmentalists and taxpayer organizations united to repeal the sugar program.

202-739-0206

EMPOWERMENT ZONES AND ENTERPRISE COMMUNITIES

#2



THE PRESIDENT HAS SEEN
10/2/95

URBAN

Empowerment Zone

- Supplemental Empowerment Zone
- Enhanced Enterprise Community
- Enterprise Community

RURAL

- Empowerment Zone
- Enterprise Community

EMPOWERMENT ZONE (EZ)

California: Los Angeles
California: Oakland
Georgia: Atlanta
Illinois: Chicago
Kentucky: Kentucky Highlands*
Maryland: Baltimore
Massachusetts: Boston
Michigan: Detroit
Mississippi: Mid Delta*
Missouri/Kansas: Kansas City, Kansas
City
New York: Harlem, Bronx
Ohio: Cleveland
Pennsylvania/New Jersey: Philadelphia,
Camden
Texas: Houston
Texas: Rio Grande Valley*

ENTERPRISE COMMUNITY (EC)

Alabama: Birmingham
Alabama: Chambers County*
Alabama: Greene, Sumter Counties*
Arizona: Phoenix
Arizona: Arizona Border*
Arkansas: East Central*
Arkansas: Mississippi County*
Arkansas: Pulaski County
California: Imperial County*
California: L.A., Huntington Park
California: San Diego
California: San Francisco, Bayview,
Hunter's Point
California: Watsonville*
Colorado: Denver
Connecticut: Bridgeport
Connecticut: New Haven
Delaware: Wilmington
District of Columbia: Washington
Florida: Jackson County*
Florida: Tampa
Florida: Miami, Dade County
Georgia: Albany

Georgia: Central Savannah*
Georgia: Crisp, Dooley Counties*
Illinois: East St. Louis
Illinois: Springfield
Indiana: Indianapolis
Iowa: Des Moines
Kentucky: Louisville
Louisiana: Northeast Delta*
Louisiana: Macon Ridge*
Louisiana: New Orleans
Louisiana: Ouachita Parish
Massachusetts: Lowell
Massachusetts: Springfield
Michigan: Five Cap*
Michigan: Flint
Michigan: Muskegon
Minnesota: Minneapolis
Minnesota: St. Paul
Mississippi: Jackson
Mississippi: North Delta*
Missouri: East Prairie*
Missouri: St. Louis
Nebraska: Omaha
Nevada: Clarke County, Las Vegas
New Hampshire: Manchester
New Jersey: Newark
New Mexico: Albuquerque
New Mexico: Moro, Rio Arriba, Taos
Counties*
New York: Albany, Schenectady, Troy
New York: Buffalo
New York: Newburgh, Kingston
New York: Rochester
North Carolina: Charlotte
North Carolina: Halifax, Edgecombe,
Wilson Counties*
North Carolina: Robeson County*
Ohio: Akron
Ohio: Columbus
Ohio: Greater Portsmouth*
Oklahoma: Choctaw, McCurtain
Counties*
Oklahoma: Oklahoma City

Oregon: Josephine*
Oregon: Portland
Pennsylvania: Harrisburg
Pennsylvania: Lock Haven*
Pennsylvania: Pittsburgh
Rhode Island: Providence
South Dakota: Beadle, Spink Counties*
South Carolina: Charleston
South Carolina: Williamsburg County*
Tennessee: Fayette, Haywood
Counties*
Tennessee: Memphis
Tennessee: Nashville
Tennessee/Kentucky: Scott, McCreary
Counties*
Texas: Dallas
Texas: El Paso
Texas: San Antonio
Texas: Waco
Utah: Ogden
Vermont: Burlington
Virginia: Accomack*
Virginia: Norfolk
Washington: Lower Yakima*
Washington: Seattle
Washington: Tacoma
West Virginia: West Central*
West Virginia: Huntington
West Virginia: McDowell*
Wisconsin: Milwaukee

* denotes rural designee