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001. memo w/attach	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Meeting with Senator Jeffords (6 pages)	6/28/93	P5

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06-10-94 03:05PM FROM JEFFORDS WDC TO 94567431 P001/007

Jeffords' [illegible]

JAMES M. JEFFORDS
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United States Senate

WASHINGTON, DC 20510-4503

FAX COVER SHEET

To: Chris Jennings

From: Mark Powden

Date: 6/10

Number of Pages (including cover sheet): 7

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JEFFORDS-DURENBERGER-KASSEBAUM AMENDMENT

Overview And Rationale

Today, Senators Jeffords, Durenberger, and Kassebaum are introducing an amendment that would make significant changes to the delivery system structure contained in Title I of the Chairman's Mark.

In order to meet our goals of universal coverage and deficit reduction, we must first get health care costs under control. Our amendment restores the buying and selling of health care coverage to greater private control and removes state governments as the intermediary between purchasers and sellers in the marketplace. In addition, the nine out of ten Americans who currently feel secure knowing they get their health coverage through their employer, can be assured that this will continue once we pass health reform.

The establishment of bright line federal rules enforced by the states, which level the playing field between fully-insured health plans and ERISA self-insured plans, will go a long way in enabling the private market to function efficiently. We believe strongly, that this approach will give us quality health care at affordable prices.

The Jeffords-Durenberger-Kassebaum amendment strikes most of the regulatory sections in Title I, and replaces them with a streamlined, market-based structure similar to provisions found in both the bi-partisan Breaux-Durenberger (S. 1579) and Chafee-Kerrey (S. 1770) bills.

Concerns with the Chairman's Mark

Where President Clinton's Health Security Act relied on mandatory "purchasing alliances" to control the health care purchase and delivery system, the Chairman's mark attempts to move to a voluntary market based system. Unfortunately, rather than allowing employers to continue as smart buyers and benefit administrators, the Chairman's Mark relegates employers to passive check writers.

Under the Chairman's Mark as presently drafted, states assume most of the functions now carried out in the private market. For example, states must, among other things:

- Provide information to consumers on all community-rated health plans;
- Establish and maintain health plan enrollment procedures, standards, and rules;
- Issue "Health Security" cards;
- Negotiate annual fee-for-service schedules with providers;

- Collect premiums from employers, individuals, and families on behalf of carriers;
- Establish premium reporting requirements;
- Make premium payments to community-rated health plans; and
- Audit records of all employers with less than 1,000 full-time employees.

In addition, the Chairman's Mark would greatly expand the states' role in several areas, including:

- Reviewing and approving the distribution of <u>any</u> materials used to market community rated plans within the state;
- Monitoring health plan quality, performance, financial stability and capacity;

This expansion of state duties, as well as the sheer number of people who would be regulated under this new regulatory structure, would greatly strain state budgets. In addition, it will greatly disrupt the way millions of Americans currently get health care in the marketplace - through their employer. It is not necessary to delegate this regulatory power to states in order to reduce health costs, and provide fair, equitable, and affordable health care coverage to Americans. This is best achieved through the private marketplace.

Key Provisions Of The Jeffords-Durenberger-Kassebaum Amendment

The Jeffords-Durenberger-Kassebaum amendment establishes a framework of NATIONAL STANDARDS that allow LOCALLY-BASED HEALTH PLANS and LOCAL MARKETS to deliver health care more effectively and efficiently to all Americans. The amendment sets out CLEAR RULES for purchasing cooperatives, small businesses, and large employer purchasers, AND CLEAR STANDARDS for health plans and insurers.

A. Sellers-- Health Plans and Insurers

The Jeffords-Durenberger-Kassebaum amendment would END UNFAIR INSURANCE PRACTICES that currently prevent many individuals from purchasing health coverage:

- AGE ADJUSTED COMMUNITY RATING for small businesses and individuals in regional Health Care Coverage Areas;
- STANDARD BENEFIT PACKAGE;
- GUARANTEED ISSUE;
- OPEN ENROLLMENT;
- PORTABILITY;
- NO DISCRIMINATION based on HEALTH STATUS; and
- NO DENIAL OF COVERAGE based on PREEXISTING CONDITIONS.

B. Employer and Individual Purchasers

The Jeffords-Durenberger-Kassebaum amendment reforms the health care delivery system without causing major disruptions in the current market. MOST AMERICANS WILL CONTINUE TO GET HEALTH COVERAGE WHERE THEY DO NOW -- AT THEIR PLACE OF EMPLOYMENT.

By permitting employers to negotiate good rates for health plans, Jeffords-Durenberger-Kassebaum recognizes that employers have been a creative and dynamic force in helping to contain rising health care costs through managed competition and other means. Unlike the Chairman's Mark, CONTACTS BETWEEN EMPLOYERS AND HEALTH PLANS ARE ENTIRELY PRIVATE.

Under the Jeffords-Durenberger-Kassebaum framework, small businesses and individuals choose whether to buy their community-rated health plans/coverage through independent insurance agents or through private, non-profit, purchasing groups.

Large businesses (250 or more full-time employees) may offer either a state-certified health plan for which the employer negotiates the rate (experience-rated), an employer-sponsored health plan (risk-bearing plan) or both types of plans as a group health plan. Large employers may group together to negotiate health plan prices.

Employers with between 101-250 full-time employees may choose to negotiate like "large employers" or to purchase insurance at the community-rate like "small businesses."

- The Chairman's Mark would prevent all employers with less than 1,000 full-time employees from bargaining for better rates for their employees. It would turn employers into check-writers-- not informed buyers-- merely allowing them to send premium payments to state governments.

Employers must offer their employees a choice of AT LEAST THREE HEALTH PLANS, one of which must be a point-of-service plan.

Existing ASSOCIATION PLANS (i.e., trade and professional associations, religious organizations, public entity associations, and Chambers of Commerce) are grandfathered if they have been in existence for three years prior to the date of enactment. However, they must meet basic solvency standards and are required to take all comers within their organization.

- The Chairman's Mark would eliminate all Association plans.

C. **The Role of Purchasing Groups**

Under the Jeffords-Durenberger-Kassebaum amendment, PURCHASING GROUPS ARE PRIVATE, ENTIRELY VOLUNTARY, and possess NO REGULATORY AUTHORITY.

Purchasing groups must:

- Take all small employers and individuals who wish to join;
- Offer the full range of health plans available in the area;
- Be private, non-profit organizations governed by a Board drawn from its own members (insurers cannot operate cooperatives);
- Provide members with comparative information about plan choices; and
- Facilitate enrollment.

D. **Establishes Proper Role For State And Federal Government**

Under the Jeffords-Durenberger-Kassebaum amendment . . .

The Federal Government will enact uniform, national standards for quality, accountability, outcomes data, and service requirements, to assure that locally-based health plans deliver quality health care. State benefit mandates are preempted, as in the Chafee bill and the Chairman's Mark.

States' responsibilities are limited to:

- Certifying health insurers (which they do now);
- Certifying purchasing cooperatives;
- Designating boundaries for Health Care Coverage Areas;
- Making available comparative information to consumers about health plans available in the state;
- Implementing a risk-adjustment mechanism; and
- Determining coordinated dates for health plan open enrollment periods.

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- Determining coordinated dates for health plan open enrollment periods.

DAVID PRYOR
CHAIRMAN

United States Senate

SPECIAL COMMITTEE ON AGING

Ira - Acknowledges that Jeffords
has approach is simpler, but
possibly too politically touchy.

- Comprehensive package

HRC:
- Medicaid - How do we
integrate the program in a way
that even poor people pay something?
- Jeffords: We lean to the states
- Don't define benefit package, then
Board do that.
- Is he meeting (?)
w/ Daschle.

DAVID PRYOR
CHAIRMAN

United States Senate

SPECIAL COMMITTEE ON AGING

Financing

- Goal Ted Equity
- 6% premium in AGI. Non-Deductible
  capped at a certain level
- Income tax collected through employer
  States - 4% employer / 2% employee - deductible
- Medicare Board established benefits
- Veterans - Separate Alliance
- Senator Jeffords acknowledges that
  Income tax increase vulnerable to that
  charge.

DAVID PRYOR
CHAIRMAN

United States Senate

SPECIAL COMMITTEE ON AGING

HRC/Jeffords Meeting 6/29/93

- Wants to help build a foundation for a positive reception
- ① Broaden Financing to insure that everyone has coverage
  ② Integrate Medicaid, Medicare, AIDS
  ③ Develop a rational budget control mechanism
- Wants a great deal of state & local flexibility
- Encouraged to work closer w/ health care providers

THE MEDICORE NATIONAL HEALTH ACT

U.S. Senator Jim Jeffords

The MediCORE National Health Act addresses several grave problems with the current American health care system. Rapidly rising health care costs and expenditures burden all Americans and are one of the leading contributors to the mounting federal budget deficit. These rising costs also exacerbate the unfairness of a health care system where many Americans lack adequate, if any, health care insurance. The MediCORE program reforms the American health care system by guaranteeing universal access to a set of basic CORE services, stemming escalating health care costs to individuals, employers and governments, and preserving quality and flexibility in health care delivery. The Act is also designed to ensure equitable financing for the provision of CORE services.

STATES DESIGN AND ADMINISTER PLANS TO PROVIDE A SET OF CORE BENEFITS TO ALL STATE RESIDENTS

The basic structure of the MediCORE program divides responsibilities for the design, administration and funding of health care delivery between federal and state governments. The Act charges states with the primary responsibility for designing and running health care programs for all U.S. citizens and legal residents within their territory. CORE services provided under state plans must cover medically necessary services, including prescription drugs, mental health treatment, and substance abuse and rehabilitative services; preventative care and long-term care must also be covered. Those presently receiving benefits under Medicare or Medicaid will receive expanded services under the CORE on an equal basis with other citizens.

FEDERAL MEDICORE BOARD OVERSEES STATE PROGRAMS AND ENSURES THAT STATES MEET MINIMUM FEDERAL STANDARDS

A federal MediCORE Board is established under the Act to oversee the design and administration of state health care plans. Though states will be given wide latitude to meet the special circumstances of their population in the design of delivery systems, the Board will ensure that states meet minimum federal standards for universal access, portability, administration, affordability and quality. For instance, state benefit packages must be substantially equivalent to a model set of CORE services to be outlined by the Board. Furthermore, in order to ensure quality and flexibility in health care services, states are encouraged to involve competition between two or more health care providers, and at least one delivery plan must permit significant freedom of choice by consumers among health care providers. If a state chooses to contract with the Board for the administration of its health care program, the Board will use networks of managed competition in all areas of the state with sufficient health care providers. Networks of managed competition will also be used if a state plan fails to meet minimum federal standards and is placed in receivership by the Board.

FEDERAL PREMIUM ON PAYROLL AND UNEARNED INCOME PROVIDES APPROXIMATELY 70% OF FUNDING FOR STATE PLANS, WITH STATES CONTRIBUTING THE REMAINDER

Most of the funding for state health care plans will derive from a MediCORE Trust Fund to be administered by the Board. A federal payroll premium--4 percent from the employer and 2 percent from the employee--will provide the principle source of monies for the Trust. Individuals who have income in addition to their earnings will be assessed up to a 6 percent health care premium on this additional income. These federal premiums will supply approximately 70% of the cost of running state health care plans. States will receive from the Trust at least those monies which have been generated from the MediCORE premiums upon their residents. They will also receive an amount equal to their portion of Medicare spending under Title XVIII of the Social Security Act for the year in which MediCORE is adopted. The Board will distribute additional funds from the Trust to states that need these monies in order to provide CORE services to their residents. The remaining funds for running state health care programs will be supplied by the states. States may use the 15 percent cost sharing permitted under MediCORE to offset their financial responsibility. If states use cost sharing, their contributions to state health care plans will be roughly equal to the amount they currently spend for health care.

SPENDING UNDER THE MEDICORE ACT WILL BE LIMITED TO CURRENT LEVELS OF NATIONAL HEALTH CARE EXPENDITURES

The financing provisions of the MediCORE plan are designed to arrest the growth of health care costs by limiting the costs of running state programs to present levels of national expenditures on health care, adjusted for growth in Gross Domestic Product (GDP). The MediCORE health plan essentially redistributes monies currently being spent on health care by government, insurance companies and individuals. Resources available to the states through the MediCORE Trust Fund will only be increased if Congress makes an express, public decision to increase health care expenditures. Nevertheless, in order to maintain flexibility in the system and to preserve incentives for technological advances in medical care, individuals are free to use private insurance to purchase services beyond CORE benefits, and states themselves may supplement CORE services at their own expense.

ADDITIONAL FEATURES FOR CONTROLLING HEALTH CARE COSTS

In addition to keeping national health care expenditures at their current levels, the MediCORE program provides for additional mechanisms to control health care costs and spending. States are encouraged to develop fee schedules for health care providers, and the Board is directed to develop model fee schedules for the benefit of states. Limited cost sharing by health care recipients is also permitted under the MediCORE Act. Furthermore, managed competition in state programs will serve to keep costs down. In addition, the MediCORE Board has an important responsibility to study and recommend ways to reform medical malpractice laws.

The various provisions of the MediCORE Act ensure a system of health care delivery which is both fair and economically sound. MediCORE guarantees universal access to CORE health care benefits and finances these benefits equitablity. At the same time, it effectively controls health care costs and preserves quality and flexibility within the American health care system.

tough votes. That is what I heard during my reelection contest last year. Ohioans said, "We're willing to do our fair share. Just be honest with us. Be honest about our Nation's problems." That is why the people of Ohio sent me back to the Senate and that is what I intend to do.

And the honest truth is that our national debt is a cancer on our economy. In effect, interest payments on this monstrous debt constitute a tax on our economy that is gobbling up America's prosperity. And it has a stranglehold on the American dream—the dream of opportunity that I want to pass on to my grandchildren. That is what we face. And its time we confronted it head on. Not with charts and graphs. Not with cartoons and one-liners. But with real action.

Mr. President, it is the unfortunate, sad truth that Americans have grown skeptical about our actions here in the Congress. They have grown weary of the bickering. Weary of the shenanigans. They expect honesty. And that's what they deserve. No more bells and whistles. No more gimmicks, no smoke and no mirrors. Just the facts. And politicians who will face up to the facts, and make the hard choices.

And supporting this bill is a hard choice. I do not like every page, every provision, every punctuation point. I do not think this bill is Nirvana. It is not. In fact, there is a great deal here I don't like. There are things that I hope will get worked out in conference—and you can bet that the conferees will be hearing from me.

But there is one thing that is far worse than even the most distasteful provision in this bill. And that is inaction. It is time to act. And it is high time for honesty here in this town. It is time to come clean about what needs to be done. It is no fun voting for taxes. It is much easier to oppose them.

And it is not easy to vote for spending cuts that will hit the elderly, that will hit retirees, that will hit farmers, that will hit Federal workers. It is much easier to oppose these cuts. But I am not here to take the easy way out.

I am here to make the hard choices. To do what is right for my State—and for the Nation. And, Mr. President, that is why I am going to vote for this bill.

BUDGET RECONCILIATION

Mr. JEFFORDS. Mr. President, I rise today to oppose the entire bill. During the past few months, the Senate has been carefully reviewing the President's economic proposal and we are presently considering the newest installment in this process, the omnibus budget reconciliation bill, S. 1134, which contains many aspects of that proposal. This proposal does not meet my goal, or the President's, of matching every dollar in increased taxes with a dollar in reduced Government spending.

First, I would like to make it clear that there are many provisions within this proposal that I could support. But, as I learned from the 1990 budget agreement, where there was supposed to be some $500 billion in budget reductions over a 5-year period, the tax increases were immediately implemented, but the spending cuts never seemed to materialize. The 1990 tax package, sought to enforce strict budgetary limits and targeted spending reductions. I can only hope that the bill we are currently considering will place enforceable budgetary caps and spending reductions.

Furthermore, I would have supported the administration's original goal of about $2 in spending cuts for every $1 in tax increases. It is understandable that this goal slipped, and indeed I would have been satisfied with a proposal that had an equal amount of tax increases and spending cuts. It strikes me as fair to ask the American people to pay more in taxes if the Government will reduce its spending by the same amount, in effect meeting the public half way.

Unfortunately, this measure fails to even come close to this goal. It contains close to $270 billion in tax increases and user fees over the next 5 years, and just over $30 billion in spending cuts over the same period. I think a 3-to-1 ratio of tax increases to spending cuts is just too steep.

The bulk of budget savings, approximately $76 billion in the proposal, come from Medicare and Medicaid. I can not, and will not support any measure that unfairly singles out one group or groups for deficit reduction, particularly those individuals who can least afford it, such as the elderly and the poor. The fact is that much of this reduction in Federal spending, if enacted into law, will be simply cost-shifting to people covered by private health insurance.

In 1998, at the end of the President's program, the deficit is expected to be around $240 billion, just about what it was in 1990. From that point on, it is expected to rise steadily. For these reasons, this proposal does not make the fundamental structural changes in Federal domestic spending necessary to create viable and sustained deficit reduction.

Further, this proposal in fiscal year 1994 has $9 in tax increases for every $1 in spending cuts. It does not meet the goal of $1 in tax increases for every $1 in spending cuts, the President's pledge, until fiscal year 1998. To borrow a phrase from the President: We can do better and we must do better in our efforts to change America's economic future. We must ensure that real spending cuts at least equal the tax increase in this proposal.

I had hoped that Congress would improve upon the original proposal offered by the President. Instead, we have a Senate bill that proposes tax increases on Social Security benefits, as well as a 4.3-cent tax increase on transportation fuel. I feel an increase in the tax on Social Security benefits is not the place to start. Furthermore, I believe that the proceeds from any tax on energy, such as the proposed gas tax increase, must be dedicated to two purposes: improving our infrastructure and developing a viable alternative fuels industry to reduce our dependency on imported oil.

In order to truly address the Federal deficit, all Americans, senior citizens included, should share in the necessary sacrifice. However, eliminating Social Security benefits disproportionately affects individuals on a fixed income. While Social Security should not be excluded from the debate on deficit reduction, we must assure that our efforts to reduce the deficit not lead to a disproportionate sacrifice by the needy.

For all these reasons, I must vote no on this measure. We have got to start making the hard choices instead.

Moreover, as many of my colleagues have stated throughout this debate, to significantly lower the Federal deficit, budget reform must go hand in hand with health care reform. We can no longer afford to deceive ourselves into thinking that tinkering with Medicare and Medicaid is the answer to our country's deficit problem. Health care plays such an important role in our economy, that without overall health care reform, not only will the deficit continue to grow, but the economy will continue to suffer. Health reform can only be achieved if it is complete, including all segments of society, working people in addition to the Medicare and Medicaid population.

I believe both my Republican and Democratic colleagues understand that we need a seamless system for good health policy. Yet, the budget proposals offered today contradicts what we know is necessary for good health policy.

We have heard a great deal about the 37 million uninsured and the inequities in our current health care policy. What we don't focus enough on is the fact that Federal entitlements and the deficit are growing largely due to the impact of health care inflation. By the end of this year, we will spend more than $912 billion on health care. That's a lot of health care, more than any other industrialized nation in the world. The public sector currently spends $422 billion on health care, $386 billion in Federal spending. The private sector spends $490 billion. The bill cut Medicare and Medicaid by $76 billion in public health care spending. But without any more reform, this will simply shift health care spending, adding to the already numerous health care cost problems in the private sector. We should not forget that private sector spending results in substantial foregone Government revenue, too. This is due to the fact that health care is tax deductible by businesses. In fact, CBO predicts that if we continue with our current health care system and spending habits, by the year 2000, the public sector will spend $832 billion on health care, $583 billion of which will

be in Federal spending. Private sector will grow to $600 billion.

That means that by the year 2000, we will spend $1.6 trillion on health care. In percentage terms, this will represent 27 percent of the overall Federal budget. State and local governments will be spending an additional 18 percent on top of this amount. How much spending on health care is enough?

Well, we already spend $3,100 per person on health care. By comparison, we spend $1,700 per person on education and $1,200 per person on national defense. In fact, per capita health care spending has and will continue to increase twice as fast as per capita GDP growth unless health care reform is enacted. This is bad news for both the budget and the economy. Moreover, we are spending more on health care than any other country in the world. On a per capita basis, we spend 1.5 times more than Canada, 1.7 times more than West Germany, and $2.6 billion more than Great Britain.

We are spending a great deal on health care, but we are financing and delivering health care in a very inequitable and irrational way. We need to rationalize the system, give health care to everyone, and pay for health care for everyone, in a straight forward, across the board fashion. When we do this, we will find that health care can be provided so that all but the poor will pay 8 percent of a person's adjusted gross income. For most people, this could be collected in the form of a payroll premium, 4 percent paid by the employer, 3 percent paid by the employee.

This is much less than the 22 percent of payroll many auto companies and small employers currently pay for health care. Costs are high for many companies because everyone is not paying their fair share and the costs of uncompensated care and very sick individuals are not evenly borne by all.

With an all inclusive health care financing scheme, businesses will be able to reduce product prices and become more competitive. Additional workers could be hired. Fair financing for health care will also free up money to be used to provide pensions, education benefits and higher wages to employees. This translates into a higher standard of living and better quality of life for all American families.

But we can't stop there. We also need a health care budget. We have too many inefficiencies in our current health care system. Americans currently pay for administrative waste, fraud and abuse in claims processing and defensive medicine, that should not be in the system. This is the kind of health care spending nobody needs. Many people believe managed competition will squeeze much of the waste out of our health care system. However, a health care budget will ensure that waste is eliminated. Over the next decade, if growth in health care spending were limited to growth in GDP, we could cut the federal deficit in half.

Finally, health care delivery systems must be created and evaluated at the State level. States are more accountable and able to respond more quickly to the needs of the people than the Federal Government. States must have the flexibility to design the delivery system that works best given each State's demographic and geographic needs. We are a diverse country with diverse needs. State flexibility will account for this and ensure that everyone's health care needs are met in the best possible way.

I have incorporated all these elements of good health care policy that translates into good budget policy in S. 1067, the MediCORE Health Act of 1993. The bill ensures that every citizen has access to a CORE set of health services. It provides a broad based financing scheme to pay for these benefits. Moreover, it sets strict budget goals to be administered by the States, to make sure health care is affordable. Finally, it gives States the flexibility to design the health care delivery system that is most ideally suited to the needs of its people.

Mr. President, once Congress tackles health care costs, our Federal budget problems should largely be under control. Therefore, the next choice Congress must address is reprioritizing expenditures in the Federal budget. The area needing the most attention is American education.

Dealing with the budget process, the reconciliation instructions to the Senate Committee on Labor and Human Resources was to reduce $4.6 billion from covered expenditures. The administration planned to achieve these savings by completely replacing the current Federal Family Loan Program with a Federal Direct Student Loan Program by 1997-98. After long negotiations and with the assistance of my colleagues Senators PELL, KASSEBAUM, DODD, MIKULSKI, and Chairman KENNEDY the committee has crafted a compromise to the President's initial bill.

The committee compromise now include the replacement of only half of the current guaranteed lending program with direct lending in the next 5 years. It also establishes a Commission to study the advisability of moving fully into direct lending before the end of the fifth year.

For those of us who support a more cautious approach to direct lending this compromise represents a step in the right direction. The committee's compromise allows the concept of direct lending to be tested before moving full speed ahead into uncharted waters. I believe that direct lending may be the best way to deliver loans to students. However, I believe just as firmly that we need to test that assumption and move slowly so that the beneficiaries of this program—the students—are not left without access to needed loan money. The committee's compromise does just that.

However, the committee compromise does more than just move cautiously to a new delivery system for student financial aid. It also saves $4.6 billion. It does that by a combination of moving 50 percent of new loan volume to direct lending, decreasing subsidies paid to lenders and guaranty agencies, and by assessing fees on lenders and Sallie Mae.

While I am pleased that the committee was able to meet the budget instructions and reduce many of the excessive costs paid to participants in the current program, I am very concerned that this money is not being funneled back into education programs but is instead going to pay off our debts.

For years we have been told that the threat from foreign enemies demanded massive defense buildup. Without question, this country threw itself behind that call and spent hundreds of billions of dollars on warplanes, submarines, and battleships. But now that threat has receded and has been replaced by a new threat—just as serious and just as frightening.

The new threat is not somewhere across the Atlantic—it is here, in our own country. It is the threat that our children are not getting a fair shot at what they deserve. Just today, the National Research Council released its 3-year study suggesting that the serious problems of the Nation's adolescents—drug use, school failure, delinquency, and violence—have grown to tragic proportions. The reasons are clear—the programs designed to assist children have come under siege over the past two decades. But teenagers are not the only losers in our country—young children and babies are also being ignored. When 1 in 5 children—14.3 million—lived in poverty in 1991 there is little wonder why children fail in school and become disillusioned with the future.

We have a clear and present danger in this country—just as we did decades ago with our foreign enemies—but we have yet to take that threat seriously. We have not—as we did with our defense buildup—understood that now is the time to build up education, health, and social services programs in the same way that we committed ourselves to the cold war buildup.

The problems of this country have moved from being a distant threat to a frightening reality. We must begin to reevaluate our priorities and devote our funding to solving the crisis at home.

AMT REPEAL

Mr. LIEBERMAN. Mr. President, yesterday, I filed an amendment to this bill which would restore one of the President's investment proposals to his economic package—the President' alternative minimum tax reform provision. I did so because I believed—and I continue to believe—that the Congress must deliver three things to the American people—deficit reduction, spending cuts, and job creating investment incentives.

We are two-thirds of the way there. The bill sent to this floor by the Senate Finance Committee cuts spending

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Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo w/attach	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Meeting with Senator Jeffords (6 pages)	6/28/93	P5

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8990

FOLDER TITLE:
[HSA]- Senator Jeffords

gf139

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]