# FOIA Marker

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Staff Secretary, White House Office of the

Yanes, Raul - Chron Files

| Stack: | Row: | Sect.: | Shelf: | Pos.: | FRC ID: | Location or Hollinger ID: | NARA Number: | OA Number: |
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| W | 17 | 17 | 9 | 1 | 6338 | 19273 | 8093 | 8146 |

Folder Title:

747600, January 2007-December 2007, Folder 1

# Withdrawn/Redacted Material
## The George W. Bush Library

| DOCUMENT NO. | FORM | SUBJECT/TITLE | PAGES | DATE | RESTRICTION(S) |
|---|---|---|---|---|---|
| 001 | Barcode Scanning Sheet | 747600 | 1 | 03/07/2008 | P2; P6/b6; |
| 002 | Letter | [Letter] [with attachment] - To: POTUS - From: Rick Perry | 3 | 08/09/2006 | P2; P5; P6/b6; |
| 003 | Envelope | [Envelope] | 1 | 11/14/2006 | P6/b6; |
| 004 | Letter | [Letter] - To: POTUS - From: Douglass C. Robison | 2 | 11/29/2006 | P6/b6; |
| 005 | Letter | [Letter] - To: POTUS - From: Robert F. Hoyt | 1 | 12/11/2006 | P6/b6; |
| 006 | Letter | [Letter] - To: POTUS - From: Dabney Langhorn Friedrich | 1 | 12/11/2006 | P6/b6; |
| 007 | Letter | [Letter] - To: POTUS - From: Corbett Howard | 1 | 12/15/2006 | PRM; |

**COLLECTION TITLE:**
**Staff Secretary, White House Office of the**

**SERIES:**
**Yanes, Raul - Chron Files**

**FOLDER TITLE:**
**747600, January 2007-December 2007, Folder 1 [1]**

**FRC ID:**
**6338**

### 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]

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

**Deed of Gift Restrictions**

A. Closed by Executive Order 13526 governing access to national security information.
B. Closed by statute or by the agency which originated the document.
C. Closed in accordance with restrictions contained in donor's deed of gift.

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

b(1) National security classified information [(b)(1) of the FOIA]
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|---|---|---|---|---|---|
| 008 | Letter | [Letter] - To: POTUS - From: Corbett Howard | 1 | 12/18/2006 | PRM; |
| 009 | Letter | [Letter] - To: POTUS - From: William J. Haynes II | 1 | 12/19/2006 | P6/b6; |
| 010 | Email | WSJ Health Tax... - To: Grey D. Baker, et al. - From: David R. Meyers | 3 | 01/21/2007 | P5; |
| 011 | Draft | WSJ Health Tax Op-Ed | 2 | 01/22/2007 | P5; |
| 012 | Draft | WSJ Health Tax Op-Ed | 2 | 01/22/2007 | P5; |
| 013 | Letter | [Letter] [with attachment] - To: POTUS - From: B.M. Rankin, Jr. | 3 | 01/22/2007 | PRM; |

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|---|---|---|---|---|---|
| 014 | Email | FW: Vetting Results... - To: David R. Meyers - From: Daniel M. Aires | 3 | 02/08/2007 | P5; P6/b6; |

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**OA Num.:**
**8146**
**NARA Num.:**
**8093**

**FOIA IDs and Segments:**
2014-0073-F
2014-0072-F

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# NATIONAL CATHOLIC PRAYER BREAKFAST

1413 K Street, NW · Suite 1000 · Washington, D.C. 20005
Phone: 202-289-2323 · Fax 202-289-2502




September 4, 2006

President George W. Bush
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mr. President:

We would like to extend our deep gratitude for addressing the 3rd Annual National Catholic Prayer Breakfast. Your presence is such an extraordinary honor for our board and for the people who attended the National Catholic Prayer Breakfast.

We are humbled, yet so excited, to see over 1,700 people from all walks of life from across the country so enthusiastic about their faith. People from across the United States, Canada and Europe were in attendance!! We have great hopes that our gathering will continue to grow.

Your presence and your very thoughtful and timely remarks made this year's event exceptional.

Please be assured or our prayers for you and your presidency. And we sincerely hope that your schedule will permit you to attend the National Catholic Prayer Breakfast next year, Friday April 13th, 2007.

Sincerely yours,

Joseph J. Cella
President

Austin Ruse
Vice President

Jacqueline Halbig
Treasurer and Secretary

Leonard Leo

Bill Saunders

**Thompson, Lakeysha R. (Records-NSC)**

**From:** Moon, Jeffrey A. (ExecSec-NSC)
**Sent:** Tuesday, September 04, 2007 1:49 PM
**To:** Haenle, Paul T. (Asia_E-NSC); Thompson, Lakeysha R. (Records-NSC); Regenor, James A. (ExecSec-NSC)
**Cc:** @Asia-NSC; @West Wing Desk
**Subject:** RE: Pkg # 0705951 Thank you letter from PM Miyazawa [UNCLASSIFIED, Record]

Approved. Jeff

---

**From:** Haenle, Paul T. (Asia_E-NSC)
**Sent:** Tuesday, September 04, 2007 1:32 PM
**To:** Thompson, Lakeysha R. (Records-NSC); Regenor, James A. (ExecSec-NSC); Moon, Jeffrey A. (ExecSec-NSC)
**Cc:** @Asia-NSC; @West Wing Desk
**Subject:** RE: Pkg # 0705951 Thank you letter from PM Miyazawa [UNCLASSIFIED, Record]

The President should see this letter prior to his bilateral meeting with PM Abe on Saturday, September 8.

---

**From:** Thompson, Lakeysha R. (Records-NSC)
**Sent:** Tuesday, September 04, 2007 1:28 PM
**To:** Regenor, James A. (ExecSec-NSC); Moon, Jeffrey A. (ExecSec-NSC)
**Cc:** @Asia-NSC; @West Wing Desk
**Subject:** Pkg # 0705951 Thank you letter from PM Miyazawa [UNCLASSIFIED, Record]

Please approve attached distribution, and does the president need to see this?
<< File: 0705951_00001.TIF >>

ATTENTION
STAFF
SECRETARY

**Gleiser Communications LLC**

Paul L. Gleiser
President & Chief Executive Officer

October 27, 2006

President George W. Bush
THE WHITE HOUSE
Washington, D.C. 20500

Mr. President:

I remain confident that you will finish your term with a Republican-controlled Congress.

Having said that, I continue to be distressed by the beating that you take from those who either genuinely don't understand what we face or choose to ignore our country's circumstances for the purpose of momentary political gain.

You're a tough guy – much tougher than I. But it has to get to you sometimes. It just has to or you're not human.

For those moments, I hope that you remember that history has been extraordinarily kind to those leaders who have stuck to their guns in the face of withering criticism. Perseverance takes character and character always wins.

Always.

You continue to be in my prayers.

All the best,

Paul

Paul L. Gleiser

PLG/ms
Enc.

P.O. Box 92 • Tyler, Texas 75710 • (903) 593-2519 • Fax (903) 597-4141
928 N.NE. Loop 323 • Tyler, Texas 75708
e-mail: pgleiser@gleisercom.com
www.gleisercom.com

NOV 8, 2006

Dear George,

Great Press Conference!

Thank you very much for declaring that you will work together with the Democrats to accomplish good things for America.

I think Christ likes to see "friendly persuasion" and cooperation. Seeing "Control" implies bossing everyone around.

Please work on cooperation.

CONGRATULATIONS!

NICE JOB!

GOOD JOB!

Sincerely,

Tom

Tom Schmidt

(b)(6)

KALISPELL MT 590 PM 9 NOV 2006

10¢ America Clock

USA 29

(b)(6)

21114@0425

NOV 1 4 2006

✓#159

Rec'd
Jun 08, 2007

Document Originally
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Following Page

JOHN F. KENNEDY
LIBRARY AND MUSEUM

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Exhibits Specialist

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e-mail: jim.wagner@nara.gov
www.jfklibrary.org

November 2

# JOHN F. KENNEDY

LIBRARY AND MUSEUM

A Presidential Library
Administered By
The National Archives
And Records
Administration

Dear Mr. President,

My friend Prashant Shankar and I greatly appreciate your staff arranging for us to visit the West Wing and view the Oval Office.

It was an awesome experience, and seeing President Kennedy's desk was particularly meaningful.

We left some souvenirs of the Kennedy Library behind

Columbia Point, Boston, Massachusetts 02125 • 1.866.JFK.1960 • 617.514.1652 (fax) • www.jfklibrary.org

for you and Mrs. Bush, but just in case they did not make their way to you, I wanted to send this note of gratitude.

Respectfully,

Jim Wallis

(& Prashant Shankar)

Scott Turner

11-27-06

Dear Mr. President,

I am writing this morning for two reasons:
1) I was praying this morning and the LORD put a Scripture on my heart for you: (Phil. 1:6) "Being confident of this very thing, HE who began a good work in you, will carry it on to completion until the day of CHRIST JESUS." Mr. President, the LORD will finish the great work HE started in you for your Presidency & every other area of your life.

over

The Second thing is this: ~~I have~~ been praying about ways I could serve you and your administration. I have studied the State Dept. Web site and others. I have had a desire to serve as an Ambassador of some sort. Whether it be in the USA or another Country. My heart is to be an encouragement and to Challenge people to live w/ excellency & fulfill their "call" in life. The LORD has put this on my heart so I wanted to share it w/ you. Anyway I can be of Service, I am willing & able. I would appreciate your thoughts on this matter & any suggestions

God Bless You,

Scott

ExL
PETROLEUM

November 29, 2006

The Honorable George W. Bush
President, United States of America

Re: China Aid Association

Dear Mr. President:

As Chairman of the Board for the China Aid Association supporting Mr. Bob Fu and his work for the persecuted church in China, please accept my most sincere appreciation for your public and private support for the religiously persecuted believers in mainland China. Your private meeting in May of this year with Dr. Li Baiguang, Esq., Wang Yi, Esq., and Yu Jie, was a source of tremendous encouragement. An example as to one of the fruits of this meeting, China Aid has recently received word from Dr. Li Baiguang that in the course of his recent detention by the Chinese Public Security Bureau, Dr. Li was politely treated with the PSB Agent acknowledging that Dr. Li's safety from arrest was due to "his friendship with President Bush".

By way of personal introduction, I met you in 1978 while serving as President of the Society for the Advancement of Management at Texas Tech University. You will most likely not remember me personally, but I organized the debate on the Tech campus between yourself and Kent Hance. Professionally, I spent 15 years with Exxon, served as General Counsel for Henry Petroleum here in Midland for 10 years until August 2005, when I and two others formed ExL Petroleum, LP a Midland based exploration and development company.

In addition to thanking you for your prayers and support I am also requesting that you consider granting Bob Fu either a personal visit or a word of thanks and encouragement. Regrettably, Bob was unable to attend your May 2006 meeting and this was a great disappointment to him. I and my family have had the privilege of becoming close personal friends with Bob and his family by virtue of our work together in China Aid and more importantly through the Fu family and the other Chinese here in Midland becoming a part of our home weekly bible study. Bob Fu is one of the most outstanding and gifted men I have ever been privileged to know. His integrity is truly beyond compare and Bob's efforts on behalf on the religiously persecuted in China are tireless and unrelenting.

***Midland, Texas Office***
*PO Box 2000 Midland, Texas 79702 432.686.8080 (off.)* (b)(6)
*400 W. Illinois, Suite 1500 Midland, Texas 79701*
***Dallas, Texas Office***
*1314 W. McDermott, Suite 106 #822 Allen, Texas 75013 432.296.0548 (off.)*

Thank you again for your example of determined consistent Christian leadership both in this country and throughout the world. If circumstances ever allow, I believe you would be encouraged to learn more about the community of Chinese believers and refugees that has gathered here in Midland. We are constantly asked why an organization with the international scope of China Aid has settled in Midland. The answer was given by one of the first Christian Chinese leaders to visit Midland two years ago. This Chinese House church leader stepping off of the plane here in Midland felt the Lord speak to him saying that the home town of the "King of the World" was going to be used for the purposes of the King of the Heavens.

Our prayers are constantly with you and your family.

Sincerely,

Douglass C. Robison
President, ExL Petroleum, LP
Chairman of the Board, China Aid Association
(b)(6)

***Midland, Texas Office***
*PO Box 2000 Midland, Texas 79702 432.686.8080 (off.)* (b)(6)
*400 W. Illinois, Suite 1500 Midland, Texas 79701*
***Dallas, Texas Office***
*1314 W. McDermott, Suite 106 #822 Allen, Texas 75013 432.296.0548 (off.)*

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**From:** Aho, John A. (Defense-NSC)
**Sent:** Thursday, December 14, 2006 2:00 PM
**To:** Turner, Gillian H. (Records-NSC)
**Cc:** Miles, Richard G. (NSA-NSC); @West Wing Desk; @Defense-NSC; @ITEE; @CT-NSC
**Subject:** RE: Staffing of FY08 Budget Chapters [UNCLASSIFIED, Non-Record]

Defense clears w/out comments the FY08 Budget Chapters on: Army Corps of Engineers
Dept of Veterans Affairs
NASA

R/

***John A. Aho***
***Colonel, U.S. Marine Corps***
***Director, Defense Strategy and Plans, and Support for Military Operations***
***Defense Policy and Strategy Directorate***
***National Security Council Staff***
***(202) 456-9107***
***(202) 456-9190 (Fax)***
***(202) 329-5015 (Blackberry)***

---

**From:** Turner, Gillian H. (Records-NSC)
**Sent:** Thursday, December 14, 2006 12:14 PM
**To:** @ITEE; @Defense-NSC; @CT-NSC
**Cc:** Miles, Richard G. (NSA-NSC); @West Wing Desk
**Subject:** FW: Staffing of FY08 Budget Chapters [UNCLASSIFIED, Record]

@ITEE/Defense/CT:

Please provide comments before 2pm TODAY. At 2pm these staffings will be returned to Staff Secretary.

Thank you.
Gillian Turner

---

**From:** Turner, Gillian H. (Records-NSC)
**Sent:** Thursday, December 14, 2006 9:42 AM
**To:** @Defense-NSC; @ITEE; @CT-NSC
**Cc:** @West Wing Desk; Miles, Richard G. (NSA-NSC)
**Subject:** Staffing of FY08 Budget Chapters [UNCLASSIFIED, Record]

@ITEE/Defense/CT:

These are available in your boxes in 373 for pick up. Please provide hard copy comments to WWD ASAP per Mr. Miles.

Thank you!
Gillian Turner

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THE PRESIDENT HAS SEEN
12/21/06

THE WHITE HOUSE

WASHINGTON

December 20, 2006

MEMORANDUM FOR THE PRESIDENT

FROM: LIZA WRIGHT LW

SUBJECT: Personnel Selection

Joshua Bolten and I recommend for possible nomination to the Senate the following individual:

Ryan C. Crocker of Washington, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Iraq, vice Zalmay Khalilzad.

Upon your approval, necessary clearances will be initiated. Announcement of intention to nominate will be made upon the completion of all necessary clearances. Nomination to the Senate will be forwarded when all clearances have been obtained.

APPROVE: ✓ DISAPPROVE: ____

THE WHITE HOUSE

WASHINGTON

THE PRESIDENT HAS SEEN
12/21/06

December 20, 2006

MEMORANDUM FOR THE PRESIDENT

FROM: LIZA WRIGHT LW

SUBJECT: Personnel Selection

Joshua Bolten and I recommend for possible nomination to the Senate the following individual:

Zalmay Khalilzad of Maryland, to be Representative of the United States to the United Nations with the rank of Ambassador Extraordinary and Plenipotentiary, vice John Robert Bolton.

Zalmay Khalilzad of Maryland, to be United States Representative in the Security Council of the United Nations, vice John Robert Bolton.

Zalmay Khalilzad of Maryland, to be Representative of the United States of America to the Sessions of the General Assembly of the United Nations during his tenure of service as Representative of the United States to the United Nations, vice John Robert Bolton.

Upon your approval, necessary clearances will be initiated. An announcement of intention to nominate will be made upon completion of a name check. Nomination to the Senate will be forwarded as soon as all clearances have been obtained.

APPROVE: ✓ DISAPPROVE: ________

THE WHITE HOUSE

WASHINGTON

THE PRESIDENT HAS SEEN
12/21/06

December 20, 2006

MEMORANDUM FOR THE PRESIDENT

FROM: LIZA WRIGHT LW

SUBJECT: Personnel Selection

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Upon your approval, necessary clearances will be initiated. An announcement of intention to nominate will be made upon completion of a name check. Nomination to the Senate will be forwarded as soon as all clearances have been obtained.

APPROVE: ✓ DISAPPROVE: ______

American Enterprise Institute for Public Policy Research

AEI

No. 2 • January 2007

Health Policy Outlook

# The Medicaid Commission Report: A Dissent

## By Robert B. Helms

*While instructive, the Medicaid Commission's final report on reforming the program does not fully address its deficiencies, particularly the problems with the formula which allocates Medicaid funds to states. Worthwhile reforms would direct Medicaid funds to the states and populations that need them most.*

In May 2005, Secretary of Health and Human Services Michael O. Leavitt established the Medicaid Commission, chartering it "to advise the Secretary on ways to modernize the Medicaid program so that it can provide high-quality health care to its beneficiaries in a financially sustainable way."[1] The commission issued two reports. The first, submitted on September 1, 2005, provided recommendations for achieving short-term budget savings. A final report, suggesting how best to reform the program, was released on December 29, 2006.[2]

There were fifteen voting members and fifteen non-voting members who met on nine occasions. During these meetings the commission members were given extensive briefings and heard public testimony from health-care experts and Medicaid recipients. In many cases, the latter group consisted of disabled recipients, or the parents, spouses, and caregivers struggling to care for them. Their common refrain was, "Don't cut our Medicaid benefits!" The public testimony was often emotional, so much so that it was sometimes difficult to see how it would help the commission address the financial and management problems presented by the experts. Still, the stories told by recipients and caregivers did affect the commission's view of Medicaid's basic problems. The public and expert testimony showed that Medicaid plays a crucial role in helping state and local governments take care of the most vulnerable people in our society. But it also reminded us that the present Medicaid program does a poor job of taking care of these individuals, and that it cannot be sustained without substantial reform. These observations delineated the basic issues that we struggled with for a year and a half.

Robert B. Helms (rhelms@aei.org) is a resident scholar at AEI. He served as a voting member of the Medicaid Commission.

I voted for the final report and for all of the specific proposals approved by the commission. The final recommendations provide a helpful, overdue road map to achieve useful reforms of the program. I submitted a dissent to the report, however, because I believe that the commission did not address an important aspect of the current program that is the root cause of many of Medicaid's problems.[3] This *Health Policy Outlook* is intended to provide background and a thorough rationale for my dissent.

### The Origin of the Problem

Medicaid has an ill-conceived—and now outdated—method for calculating the level of federal financial support for the states. Until this issue is addressed, and a fairer and more equitable method is developed, Medicaid will continue to be plagued by problems, including:

- poor targeting of resources to help the poorest and most disadvantaged members of our communities
- uncontrolled growth of federal and state spending
- rampant fraud and abuse
- incentives for states to use questionable accounting schemes to increase federal funding
- federal subsidy formulas that are unable to sufficiently respond to changing economic conditions
- intensifying adversarial relationships between the states and the federal government that reduce the chance of political compromise on policy reforms

Since its passage in 1965, the Medicaid program has operated as a joint effort between the federal and state governments to finance health care for a population that has grown to 55 million people.[4] It is an open-ended entitlement program financed with both federal and state funds, with the federal government financing approximately 57 percent of Medicaid's total cost of $301 billion in FY 2005.[5] The amount of federal money that flows to the states is partially determined by the Federal Medical Assistance Percentage (FMAP).[6] This formula compares each state's per-capita personal income to the national per-capita personal income and is designed to provide larger federal subsidies to states with relatively low incomes.[7]

The FMAP formula determines only the percentage rate at which the federal government matches claims submitted by the states. The total amount of federal funds flowing to each state is also a function of the number of claims that a state submits to cover the costs of providing mandatory and optional benefits for the populations the program can serve. This feature of Medicaid financing—allowing each state to determine how much it will spend and obligating the federal government to match what the state chooses to spend—has been a popular feature of the program. For the politicians who designed the original program, it met the national objective of subsidizing medical coverage for those with low incomes while allowing each state great flexibility to choose its own level of desired and affordable support, threading the twin political needles of compassion and federalism.[8] In a recent AARP report, Vic Miller and Andy Schneider point out that the original objective of the FMAP was to:

- enable states of varying means to provide roughly equivalent benefits to their Medicaid-eligible populations
- increase and decrease federal matching payments to states to reflect changed economic circumstances
- target states with higher concentrations of individuals in poverty[9]

However, they also point out that these objectives were not fully realized, concluding: "The FMAP formula, most analysts agree, does not adequately reflect the different fiscal capacities of the states and does not take into account the circumstances of states with high concentrations of poor citizens."[10]

The following data on the distribution of federal Medicaid payments illustrates how the current financing system has failed to allocate federal subsidies to the poorest people in our population. In 2004, the most recent year of available Medicaid data from the Center for Medicare & Medicaid Services (CMS), federal Medicaid payments to the states ranged from a low of $233 *million* to Wyoming to a high of $21.4 *billion* to New York. Since there are large differences in the population of the various states, however, federal expenditures are more easily compared when expressed on a per-population basis, independent of a state's Medicaid enrollment policies. This can be achieved by dividing federal Medicaid payments to each state by the number of poor and near-poor people in poverty (below 125 percent of the federal poverty line). These per-capita federal payments in FY 2004 ranged from $1,736 in Nevada to $6,780 in Maine.[11]

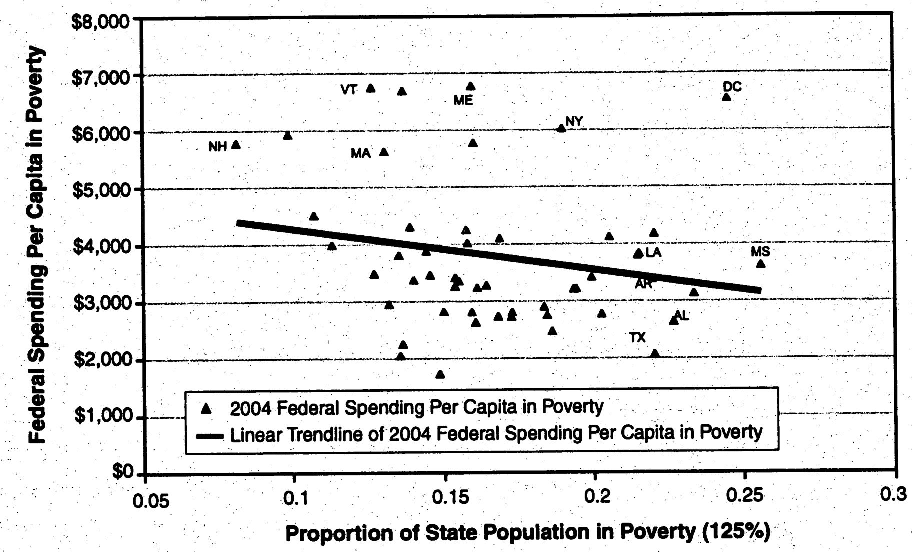
As illustrated in figures 1 and 2 on the next page, data for all states reveal that there is a negative relationship between the per-capita amount of federal funds flowing to the states and the amount of poverty in the states—that is, as a general tendency, the poorer the state, the less federal money that state receives.

The official audited data for state Medicaid expenditures for FY 2005 have not yet been released by CMS. Preliminary data represented in figure 2, however, indicate an almost identical pattern.

Once again, there is an inverse correlation between poverty rates and federal per-capita Medicaid reimbursement. States with the highest poverty rates—such as Alabama, Louisiana, and Mississippi—received much lower Medicaid payments per-capita than did wealthier states like New York and several New England states.[12]

FIGURE 1

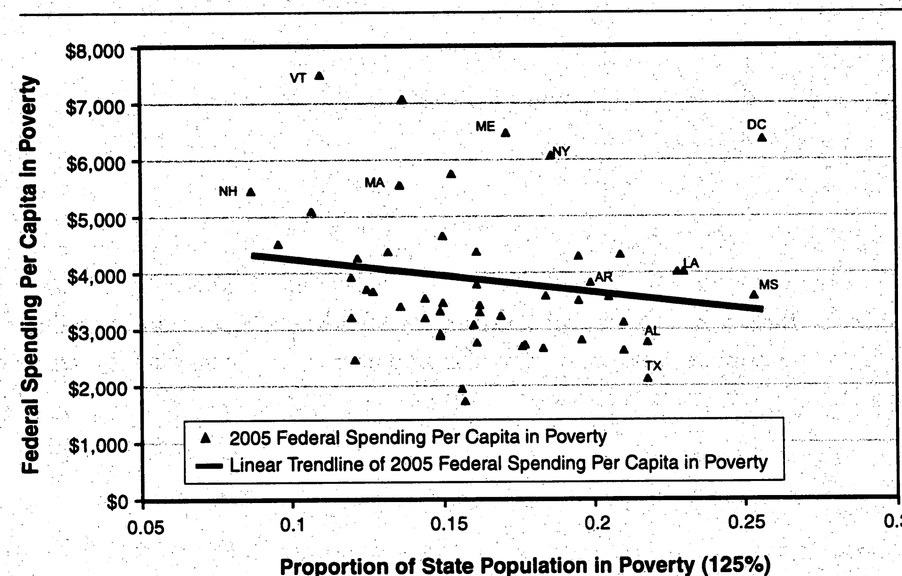
**2004 FEDERAL MEDICAID SPENDING PER CAPITA IN POVERTY VERSUS PERCENT OF STATE POPULATION IN POVERTY**




SOURCE: Author's calculations based on CMS Medicaid data and Census Bureau poverty data. See note 11 for calculation details.

FIGURE 2

**2005 FEDERAL MEDICAID SPENDING PER CAPITA IN POVERTY VERSUS PERCENT OF STATE POPULATION IN POVERTY**



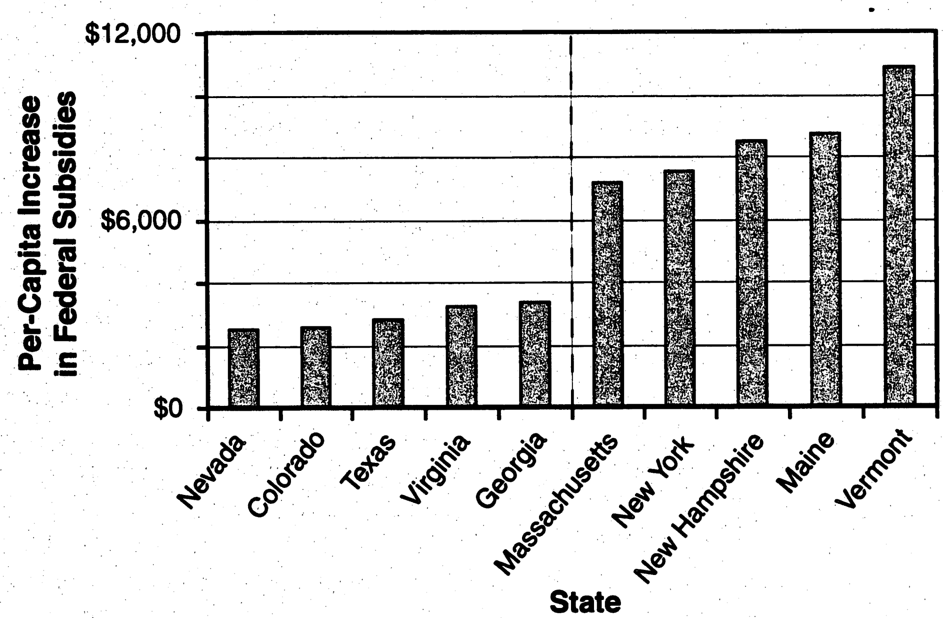

SOURCE: Author's calculations based on CMS Medicaid data and Census Bureau poverty data. See note 11 for calculation details. FY 2005 Medicaid data are preliminary and are subject to change. These data were obtained directly from CMS.

Not only can the wealthier states afford to spend more on Medicaid, the open-ended process of obligating the federal government to match what the state chooses to spend creates an incentive for states to increase Medicaid spending relative to all other priorities. When a state is forced to cut budget expenditures, the FMAP procedure gives the state an incentive not to cut matched expenditures relative to unmatched state expenditures. With a minimum matching rate of 50 percent, a state would have to cut total Medicaid expenditures by $2 in order to cut state expenditures by $1, thereby foregoing $1 in federal funds.[13] This incentive results in a ratchet effect in state Medicaid budgets, since Medicaid expenditures tend to rise in times of plenty but are rarely reduced when states must cut back.[14]

Another way to look at the effects of current Medicaid payment policy is to examine which states have increased their federal payments the most over an extended period. I obtained records of federal Medicaid payments to the states for FY 1970 and expressed them on a per-capita basis using the number of people at or below 100 percent of poverty in 1970.[15] Figure 3 shows the five states with the smallest increases and the five states with the largest increases for the period 1970–2005.[16] Again, New York and several New England states have consistently taken greater advantage of the open-ended federal assistance formula than the poorer Southern states.

Clearly, the FMAP procedure is not successfully achieving the original objective of Medicaid: targeting federal assistance toward the states with the greatest share of poverty. Poorer states today are falling behind as wealthier states are collecting a disproportionate share of federal Medicaid dollars.

FIGURE 3
STATES WITH SMALLEST AND LARGEST INCREASES IN FEDERAL MEDICAID SUBSIDIES, 1970–2005




SOURCE: Author's calculations based on CMS Medicaid data and Census Bureau poverty data. See note 15 for calculation details.

The FMAP formula also poorly counteracts the effects of changes in a state's economic activity. The measurement of a state's per-capita personal income does not accurately track changes in state economic activity. The three-year averaging procedure, as well as delayed updating, results in a substantial lag in FMAP adjustments.[17] If a state's economy begins to decline relative to other states, it may take from three to six years for FMAP to adjust to this change.

The FMAP procedure of Medicaid financing has been criticized by policy analysts and government agencies for decades.[18] This criticism comes from analysts representing a wide spectrum of policy-oriented and philosophical approaches to health policy, proving that this debate is not just a matter of government budgets. The perverse incentives created by this method of financing would be present at any level of spending. In addition to the AARP report, a recent report from the National Academy of State Health Plans refers to the Medicaid "tug of war" and calls for steps to improve the fiscal integrity of federal financing.[19] The authors of the report point out that the FMAP procedure creates strong incentives for states to engage in accounting schemes that enhance federal funding, and for the federal bureaucracy to attempt to control these schemes—hence the "tug of war." Numerous analysts have pointed out that we have created a situation in which each governor and state Congressional delegation has a strong incentive to increase federal funding under the FMAP procedures rather than consider reforms that would be in the best interest of those Medicaid is intended to serve.

## Moving Forward

How should Medicaid be reformed? The literature on reform suggests myriad approaches for using alternative population or economic variables in the formula and for making the formula more responsive to changing economic conditions in the states.[20] But before these approaches can be considered, it is important to understand how the existing system affects the politics of Medicaid reform. Overcoming the political obstacles to reform is daunting. The problem is linked to the incentives created by the open-ended nature of the current payment policy and the fact that no state, regardless of its economic status, receives less than a 50 percent match from the federal government. Any state willing to spend more on expanding optional benefits or covering optional beneficiaries—including beneficiaries with higher incomes—will only incur at most half the additional cost of the expansion. This creates strong pressure for a state to increase its Medicaid program and, as argued earlier, creates disincentives to control these costs. In this situation, any discussion of a change in the FMAP formula is seen as a possible threat to the open-ended flow of federal funds to the state. Any formula based on estimates of the number of poor, disabled, or aged—or any new idea to reduce the marginal reward for additions to the program—can easily be turned into a table of winners and losers by a good number cruncher.[21]

This is not conducive to any serious discussion of reform. The result is a continuation of the decade-long political stalemate. As pointed out by Sonya Schwartz, Shelly Gehshan, Alan Weil, and Alice Lam, CMS is on the defensive in trying to issue new regulations to control state-level program expansions.[22] Meanwhile, Congress tries to control costs by passing new controls on payment rates to providers and suppliers.[23] This dissonance between state incentives to expand eligibility and federal attempts to control expenditures can only be expected to intensify in future years as the population ages and the cost of caring for the disabled puts more pressure on federal and state budgets.[24] As in any system that relies primarily on price controls and government rationing, Medicaid beneficiaries will have access to fewer providers and will experience decreases in the quality of care.

The commission was presented with ample evidence that the millions of poor, aged, and disabled people—the types of people that the commission heard from during the public testimony—were not being well-served in most states. This does not mean that some individuals with higher incomes or less-severe disabilities could not be helped by some subsidies. It only illustrates the basic problem with all welfare programs: targeting assistance to those most in need without creating incentives for others to take advantage of the program. With limited resources, how does the government target resources to the neediest? The present Medicaid program seems designed to do just the opposite, shifting resources toward citizens who live in wealthier states.

I believe that Congress will eventually be forced to abandon the current funding structure and severely limit Medicaid expenditures in future years.

Medicaid advocacy groups and others who seem to have a near-religious belief in the concept of open-ended entitlements will not like to hear it, but I believe that Congress will eventually be forced to abandon the current funding structure and severely limit Medicaid expenditures in future years. The annual projections of the future costs of entitlements from the Congressional Budget Office show that the three largest entitlement programs (Social Security, Medicare, and Medicaid) will grow from 42.9 percent of federal spending in 2006 to 49.3 percent by 2015, and to 52.6 percent by 2020.[25] While these projections are driven more by Medicare than by Medicaid or Social Security, such growth in total entitlement spending will require either large tax increases or drastic reductions in all categories of discretionary spending (education, defense, and infrastructure, for example)—a highly improbable outcome. Likelier is a continuing Congressional effort to control Medicaid expenditures by imposing more controls on payments and benefits, an approach that will only exacerbate today's access and quality problems.

The extensive literature on Medicaid reform offers a number of ideas about how to correct these perverse incentives and to ensure that the program focuses on helping the poorest and most vulnerable of our citizens. My preferred approach would be to block-grant the program and force Congress to decide how much money it wants to devote to Medicaid compared to all other budget priorities. With that amount determined, a revised formula based on the number of disabled, aged, and low-income people in each state could be used to distribute the money to the states. A relatively long transition period (at least ten years) would give the states ample time to redesign their programs. However, since block-granting any entitlement program is now out of favor, my second choice would be to reform the current FMAP formula to target the poorest and most disabled beneficiaries and to reduce the matching percentage for program extensions beyond current mandatory coverage for those with higher incomes or for optional benefits.[26] The latter approach would reduce the incentive for states to game the system, and it would give them reasons to find better ways to help the neediest. Meanwhile, this approach would also leave states free to expand their own programs if they wish to do so.

In 1996, Congress reformed welfare programs when it became clear that they were not achieving their intended purposes.[27] It is now time to do the same for Medicaid. The Medicaid Commission's recommendations to increase state flexibility constitute a good start, but they will not correct the massive, perverse incentives now disrupting the program. Until these issues are addressed, the budgetary and policy deficiencies that led to the formation of this commission will continue to fester.

*AEI research assistant Jonathan Stricks and editorial assistant Evan Sparks worked with* Mr. Helms *to edit and produce this* Health Policy Outlook.

## Notes

1. The final report, the charter, and a complete record of commission meetings can be found at http://aspe.hhs.gov/medicaid/ (accessed December 30, 2006).

2. U.S. Department of Health and Human Services, Medicaid Commission, *Final Report and Recommendations: Medicaid Commission*, December 29, 2006, available at http://aspe.hhs.gov/medicaid/122906rpt.pdf (accessed January 3, 2007).

3. Ibid., 28–29.

4. For an historical account of the passage of Medicaid in 1965 and its early years, see Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (New York: Free Press, 1974).

5. U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, preliminary Form CMS-64 data (FY 2005) on federal and state total net expenditures.

6. For a more complete description of the FMAP formula and procedures, see Vic Miller and Andy Schneider, "The Medicaid Matching Formula: Policy Considerations and Options for Modification" (research report 2004-09, Public Policy Institute, AARP, Washington, DC, September 2004), available at http://assets.aarp.org/rgcenter/health/2004_09_formula.pdf (accessed December 30, 2006).

7. The formula for each state is: FMAP equals 100 percent – the state's share. The state's share equals 0.45 × (state's per-capita income ÷ national per-capita income)$^2$. Multiplying by 0.45 was to ensure that a state with per-capita income near the national average received a 55 percent federal subsidy. The ratio of a state's per-capita income to national per-capita income was squared as a way of providing a larger federal subsidy to the poorest states. The calculation each year uses state and national per-capita income over a three-year period. Congress has established special matching rates for Alaska and the District of Columbia. No state receives less than a 50 percent matching rate, a rule that protected thirteen states and the District of Columbia in FY 2004. See Vic Miller and Andy Schneider, "The Medicaid Matching Formula," 9. Congress has also provided enhanced matching rates for limited periods of time and for specific purposes.

8. Thomas W. Grannemann and Mark V. Pauly, *Controlling Medicaid Costs: Federalism, Competition, and Choice* (Washington, DC: AEI Press, 1983), 30–41.

9. Vic Miller and Andy Schneider, "The Medicaid Matching Formula," 16.

10. Ibid., 17. See especially the authors' list of studies backing up this conclusion in their note 40.

11. The calculations were made by the author based on data from two government sources. Federal Medicaid payments to the states is from CMS, Form CMS-64 data (FY 2004), available at www.cms.hhs.gov/MedicaidBudgetExpendSystem/02_CMS64.asp#TopOfPage (accessed December 30, 2006); the number of people at or below 125 percent of poverty in each state, and the percent of poverty in each state, is from the Census Bureau, CPS, 2004, available at http://pubdb3.census.gov/macro/032005/pov/new46_100125_01.htm (accessed December 30, 2006).

12. New York, Massachusetts, Vermont, Connecticut, and New Hampshire received average per-capita federal payments of $5,848 in FY 2004; Texas, Alabama, Louisiana, Arkansas, and Mississippi received average per-capita payments of $2,585.

13. Vic Miller and Andy Schneider, "The Medicaid Matching Formula," 3–4. The higher the federal matching rate, the greater the penalty for cutting a matched expenditure. A state with a 70 percent match would have to reduce total Medicaid spending by $3.33 in order to save the state $1.

14. The FMAP procedure also affects a state's incentive to fight fraud and abuse in Medicaid since it affects the relative return from controlling fraud and abuse in matched—versus unmatched—state programs. If a state saves $1 by investing in fraud and abuse control in Medicaid, it must share 50 percent or more (depending on the state's matching rate) of the savings with the federal government. If a state saves $1 by reducing fraud and abuse in an unmatched program, all of the $1 savings accrue to the state.

15. With the help of John Klemm in the CMS Office of the Actuary, we obtained records of FY 1970 federal medical assistance payments for the forty-eight states (Alaska and Arizona had no such payments in 1970) from the Medicaid Financial Management Reports (Form OA-41). We then computed per-capita federal expenditures by dividing by the number of people at or below 100 percent of poverty in those states in FY 1970 and FY 2005. The mean absolute increase in per-capita federal payments for all forty-eight states was $5,075. Arkansas ($5,502) was the only Southern state with an increase above the mean.

16. The District of Columbia's matching rate is set by Congress at 70 percent, and therefore is not based on the FMAP formula. Excluding the District from the five states with the largest increases moves Massachusetts into the top five states.

17. Vic Miller and Andy Schneider, "The Medicaid Matching Formula," 4. See also their references to studies of the impact of Medicaid on state economic activity in their note 9.

18. Thomas W. Grannemann and Mark V. Pauly, *Controlling Medicaid Costs*. Miller and Schneider list the following Government Accounting Office (GAO) studies: GAO, *Changing Medicaid Formula Can Improve Distribution of Funds to States*, GAO/GGD-83-27, March 9, 1983; GAO, *Medicaid Matching Formula's Performance and Potential Modifications*, GAO/T-HEHS-95-226, July 27, 1995; GAO, "Medicaid Formula: Effects of Proposed Formula on Federal Shares of State Spending," memo to Senator Daniel Patrick Moynihan (D-N.Y.), GAO-HEHS-99-29R, February 19, 1999; and GAO,

"Medicaid Formula: Differences in Funding Ability among States Often Are Widened," GAO-03-620, July 2003. For more recent criticisms, see John R. Graham, "Taming the Medicaid Monster," *Health Policy Prescriptions* 4, no. 8 (August 2006); Tommy G. Thompson, *Medicaid Makeover: Four Challenges and Potential Solutions on the Road to Reform*, (Washington, DC: Medicaid Makeover, 2006), available at www.medicaidmakeover.org/MedicaidMakeoverPlan.pdf (accessed December 29, 2006); and Pamela Villarreal, "Federal Medicaid Funding Reform" (brief analysis 566, National Center for Policy Analysis, Dallas, TX, July 31, 2006, available at www.ncpa.org/pub/ba/ba566/ (accessed December 29, 2006).

19. Sonya Schwartz, Shelly Gehshan, Alan Weil, and Alice Lam, *Moving beyond the Tug of War: Improving Medicaid Fiscal Integrity* (Portland, ME: National Academy for State Health Policy, 2006), available at www.nashp.org/Files/Medicaid_Fiscal_Integrity.pdf (accessed December 29, 2006).

20. See Vic Miller and Andy Schneider, "The Medicaid Matching Formula"; and the references in note 18 of this *Health Policy Outlook*.

21. For examples, see Vic Miller and Andy Schneider, "The Medicaid Matching Formula," tables 6 and 8–14; GAO, *Medicaid: Strategies to Help States Address Increased Expenditures during Economic Downturns*, GAO-07-97, October 2006; and Donald B. Marron, "Medicaid Spending Growth and Options for Controlling Costs" (statement of the CBO acting director before the U.S. Senate Special Committee on Aging, Washington, DC, July 13, 2006).

22. Sonya Schwartz *et al.*, *Moving beyond the Tug of War*, 6.

23. See Andy Schneider, "Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33" (Center on Budget and Policy Priorities, Washington, DC, September 8, 1997), available at www.cbpp.org/908mcaid.htm (accessed December 29, 2006).

24. See Donald B. Marron, "Medicaid Spending Growth and Options for Controlling Costs," especially at table 4.

25. Congressional Budget Office, *The Long-Term Budget Outlook*, December 2005, scenario 1, calculated from data in supporting tables.

26. Medicaid Commission, *Final Report and Recommendations*, viii. The "scaled match" that the commission recommends be studied in recommendation C-3 would be a step in this direction.

27. See Douglas J. Besharov and Peter Germanis, "Welfare Reform and the Caseload Decline," in *Family and Child Well-Being after Welfare Reform*, ed. Douglas J. Besharov (New Brunswick, NJ: Transaction, 2003), 35–65, available at www.aei.org/book431/.

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Health Policy Outlook

# Medicinal Malpractice: Improving Drug Access and Reducing Corruption

## By Roger Bate and Kathryn Boateng

*Current global efforts to improve access to medicines in the developing world have hit a major roadblock. Too often, the medicines do not reach the impoverished sick because governments of many poor countries impose substantial tariffs, taxes, and customs duties on imported drugs. These fees make drugs more expensive and encourage corruption, making the delivery process from port to patient more difficult. While donations from governmental aid agencies can often neutralize the effects of such tariffs, private-donor organizations from these countries cannot. Some drug-donating groups are fed up with the abuse of their philanthropy and may no longer help countries extracting bribes, which could be fatal for the millions of people for whom affordable, lifesaving medicines remain out of reach. Governments should eliminate tariffs and other impediments to the importation of medicines.*

Nowhere in the world are the effects of poor health-care systems as visible and pervasive as in impoverished countries. Many patients no longer bother to seek care because qualified staff are frequently absent and doctors regularly run out of necessary drugs. Ironically, the much-needed drug shipments are often just miles away, sitting in ports while onerous customs clearance regulations are "worked out."

Currently, the World Health Organization (WHO) reports that two-thirds of the world's population—and 80 percent of Africans—do not have adequate access to drugs. Attention to this problem is, of course, nothing new, reappearing on the agendas of World Health Assemblies, G8 summits, and World Trade Organization meetings. In these forums, governments are repeatedly urged to "increase access to medicines, in accordance with the health needs of people, especially those who can least afford the costs."[1]

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At the turn of the century, low life expectancies and high disease rates—even for those illnesses that had supposedly been eradicated—impelled world leaders to identify underlying factors that could explain why, in an era of such unprecedented medicinal innovation and economic development, millions of people still go without adequate health care. Some spirited activists pointed to pharmaceutical companies, which did not always sell drugs to poorer countries at prices they could afford. Such charges soon sounded hollow as more and more pharmaceutical companies responded by tiering their prices (with the lowest prices in the poorest countries), and in some cases donating essential drugs. The international donor community was also accused of being far too "stingy." Since then, many nations—notably the United States—have drastically increased their aid budgets.

The solution to the medicine-access crisis in poor nations today goes far beyond browbeating pharmaceutical companies and a parsimonious donor community; domestic policy failures in recipient countries must also be addressed.

## Government Inaction in Africa

Many poor countries impose tariffs on medicines and medical devices. The Democratic Republic of Congo, Nigeria, and Zimbabwe, for instance, impose tariffs of about 8 percent on pharmaceutical products and active ingredients in pharmaceuticals. Other countries, such as India and Morocco, impose tariffs that are double that. Some countries even tax drugs and health-care products that are donated for free, and others have high taxes on all medical products without exception; cases in point are South Africa and Armenia, which maintain a 14 percent and 20 percent value-added tax (VAT), respectively. But how exactly do tariffs restrict access to medicines—aside from the obvious effect of price inflation? More importantly, at what point do tariffs become a public health hazard?

> Governments could increase access to medicines by lowering tariff rates.

There is plenty of evidence to show that reducing tariffs on medicine and other health-related products yields abundant rewards. An earlier study of the effects of tariffs, domestic taxes, and other regulatory restrictions on access to essential drugs, vaccines, and devices concluded that governments could increase access to medicines by lowering tariff rates, as any decrease in tariffs for a particular class of medical products is directly associated with increased access to that class of products.[2]

Other scholarly studies have also shown that countries with high tariff rates are often those with the lowest rates of access to available medicines. A study comparing the prices and availability of fifteen different essential medicines in Ethiopia, Kenya, Uganda, and Tanzania reinforced this assessment. In Ethiopia and Tanzania, where tariff rates are very high, there was little to no availability of the studied essential medicines.[3]

How extensive is the practice of imposing tariffs on medicines? In a 2005 study, two WHO economists, after reviewing available data on tariff rates and revenue generated by over 150 countries on different categories of pharmaceutical products, found that 59 percent of countries levy tariffs on active pharmaceutical ingredients, 61 percent levy tariffs on finished pharmaceutical products, and 35 percent levy import duties on vaccines. Furthermore, the authors argued that while tariffs may not fully explain why medicines are inaccessible in developing countries, there is still no legitimate reason to retain them. Ultimately, "tariffs on medicines target the sick, which cannot be good public policy."[4]

Many anecdotal examples of the problems associated with tariffs have surfaced recently. Mikkel Frandsen, chief executive officer of Vestergaard Frandsen, a company that produces and exports bed nets to prevent insect-borne diseases such as malaria, spoke at length about his experience at a recent meeting of the United Kingdom's All Party Parliamentary Group for Malaria. He affirmed that "tariffs do create problems, for example [in] Nigeria, where they change quickly and create delays."[5]

Local tariffs and taxes on medicines are precisely what limit the provision of essential medicines in many developing countries. Furthermore, they contribute to corruption, smuggling, and counterfeiting, and they reduce the supply of drugs available to those in need.

## Corruption, Smuggling, and Counterfeiting

For anyone who has tried to clear an item through customs in Africa, the seemingly endless paperwork and bureaucratic heavy-handedness is all too familiar. A *Customs Modernization Handbook* published by the World Bank lists eleven different steps necessary to clear customs. Throw into this burdensome mix poorly paid and occasionally unscrupulous customs agents, as well as a highly variegated tariff system in which no one seems to know the exact rates or bothers to look them up, and corruption is almost inevitable.

Our new research studies the link between tariffs and corruption.[6] It assembles over a hundred firsthand accounts from global health and pharmaceutical agencies and organizations working to provide essential medicines to developing countries (see table 1). We found that tariffs provide opportunities for irregular payments and delay product shipment. Also, frequently altered tariff rates create an opportunity for public officials to extract bribes. Local officials often have asymmetric knowledge about the correct fees, and are endowed with the authority to change them locally, giving the officials improper leverage. In some cases, they waive official fees in exchange for bribes.

Capricious intervention by customs officials makes criminals of importers by leaving them with little choice but to pay bribes to avoid delays, especially where goods with short shelf lives (for example, antibiotics that need refrigeration) are concerned. In about a third of the cases we surveyed, bribes were demanded

TABLE 1
**TARIFFS AND CORRUPTION: SUMMARY**

| Country | Number of cases/ tariffs paid | Unnecessary delay | | Nonofficial payment | | |
|---|---|---|---|---|---|---|
| | | Time[1] | Legal cost[2] | Admin. charge | Other charge | Bribe[3] |
| Uganda | 14/12 | 14 | 4 | 6 | 11 | 3 |
| Ethiopia | 11/9 | 11 | 2 | 4 | 11 | 3 |
| Nigeria | 21/18 | 17 | 4 | 13 | 18 | 7 |
| Kenya | 18/16 | 16 | 3 | 9 | 14 | 6 |
| Vietnam | 12/8 | 4 | 5 | 3 | 12 | 10 |
| China | 14/12 | 12 | 0 | 1 | 12 | 3 |
| India | 15/14 | 15 | 3 | 4 | 15 | 4 |
| **Total** | **105/89** | **89** | **21** | **40** | **93** | **36** |

NOTES: 1. Excess of at least twenty-four hours over what is considered good practice in these locations by exporters/importers. 2. Exporter/importer incurred significant excess legal cost. 3. A bribe was demanded. There is no consistent data on whether bribes were paid.
SOURCE: Roger Bate, Richard Tren, Lorraine Mooney, and Kathryn Boateng, "Tariffs, Corruption and Other Impediments to Medicinal Access in Developing Countries: Field Evidence," (working paper 130, AEI, Washington, DC, 2006), available at www.aei.org/publication24749/.

from drug exporters at ports; in particular, Vietnamese officials routinely demand bribes. Such corruption contributes to the instability of access to medicines. Unsurprisingly, most respondents stated that tariffs are a "serious threat" to medicinal access.

But this is not all. Just as high customs charges foster bribery, they also encourage the smuggling of drugs and the counterfeiting of medicines. Several respondents stated that they occasionally resorted to smuggling drugs hidden under vacation clothes in otherwise ordinary suitcases. By not declaring the goods, they avoid the often outrageously high tariff rates and demanded bribes.

Likewise, counterfeiting is encouraged by the existence of high tariffs. In Nigeria, counterfeit medicines, most of which originate from India, constitute between 40 and 50 percent of total supply. Both Nigeria and India have extremely high tariff rates, and while the link between counterfeit medicines and tariffs may not be immediately obvious to the casual observer, a closer look shows that developing countries "stimulate demand for cheaper fakes by artificially driving up the price of legitimate drugs through taxes and tariffs which further inflate the retail price of the drugs."[7] We believe that this link is not entirely coincidental.

## Declining Interest in Drug Donation

Our study also revealed that the pernicious effects of tariffs on medical goods are damaging future prospects for drug supply from international suppliers to poorer countries. Drug exporters to Ethiopia, where less than 20 percent of the population have access to medical care, complain repeatedly that customs fees are too high for drugs with a limited market in the country, forcing companies to consider the volume of potential sales before they incur such costs. To make matters worse, strict documentation requirements and the payment of "small" fees—supposedly for customs "support" services—are bound to make exporters increasingly wary. Consequently, imported drugs can sometimes languish for months in customs warehouses, awaiting required laboratory tests, even though local labs are rarely ever stocked with the reagents and other chemicals necessary to carry out the procedures.

A leading U.S.-based global health-care provider, the Catholic Medical Mission Board (CMMB), donates approximately $175 million of pharmaceuticals each year to over fifty countries in approximately 500 different shipments. CMMB crosses many borders and is familiar with customs operations around the world. Since all CMMB pharmaceutical shipments are humanitarian donations, one would think they would be exempt from all duties and customs clearance fees. But each time CMMB brings goods into a country, it is asked by customs officials to pay questionable "administrative handling fees" for documentation filings in proportion to the statistical value of each shipment. In Vietnam, some form of payment is regularly demanded of CMMB upon the entry of its donated medicines.

CMMB is not alone in its experience. Janssen-Cilag, a United Kingdom–based research and pharmaceutical company, also reports a similar experience in Burma, where it frequently pays a "premium in addition to the import duties and VATs imposed by the country,"[8] increasing the price of the drugs by an additional 15 to 20 percent.

Gilead Sciences, a biopharmaceutical company, had its global-outreach commitment tested in 2004 and 2005 when drugs shipped to Kenya, Uganda, and South Africa were held up at ports. In one case, a drug shipment meant for Médecins Sans Frontières (MSF, known in English as Doctors Without Borders) treatment programs in South Africa was repeatedly delayed. To make matters worse, MSF—which is only in the business of providing medical care—was ill-equipped to tackle the bureaucratic requirements of obtaining permits and securing prepayments for the release of the drugs, leading to even greater delays. After three years the situation was resolved, but only after the services of local distributors had been secured. To sum up their frustrations, some Gilead officials remarked that such hurdles are a significant deterrent to their ongoing commitment to the region.[9]

Just as high customs charges foster bribery, they also encourage the smuggling of drugs and the counterfeiting of medicines. Several importers resort to smuggling drugs hidden under vacation clothes in otherwise ordinary suitcases.

Certainly not all drug supply efforts have met with this frustrating opposition. Larger donors, such as the President's Emergency Plan for AIDS Relief and the U.S. Agency for International Development, have successfully demanded that tariffs and all forms of nonofficial payments be suspended for their donations. Other nongovernmental groups, however, have not been as successful. Unlike aid from European Union (EU) member countries, a significant amount of American foreign aid is disbursed by private organizations,[10] which means that they are not exempt from tariffs.

With bureaucratic hurdles and mounting costs, it would not be surprising if global health groups abandoned their efforts altogether. In the face of impending disaster, why do some governments keep their tariffs in place?

## Stark Realities

Today, many developing countries struggle with the most appropriate way to ensure that sufficient resources are available for the provision of basic amenities and services: law and order, national defense, clean drinking water, health care, and education. Historically, nations have been allowed to raise government revenue from a variety of sources, including tariffs on goods (subject to world trade rules). So it may seem paradoxical—perhaps even hypocritical—for rich countries to advocate loosening or removing tariff restrictions which would theoretically deprive poor countries of needed revenue. However, studies have shown that most countries receive very little revenue from medical tariffs. According to one survey, revenue from tariffs on medicines accounts for less than 1 percent of total government revenue in most countries, and in all but a handful of these countries, it is even less than 1 percent of the national health-care budget.

Many countries also shy away from eliminating tariffs because they protect domestic drug industries. This argument makes little economic sense. Granted, there are a few countries—Brazil, Kenya, and India—with thriving local drug industries. Most developing countries, however, lack the requisite pharmaceutical manufacturing capacity and are dependent on drug imports or the benevolence of philanthropic organizations for their supplies. Even so, protecting local industries from international competition does not necessarily guarantee that sustainable companies will emerge to meet consumer demand internationally and generate long-run income. For emerging economies, protecting local industry is usually perverse, especially if the overall effect is an unhealthy and dying population.

Governments in many developing countries believe that rich nations are devious and conniving when it comes to global trade. The Doha trade talks have repeatedly stalled, mostly because wealthy countries (particularly the United States and EU countries) refuse to end indefensible agriculture subsidies. In return, developing countries will not budge on anything else until the agriculture-subsidy issue is resolved, despite the attendant harm to their populations. While the West deserves criticism, leaders of poor nations must realize that they can hold no other entity but themselves accountable for their nations' tariffs on medicine. Tackling other trade inequities must not prevent them from addressing this responsibility.

The United States, Switzerland, and Singapore have proposed removing import tariffs on medicines. G8 leaders also advocated this course at their 2006 summit in St. Petersburg: "We encourage governments around the world to consider eliminating import tariffs and non-tariff barriers on medicines and medical devices, where appropriate, as a measure to reduce further the cost of health care for the poor and expand their access to effective treatments."[11] Developing countries must respond to this urgent call before it is too late.

## Examples to Emulate

The first action taken by developing countries that could be considered promising occurred in 2000, when several African countries promised to reduce taxes on bed nets. In January 2005, India markedly lowered both its import tariff and VAT rates, although rates are still high. Last summer, Kenya dropped its 10 percent import tariff on essential medicines and medical devices; regrettably, other port charges remain. More needs to be done if millions more are to have access to vaccines and HIV drugs.

Tariffs fund corrupt bureaucracies, keeping valuable medicines out of the hands of desperate patients. Furthermore, charitable pharmaceutical organizations may decline to assist stubborn countries that maintain barricaded fortifications against the importation of drugs. A global health policy in which pharmaceutical companies pick and choose the nations they help based on trade rules would be unfortunate, but it may be the direction of international health if the governments of poor nations continue to slap tariffs and taxes on medicines that can prevent death and disease among their citizens.

*AEI editorial assistant Evan Sparks worked with Mr. Bate and Ms. Boateng to edit and produce this* Health Policy Outlook.

## Notes

1. World Health Organization, Fifty-Fourth World Health Assembly, *World Medicines Strategy*, WHA 54/11, 2001, available at http://ftp.who.int/gb/pdf_files/WHA54/ea54r11.pdf (accessed December 6, 2006).

2. Roger Bate, Richard Tren, and Jasson Urbach, "Still Taxed to Death: An Analysis of Taxes and Tariffs on Medicines, Vaccines and Medical Devices" (related publication 05-04, AEI-Brookings Joint Center for Regulatory Studies, Washington, DC, 2006) available at www.aei-brookings.org/admin/authorpdfs/page.php?id=1136.

3. Kirsten Myhr, "Comparing Prices of Essential Drugs between Four Countries in East Africa and with International Prices," (conference presentation, Improving Access to Essential Medicines in East Africa, Nairobi, Kenya, June 15–16, 2000), available at www.accessmed-msf.org/upload/ReportsandPublications/3920012349208/East%20Africa.pdf (accessed December 6, 2006).

4. Müge Olcay and Richard Laing, "Pharmaceutical Tariffs: What Is Their Effect on Prices, Protection of Local Industry and Revenue Generation?" (paper prepared for the Commission on Intellectual Property Rights, Innovation and Public Health, World Health Organization, Geneva, 2005), available at www.who.int/intellectualproperty/studies/TariffsOnEssentialMedicines.pdf (accessed September 27, 2006).

5. Mikkel Frandsen, discussion of tariffs on medicines (transcript, All Party Parliamentary Group for Malaria, London, July 2005).

6. Roger Bate, Richard Tren, Lorraine Mooney, and Kathryn Boateng, "Tariffs, Corruption and Other Impediments to Medicinal Access in Developing Countries: Field Evidence," (working paper 130, AEI, Washington, DC, 2006), available at www.aei.org/publication24749/.

7. *Civil Society Report on Intellectual Property, Innovation and Health* (London, International Policy Network, 2006).

8. Roger Bate et al., "Tariffs, Corruption and Other Impediments to Medicinal Access in Developing Countries: Field Evidence."

9. Ibid.

10. See Karina Rollins, ed., *The Index of Global Philanthropy* (Washington, DC: Hudson Institute, 2006).

11. Group of Eight, Summit 2006, *Fight Against Infectious Diseases* (St. Petersburg, Russia, July 16, 2006), available at http://en.g8russia.ru/docs/10.html (accessed December 6, 2006).

**Keller, Karen E.**

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Records Not Subject to FOIA

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# EXECUTIVE OFFICE OF THE PRESIDENT
## Office of Management and Budget

From the Office Of

Human Resource Programs

# FAX TRANSMITTAL COVER SHEET

Number of pages (including cover sheet): 3

Date: 1/22

To: STAFF SECRETARY / Lois

Fax Number: ______ Voice Number: ______

Comments:
J.D. Foster's comments to WSJ OpEd
HD comments to follow

From: Maiselle -- 5-9132

Eisenhower Executive Office Building, Room 358
Voice (202) 395-5178 • Fax (202) 395-4639

# Withdrawal Marker
## The George W. Bush Library

| FORM | SUBJECT/TITLE | PAGES | DATE | RESTRICTION(S) |
|---|---|---|---|---|
| Draft | WSJ Health Tax Op-Ed | 2 | 01/22/2007 | P5; |

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**COLLECTION:**
**Staff Secretary, White House Office of the**

**SERIES:**
**Yanes, Raul - Chron Files**

**FOLDER TITLE:**
**747600, January 2007-December 2007, Folder 1 [1]**

**FRC ID:**
**6338**

**OA Num.:**
**8146**

**NARA Num.:**
**8093**

**FOIA IDs and Segments:**

2014-0073-F

2014-0072-F

**RESTRICTION CODES**

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| FORM | SUBJECT/TITLE | PAGES | DATE | RESTRICTION(S) |
|---|---|---|---|---|
| Letter | [Letter] [with attachment] - To: POTUS - From: B.M. Rankin, Jr. | 3 | 01/22/2007 | PRM; |

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DPC
Kcatz

# THE HEBREW IMMIGRANT AID SOCIETY

HIAS Washington DC • 2020 K St., NW, Suite 7700 • Washington, DC 20006
Tel. (202) 857-6616 • Fax. (202) 857-2770 • Web: www.hias.org

## FACSIMILE TRANSMITTAL SHEET

TO:
The Honorable George W. Bush

FROM:
Gideon Aronoff
President & CEO
HIAS

FAX:
202-456-0200

EMAIL: gideon.aronoff@hias.org

DATE:
February 2, 2007

# OF PAGES
WITH COVER: 2

NOTES:
Please see enclosed letter regarding your State of the Union Address.

HIAS

January 31, 2007

The Honorable George W. Bush
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear Mr. President:

I am writing on behalf of the Hebrew Immigrant Aid Society (HIAS), which has been the international migration agency of the American Jewish community for over 125 years.

I would like to express our great appreciation and enthusiasm for your State of the Union address, in which you asserted that "extending hope and opportunity in our country requires an immigration system worthy of America, with laws that are fair, and borders that are secure." We are particularly pleased by your urging Congress to engage "in a serious, civil and conclusive debate, so that (Congress) can pass, and (you) can sign, comprehensive immigration reform into law."

The philosophy of HIAS is consistent with the approach toward immigration which you articulated in the State of the Union and is in our national interest.

The Jewish tradition – like the American tradition – teaches that "the strangers who sojourn with you shall be to you as the natives among you, and you shall love them as yourself," for nearly all of us were once strangers – our Jewish ancestors in the land of Egypt; and ourselves, our parents and our grandparents in the United States.

HIAS appreciates your willingness to work with Congress in a bipartisan fashion to enact comprehensive immigration reform this Congress. Your leadership is critical to the success of this effort. We urge you to continue pushing for its passage.

We look forward to working with the Administration and the Congress to ensure the enactment of workable and fair legislation which is "worthy of America."

Sincerely,

Gideon Aronoff

Gideon Aronoff
President and CEO

NSC
Katz

בס"ד

# FAX

Agudath Israel of America
Washington Office
1730 Rhode Island Avenue, N.W.
Suite 504
Washington, D.C. 20036
(202) 835-0414 * fax (202) 835-0424
e-mail: acohen@agudathisrael-dc.org

TO: The President

FROM: Rabbi Abba Cohen

DATE: February 2, 2007

FAX: 202-456-0200

PAGES: 3, including cover

SUBJECT: UN Holocaust Denial Resoluton

---

MESSAGE:

בס"ד

WASHINGTON OFFICE • 1730 RHODE ISLAND AVENUE, N.W. • WASHINGTON DC 20036
202-835-0414 • Fax: 202-835-0424

Agudath Israel of America
אגודת ישראל באמריקה

Rabbi Abba Cohen
*Director and Counsel*

January 30, 2007

The President
The White House
Washington, D.C. 20500

***Re: U.N. Resolution on Holocaust Denial***

Dear Mr. President:

We write on behalf of Agudath Israel of America to congratulate you on your leadership in championing passage of the U.N. Resolution on Holocaust Denial. Agudath Israel, and the Orthodox Jewish community it represents, arose on these shores from the ashes of the Holocaust. Thus, even as our community continues to experience phenomenal renewal in this magnanimous country, we remain mindful of the forces of anti-Semitism at home and abroad. Tragically, as an N.G.O. that has observed events at the U.N. for many decades, our group's international affiliate, Agudath Israel World Organization, has been witness to some of the most heinous expressions of hatred of the Jewish people by members of the international community.

The United States has remained steadfast, and no less than courageous, in keeping the unspeakable tragedy that was the Holocaust embedded in the world's consciousness. The Justice Department's Office of Special Investigations and the State Department's Office of the Special Envoy for Holocaust Issues, and other offices, have done extraordinary work in bringing Nazi criminals to justice and bringing some degree of justice to the dwindling number of survivors. The U.S. Holocaust Memorial Museum was established to recognize and remember the extermination of European Jewry for all posterity. And it is particularly significant that a new Special Envoy for Monitoring and Combating Anti-Semitism has recently been appointed at the State Department, who has already broken important ground in this vital endeavor.

Indeed, it is only fitting that the Resolution on Holocaust Denial was introduced within this context, and at a time when we are seeing the resurgence of anti-Semitism in Europe and the shameful farce of the recent conference in Iran. Holocaust denial and the scourge of anti-Semitism are inextricably linked and this reality must never be allowed to become obscured. The phenomena of revisionism and denial of Nazi barbarism is not "historical"; it is not "scholarship"; and it is not "academic freedom." It is anti-Semitism, pure and simple. Countries must recognize that when they passed this Resolution on

NATIONAL OFFICE: 42 Broadway • New York, NY 10004 • 212-797-9000 • Fax: 646-254-1600

Holocaust Denial, they were in no uncertain terms condemning anti-Semitic hatred and expression themselves.

The point, then, must be driven home to the U.N., and its constituent members, that it is utterly incongruous to vote for this resolution while, at the same time, tolerating and even fostering an atmosphere that allows anti-Semitic poison to grow and thrive in their own countries and among their own citizens. And it is especially disgraceful that the "new" anti-Semitism -- manifest in the form of incessant and obsessive anti-Israel censure and scapegoating -- be actively articulated and condoned by these nations in the very halls of the U.N. itself.

This is the challenge of future generations and all people of conscience. To never allow another Holocaust, to never allow the Nazi horror to be denied or forgotten, and to never allow the cancer of anti-Semitism to fester and spread.

The United States is a nation that seeks to do right and to right wrongs. The Jewish people – indeed, the entire world – can never truly recover from a tragedy of such enormity. But our country can take meaningful steps that bring honor to those who perished and dignity to those who survived. This resolution is one such step, and it attests yet again to the moral clarity of your leadership and the enduring legacy your presidency will have on all nations for future generations.

Sincerely yours,

David Zwiebel

Rabbi David Zwiebel
Executive Vice President for
Government and Public Affairs

Rabbi Abba Cohen
Director and Counsel
Washington Office

RDZ, RAC / me

cc: The Honorable Condoleeza Rice
The Honorable Ban Ki-moon
The Honorable Alejandro D. Wolff
The Honorable Dan Gillerman

**FRANK R. WOLF**
10TH DISTRICT, VIRGINIA

COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEES:

CHAIRMAN—SCIENCE-STATE-JUSTICE-COMMERCE

TRANSPORTATION-TREASURY-HUD-JUDICIARY-DISTRICT OF COLUMBIA

CO-CHAIR—CONGRESSIONAL HUMAN RIGHTS CAUCUS

# Congress of the United States
## House of Representatives

241 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–4610
(202) 225–5136

13873 PARK CENTER ROAD
SUITE 130
HERNDON, VA 20171
(703) 709–5800
(800) 945–9653 (IN STATE)

110 NORTH CAMERON STREET
WINCHESTER, VA 22601
(540) 667–0990
(800) 850–3463 (IN STATE)

www.house.gov/wolf

February 7, 2007

The President
The White House
Washington DC 20500

Dear Mr. President:

As a follow-up to my letter of January 12, in which I suggested you consider the Iraq Study Group's recommendation to add a diplomatic component to the way forward in Iraq, I write today to urge you and your staff to watch the study group's co-chairs' – former Secretary of State James Baker and former Congressman Lee Hamilton – testimony last week before the Senate Foreign Relations Committee.

I had the opportunity over the weekend to watch the re-broadcast of their testimony on C-SPAN. What they said made so much sense, and it pains me that the administration has failed to follow the recommendations of the Iraq Study Group. It is my sincere belief that the bipartisan Iraq Study Group offered a way to unite our country and give us a better chance of success.

A large part of what your administration is doing fits into the study group's report, but the failure to move aggressively on the diplomatic front is troubling, particularly the failure to engage the Syrians. I won't repeat here the Baker-Hamilton arguments; hopefully your staff watched the hearings. As I noted in my earlier letter, President Ronald Reagan engaged the Soviets from a position of strength – and was successful. He had the confidence to do so, and there is no reason your administration should not have the same confidence.

I recently heard a radio news report which included an interview with a soldier and his 8-year-old son before the dad boarded an airlift for his third tour to Iraq. If we can ask our nation's military men and women to go to Iraq three times, should we not be prepared to pursue every diplomatic avenue available in our Iraq strategy, including talking with Syria?

Both Secretary Baker and Congressman Hamilton are honorable, patriotic Americans who want us to succeed in Iraq. If asked, I believe they would be willing to help engage Syria. Lives are involved so I think it is worth a try. It could work. God himself in communicating to mankind to bridge a relationship says in Isaiah 1:18: "Come now, and let us reason together," says the Lord. "Though your sins are as scarlet, they will be as white as snow; though they are red like crimson, they will be like wool."

I offer these observations with the utmost respect and sincerity. My prayers continue to be with you and with our nation.

Sincerely,

Frank R. Wolf
Member of Congress

Thank You

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| FORM | SUBJECT/TITLE | PAGES | DATE | RESTRICTION(S) |
|---|---|---|---|---|
| Email | FW: Vetting Results... - To: David R. Meyers - From: Daniel M. Aires | 3 | 02/08/2007 | P5; P6/b6; |

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February 12, 2007

Ms. Mary Tyler Moore
International Chairman
Juvenile Diabetes Research Foundation International
120 Wall Street
New York, New York 10005

Dear Ms. Moore:

Thank you for your letter requesting President George W. Bush and Mrs. Laura Bush to serve as Honorary Chairs of the Juvenile Diabetes Research Foundation's 2007 Children's Congress. The President and Mrs. Bush are pleased to accept your gracious invitation.

In order to include the President and Mrs. Bush's names on invitations, letterhead, and brochures, prior approval of language must be obtained. Requests for approval may be faxed to my attention at (202) 456-6604.

Please note the following guidelines: Neither the President or Mrs. Bush's name nor title may appear on invitations, letterhead, or brochures that request contributions for the organization. No commercials or advertisements may be created that in any way reference the President and Mrs. Bush's participation in the organization. The President and Mrs. Bush's participation with the organization must not be referenced in any way, either orally or in written materials, in connection with any competitive bidding process for Federal Government funds. If you have any questions concerning these restrictions, you may call the Office of Counsel to the President at (202) 456-7900.

Once again, thank you for inviting the President and Mrs. Bush to serve as Honorary Chairs. Please be aware that this acceptance is for the honorary chair position and does not imply a decision concerning attendance. If I can be of further assistance, please contact me at (202) 456-5127.

Sincerely,

Kelli Allred
Deputy Associate Director
Honorary Chairs and Awards

~~ARH/DH (Corres. #4732329)~~ (arh5.doc) ((>>))
cc w/incoming Raul Yanes, GFL/WW
cc w/incoming Misty Marshall, 2FL/EW
cc w/incoming Kelli Allred, 9th FL/1800 G Street, N.W.

120 Wall Street, 19th Floor
New York, NY 10005
t: (212) 785-9500 f: (212) 785-9595

JDRF Juvenile Diabetes Research Foundation International

*dedicated to finding a cure*

October 31, 2006

The Honorable George W. Bush and Mrs. Laura Bush
The White House
Washington, DC 20500

Dear President and Mrs. Bush:

As International Chairman of the Juvenile Diabetes Research Foundation (JDRF), I have had the privilege of joining hundreds of children with juvenile diabetes from all 50 states at the JDRF Children's Congress in 1999, 2001, 2003 and 2005. I was so pleased that you served as Honorary Chairs for the 2001, 2003 and 2005 events, helping make them tremendous successes.

I will also be chairing the 2007 Children's Congress, which will be held in Washington DC between June 17th and 20th. The Children's Congress will allow child delegates and their families to tell the nation what it is like to live with juvenile diabetes and why a cure is so desperately needed. I am writing to request that you once again demonstrate your support for curing juvenile diabetes by serving as Honorary Chairs for this important event.

As Honorary Chairs, we request permission to include your names on the Children's Congress letterhead and related items. This letterhead will not be used for soliciting sponsors.

As you may know, I have suffered with diabetes for almost forty years and have had to deal with some of its life-limiting complications. My goal is to ensure that a cure is found as soon as possible, so that all of the children who have juvenile diabetes today can look forward to a healthy tomorrow, free of all of the problems associated with this disease. Children's Congress helps make this goal a reality.

Hillary Berman, one of the Children's Congress event coordinators, will follow up with your office next week. In the interim, should you have any questions or require additional information, please feel free to have your office contact her at 301.460.8652. I look forward to working with you to make this event a tremendous success, and I hope that you will join me in supporting this cause.

Best regards,

Mary Tyler Moore

Mary Tyler Moore

February 12, 2007

Mrs. Evelyn H. Lauder
60 East 56th Street, 8th Floor
New York, New York 10022

Dear Evelyn:

Thank you for your letter requesting President George W. Bush and Mrs. Laura Bush to serve as Honorary Committee Members for the Spring Benefit. The President and Mrs. Bush are pleased to accept your gracious invitation.

In order to include the President and Mrs. Bush's names on invitations, letterhead, and brochures, prior approval of language must be obtained. Requests for approval may be faxed to my attention at (202) 456-6604.

Please note the following guidelines: Neither the President or Mrs. Bush's name nor title may appear on invitations, letterhead, or brochures that request contributions for the organization. No commercials or advertisements may be created that in any way reference the President or Mrs. Bush's participation in the organization. The President and Mrs. Bush's participation with the organization must not be referenced in any way, either orally or in written materials, in connection with any competitive bidding process for Federal Government funds. If you have any questions concerning these restrictions, you may call the Office of Counsel to the President at (202) 456-7900.

Once again, thank you for inviting the President and Mrs. Bush to serve as Honorary Committee Members. Please be aware that this acceptance is for the honorary committee member and does not imply a decision concerning attendance. If I can be of further assistance, please contact me at (202) 456-5127.

Sincerely,

Kelli Allred
Deputy Associate Director
Honorary Chairs and Awards

~~ARH/DH~~ ~~(Corres. #4733734)~~ (arh5.doc) ((>>))
cc w/incoming Raul Yanes, GFL/WW
cc w/~~incoming Misty Marshall, 2FL/EW~~
cc w/incoming Kelli Allred, 9th FL/1800 G Street, N.W.

The Breast Cancer Research Foundation

Founded in 1993 by Evelyn H. Lauder

November 14, 2006

President and Mrs. George Bush
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear President and Mrs. Bush,

Since our inception in 1993, The Breast Cancer Research Foundation has been making critical progress towards prevention and a cure for breast cancer in our lifetime. Thanks to the support and commitment of thousands of individuals, corporations and foundations, we are making a difference!

Please join us as an Honorary Committee Member for our **Spring Benefit** which will be held on **Tuesday, April 24, 2007**, at the Waldorf=Astoria in New York City. The evening will include cocktails at 7:00 pm, dinner at 7:45 pm and a concert at 9:00 pm. The 2006 Spring Gala raised over $4.4 million. We were fortunate to have Elizabeth Hurley as our Mistress of Ceremonies and our 1000 guests enjoyed a rousing performance by Sir Elton John and Tony Bennett. This year, we are delighted to say that Sir Elton John has secured Sheryl Crow to be the featured performer.

We hope that you will participate and lend your support as an Honorary Committee Member for these important events. Your name would lend tremendous weight to our efforts. We would be so pleased if you could join us for these events, but understanding your busy schedule, we recognize that you may be unable to attend. In any case, it would mean so much to us to have your name on our invitations and programs. ***Please let us know by January 19th if you would like to participate as a member of the Honorary Committee.***

The mission of The Breast Cancer Research Foundation is to achieve prevention and a cure for breast cancer in our lifetime by providing critical funding for innovative clinical and genetic research at leading medical centers worldwide, and increasing public awareness about breast health. We have earned top ratings from agencies that monitor charitable organizations and guarantee that a minimum of 85 percent of all funds raised by the Foundation, more than $150 million since 1993, will go directly to breast cancer research and awareness programs.

I am so grateful for your continued commitment to our cause. Should you have any questions, please do not hesitate to contact our Assistant Director of Special Events, Stephanie Hamburger, at (646) 497-2605 or email her at shamburg@bcrfcure.org.

Sincerely,

Evelyn H. Lauder
Founder and Chairman

60 EAST 56th STREET, 8th FLOOR, NEW YORK, NY 10022 TEL 646.497.2600 FAX 646.497.0890 www.bcrfcure.org