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THE WHITE HOUSE
WASHINGTON

February 22, 1989 *Betty*

MEMORANDUM FOR DICK DARMAN

FROM:

BILL ROPER *BR*

4515

Come see me!

with Dorman!!!

SUBJECT:

Proposal for Savings in ESRD Program

Last evening Governor Sununu asked me about a proposal for changing the Medicare End Stage Renal Disease Program, which he received from Gus Hampers.

I mentioned to the Governor that I was familiar with the proposal from my HCFA days, and then he called you about it.

Here is a copy of the details. Let me know how you want to proceed. The Governor wants me to follow up on it with him.

Attachment

THE CHIEF of STAFF
has seen

CONSTANTINE L. HAMPERS, M.D.

OAK HILL, BOX Z

DUBLIN, NEW HAMPSHIRE 03444

2/11/84

John:

As per your request her is
a copy of memo for 500 M savings
with secondary insurance proposal &
the details on rate reduction. The
difference in savings between 45 M (rate reduction
proposed) & insurance savings (500 M) -
makes this a "no brainer". -

Please let me know if you
need more info. & what OMB's going
to do

Ken
Jus

Withdrawal/Redaction Sheet

(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
01. Report	Executive Summary: End Stage Renal Disease (ESRD) Reimbursement and the FY1990 Budget Program Savings and Quality of Care (21 pp.)	n.d.	P5	

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Open on Expiration of PRA
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 By *Jf* (NLGB) on 5/12/05

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EXECUTIVE SUMMARY

END STAGE RENAL DISEASE (ESRD) REIMBURSEMENT AND THE FY 1990 BUDGET PROGRAM SAVINGS AND QUALITY OF CARE

Summary.

- * The DHHS Office of the Inspector General, in a 1987 report, proposed that Medicare could save \$500 million in the first year, and \$3 billion over five years, by making ESRD Secondary Payor rules consistent with those for other Medicare beneficiaries (see Appendix A).
- * This change would be neutral to beneficiaries in terms of both cost and access to care.
- * It would eliminate the budget pressures behind OMB's proposals to reduce dialysis reimbursement in two stages by \$45 million and \$85 million respectfully (see Appendix B). OMB is opposed by every significant group involved in ESRD policy, including DHHS, on the grounds that a reduction would harm patients by further eroding quality of care.

Narrative.

- * In 1988, OMB attempted to reduce dialysis reimbursements by forcing implementation of a rate cut ordered by HCFA in 1986 but overturned that year by OBRA-86. OMB was opposed by dialysis patients, professional organizations, providers, many members of the Senate and the House, and by DHHS Secretary Bowen and HCFA Administrator Roper, who reversed their 1986 position.
- * The opposition was based upon compelling evidence of increasing patient death rates, likely due to erosion in the quality of dialysis care in the wake of past rate reductions. All parties except OMB agreed that there should be no dialysis rate reduction pending completion of the ESRD program study being conducted by the Institute of Medicine pursuant to OBRA-87.
- * HCFA prevailed in the 1988 dispute with OMB, in that it was decided that any change in dialysis reimbursements would be deferred to the new administration.
- * OMB's Medicare Part B passback for the FY 1990 budget proposed two distinct reductions in dialysis reimbursements: February 1989 implementation of the 1986 rate cut rejected that year by Congress and opposed in 1988 by every element in the ESRD community and by DHHS (\$45 million); and a further \$85 million reduction in October 1989. HCFA has appealed these proposals.

EXECUTIVE SUMMARY - 2

Discussion.

- * Dialysis providers have been extremely cost-efficient over the years; they received \$138 per treatment in 1973; today's \$125 rate is equivalent to less than \$40 in 1973; through excellent management and technological innovation, they have effectively absorbed 15 years of inflation in operating costs.
- * Inflation has inexorably required reduction in the resource inputs to patient care; such reductions continue in response to annual cost inflation of 7%.
- * Death rates have risen since 1983, when reimbursements were first cut, testimony to the link between rates, provider resource constraints, and quality of care.
- * The U.S. contrasts sharply with Europe where no payment decrease has occurred and where patient mortality rates have declined in the same time period.

An Alternative Source of Savings.

- * In 1987, the OIG proposed Medicare savings of \$500 million in the first year, increasing to over \$700 million in the fifth year, by amending the ESRD Secondary Payor rule to conform to the rule for all other Medicare beneficiaries; Medicare is secondary indefinitely to employer group health plans for most beneficiaries; it now becomes primary after only one year for ESRD beneficiaries.
- * This reform, which would require legislative action, would not increase beneficiaries' costs, reduce their access to care, or affect the quality of care; it would have no adverse effects on providers.
- * In 1988, DHHS supported the OIG proposal only partially, due to political concern that it might be perceived as reducing benefits. HCFA Administrator Roper would now support it fully.

Action Required.

- * The Administration should sponsor legislation to make ESRD Secondary Payor rules consistent with those for other Medicare beneficiaries.
- * The Administration should reject OMB's dialysis rate reduction proposals.

Appendix A

REVISION OF MEDICARE SECONDARY PAYER PROVISIONS FOR END STAGE RENAL DISEASE BENEFICIARIES

SIGNIFICANT PROGRAM SAVINGS ARE POSSIBLE

At present, the ESRD program is unique within Medicare in that Employer Group Health Plans (EGHPs) become secondary payers to Medicare after the first 12 months of Medicare eligibility. For all other beneficiaries, EGHPs remain the primary insurer as long as the beneficiary retains EGHP coverage. In the attached December, 1987 audit report (CIN: A-10-86-62016), the DHHS Office of the Inspector General (OIG) proposed a statutory change to make the ESRD secondary payer provision consistent with the general Medicare provision, and estimated that the proposal would yield program savings of \$500M in the first year, and \$3,000M over five years.

Implementation of the OIG's proposed Secondary Payer reform would eliminate the need for dialysis rate reductions proposed by OMB. A rate reduction would pose serious danger to patients by causing erosion in the quality of dialysis care, and would be extremely controversial.

OIG's savings estimates are based upon Medicare program projections provided by the HCFA Office of the Actuary, and additional data on EGHP coverage from the Department of Labor and the Health Insurance Association of America. They do not factor in the increase in Medicare's primary payer obligation under Catastrophic Health Insurance, and are in that regard too low.

The proposal would have no negative effects on beneficiaries, and some positive effects on the system of care:

- * beneficiary costs would remain constant;
- * beneficiary access to care would be unchanged, and could be protected by existing laws prohibiting EGHP discrimination against ESRD patients;
- * the adverse effects of further rate reductions on quality of care would be avoided; and
- * EGHPs would have new incentives to help improve the cost-efficiency of ESRD patient care.

Amending the Medicare Secondary Payer Provision
for ESRD Beneficiaries Could Save
the Medicare Program
\$3 Billion Over the Next 5 Years



OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT

CIN: A-10-86-62016



Memorandum

DEC 1 1987

Date

From

Richard P. Kusserow
Inspector General*Bryan Mitchell*

Subject

OIG Final Audit Report - Amending the Medicare Secondary Payer
Provision for ESRD Beneficiaries Could Save the Medicare
Program \$3 Billion Over the Next 5 Years - CIN: A-10-86-62016

To

William L. Roper, M.D.
Administrator
Health Care Financing Administration

This report summarizes the results of our review of the Medicare Secondary Payer (MSP) provision for End Stage Renal Disease (ESRD) beneficiaries. Currently, if an ESRD beneficiary has Employer Group Health Plan (EGHP) coverage, that plan is the primary payer for the first 12 months of Medicare eligibility. After the 12-month period, Medicare becomes the primary payer. The MSP provision for ESRD beneficiaries is the only MSP provision under Medicare that is limited to a specified period of time. An estimated 56 percent of all ESRD beneficiaries have EGHP coverage.

We are recommending that a legislative change be proposed by HCFA to make the MSP provision for ESRD beneficiaries consistent with legislation passed by Congress for working aged and disabled beneficiaries. We found no rationale in the prior legislation for limiting the MSP provision for ESRD beneficiaries to 12 months, other than to meet a limited cost savings goal. If the 12-month limitation is repealed, many impacted beneficiaries will have years of benefits available under their EGHP's before exhausting their coverage and the Medicare program would benefit through substantial savings--an estimated \$3 billion over the budget cycle.

BACKGROUND

In the 1980's Congress amended Section 1862(b) of the Social Security Act several times to require that private insurance companies pay before Medicare in certain cases where health benefits are available. Congress took these actions because substantial savings would accrue to Medicare without materially affecting the coverage of services or costs to the beneficiaries.

The Omnibus Budget Reconciliation Act (OBRA) of 1981 changed the status of Medicare from primary to secondary payer for beneficiaries with ESRD. The provision, effective October 1, 1981, designated EGHP's as primary payers during the first 12

months of Medicare eligibility. This was the first of several amendments to the Social Security Act making Medicare the secondary payer to EGHP's and is the only amendment where the MSP provision is limited to a specific period of time.

Since 1981, Congress has amended the MSP provisions four times. The effect of these amendments was to make Medicare the secondary payer for working aged and disabled beneficiaries when they have EGHP coverage. None of these amendments restrict the period of time that Medicare would be secondary. The MSP provision for ESRD beneficiaries is the only exception.

SCOPE OF REVIEW

Our review was made in accordance with generally accepted government auditing standards. However, we did not evaluate internal controls during our audit because they were not pertinent to our limited scope work. The objectives of the review were to:

- ascertain the rationale for limiting the MSP provision for ESRD beneficiaries to only 12 months of eligibility,
- determine how many years of EGHP coverage would be available if the provision was changed, and
- estimate how much could be saved if the provision was extended to the period of time that ESRD beneficiaries have EGHP coverage available.

To ascertain the rationale for the 12-month period, we researched the Congressional Record and held discussions with personnel from the Senate Committee on Finance, the Health Care Financing Administration (HCFA), and the Assistant Secretary for Planning and Evaluation (ASPE).

To determine how many years of EGHP coverage would be available, we used data from a study prepared by the Health Insurance Association of America (HIAA) on maximum lifetime coverage and statistics obtained from HCFA on annual medical costs.

The savings estimate was based on nationwide statistics on (i) enrollment projections of Medicare beneficiaries who had completed their first year of eligibility, (ii) percentage

of enrollees with EGHP coverage, and (iii) annual medical costs. (See Appendix II for an explanation of the methods used for determining our savings estimate.)

We also held discussions with and reviewed reports prepared by officials of HCFA's Office of the Actuary, the Department of Labor, and the Department of Commerce.

RESULTS OF REVIEW

Rationale for Limiting the MSP Provision to 12 Months

Neither the legislative history nor committee hearings could provide an explanation as to why the MSP provision for ESRD beneficiaries was limited to their first 12 months of eligibility. Therefore, we contacted staff working for the Senate Committee on Finance who were involved in health care issues. In response to our inquiry, we were advised that the period may have been established to meet a specific cost savings goal. However, the staff were not certain as to why the limitation was enacted.

Discussions were also held with staff in HCFA and ASPE with similar results. Neither HCFA nor ASPE officials we contacted could explain why the 12-month period was established. Staff proposals to extend or eliminate the 12-month limitation have been discussed within both HCFA and ASPE. Particularly, services relating to facility-dialysis and transplantation are now under consideration as part of the Fiscal Year 1989 Legislation program.

Available EGHP Coverage

A prior OIG review, discussed in Appendix II, estimated that EGHP's provide coverage to about 56 percent of Medicare ESRD beneficiaries. Using 56 percent, we estimated that 14,336 beneficiaries in 1988 would have EGHP coverage after their first year of eligibility and would be impacted by our proposal. Many of these ESRD beneficiaries would have years of benefits available before their EGHP coverage would be exhausted if the 12-month period was extended. A study obtained from HIAA on the maximum health benefits available to employees with EGHP coverage concluded that 96 percent of the employees had coverage of \$250,000 or more, and that 79 percent had coverage of \$1 million or more.

HCFA program statistics show that annual medical costs per ESRD beneficiary would be about \$38,000 in 1988. Based on this information, individuals with \$250,000 of coverage would have about 7 years of benefits available before their EGHP coverage would be exhausted while individuals with \$1 million of coverage would have about 26 years. Should beneficiaries exhaust their benefits, Medicare becomes the primary payer.

An indefinite secondary payer provision might encourage insurers or employers to consider dropping expensive services needed by ESRD patients, such as facility-dialysis and transplantation. However, current legislation already includes safeguards to preclude discrimination against ESRD beneficiaries in the work place.

Section 162(i)(1) of the Internal Revenue Code provides that:

"Coverage relating to end stage renal disease. The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section if the plan differentiates in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner."

Other safeguards could be penalty provisions such as those recently implemented for the disabled. Under Section 9319 of the Omnibus Budget Reconciliation Act of 1986, Medicare became the secondary payer for disabled beneficiaries who are receiving Social Security benefits and elect to be covered by EGHP's. Among other things, it provides that the Federal Government or beneficiaries may recover double damages from group health plans that fail to make primary payments as required by law. In addition, a tax is imposed on employers and employee organizations that contribute to plans that do not conform to the disabled provision. The tax would equal 25 percent of the employer's or employee organization's annual contributions to nonconforming group health plans.

Estimated Savings by Amending the MSP Provision

We estimated that the maximum savings available to Medicare would be about \$500 million in Fiscal Year 1988 and about \$3

billion over the budget cycle, if the MSP provision for ESRD beneficiaries was extended to the period of time that ESRD beneficiaries have EGHP coverage available. Appendix I provides the basis for these savings estimates.

Recommendations

1. We recommend that HCFA propose legislation to remove the 12-month limitation and extend the MSP provision to the period of time that ESRD beneficiaries have Employer Group Health Plan insurance available.
2. We also recommend that HCFA propose legislation for ESRD beneficiaries similar to that imposed by Section 9319 of the Omnibus Budget Reconciliation Act of 1986 for disabled beneficiaries. That is, we recommend a legislative provision that would permit the Federal Government or beneficiaries to recover double damages from group health plans that fail to make primary payments as required by law and impose a tax on employers and employee organizations that equal 25 percent of annual contributions to nonconforming group health plans.

HCFA Comments and OIG Response

On June 17, 1987, we provided HCFA with a Priority Audit Memorandum on the preliminary results of this review. In response, HCFA did not concur to propose legislation to remove the 12-month limitation and extend the MSP provision to the period of time that ESRD beneficiaries have Employer Group Health Plan insurance available. HCFA favors making Medicare indefinitely secondary for all Medicare services other than facility-dialysis and transplantation services, the most costly ESRD services (See Appendix III for the full text of HCFA's comments). HCFA's comments were that:

- o An indefinite secondary payer provision might encourage insurers to drop uneconomical services such as facility-dialysis and transplantation. And, the only way to protect beneficiaries under such a proposal would be to explicitly mandate that EGHP's provide coverage for facility-dialysis and transplantation services, a requirement that is highly regulatory, unprecedented and difficult to administer.

We share HCFA's concern. However, HCFA comments disregard a safeguard to preclude discrimination against ESRD beneficiaries already provided by the

Internal Revenue Code. According to the code, employers with EGHP's could not limit services, such as facility-dialysis and transplantation, for ESRD beneficiaries without violating the code and losing their tax deduction. In our opinion, prudent employers would not purchase non-deductible EGHP's for their employees. In addition, we are recommending new legislation in conjunction with our first recommendation that would provide for recovery of double damages from group health plans that fail to make primary payments and impose a tax on employer's and employee organizations that contribute to nonconforming group health plans.

- o The HIAA's study mentioned in the report does not appear to have relevance for ESRD beneficiaries.

The HIAA study provides statistics on lifetime benefits for all employees, which include ESRD beneficiaries. Thus, we consider the study relevant and appropriate for use in this report.

- o Our statement in the report that many individuals would have many years of benefits before their EGHP coverage would be exhausted, according to HCFA, begs the question of how plans would modify coverage in response to the recommended policy.

OIG disagrees. Employers that modified EGHP coverage for ESRD beneficiaries would lose as a tax deduction expenses paid or incurred for the EGHP. In addition, as previously stated, we are proposing legislation that would permit double recovery by the Federal Government or beneficiaries from EGHP's that fail to make primary payments and impose a tax on employer's and employee organizations that contribute to nonconforming group health plans.

- - - - -

We would appreciate receiving a status report within the next 60 days of any action taken or planned on our recommendation. Copies of this report are being provided to other Departmental officials.

Attachments

APPENDIXES

Appendix I

ESTIMATE OF MAXIMUM POTENTIAL SAVINGS
IF THE MEDICARE SECONDARY PAYER PROVISION
FOR ESRD BENEFICIARIES WAS EXTENDED

	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>1992</u>
Total Enrollment(a)	35,000	36,000	37,000	38,000	39,000
Less:					
First Year Enrollment	<u>(9,400)</u>	<u>(9,700)</u>	<u>(9,900)</u>	<u>(10,200)</u>	<u>(10,500)</u>
Enrollment (After First Year)	25,600	26,300	27,100	27,800	28,500
X % with EGHPs	<u>.56</u>	<u>.56</u>	<u>.56</u>	<u>.56</u>	<u>.56</u>
Enrollees with EGHP Coverage	<u>14,336</u>	<u>14,728</u>	<u>15,176</u>	<u>15,568</u>	<u>15,960</u>
Cost per Enrollee(b) (Medicare Primary)	\$37,940	\$40,259	\$42,638	\$45,242	\$48,007
Less:					
Copayment(b) (Medicare Secondary)	<u>(2,856)</u>	<u>(2,979)</u>	<u>(3,102)</u>	<u>(3,233)</u>	<u>(3,377)</u>
Net Savings (per Enrollee)	<u>\$35,084</u>	<u>\$37,280</u>	<u>\$39,536</u>	<u>\$42,009</u>	<u>\$44,630</u>
Total Savings (\$ Millions)	<u>\$503</u>	<u>\$549</u>	<u>\$600</u>	<u>\$654</u>	<u>\$712</u>

Total Savings Over the 5-Year Budget Cycle

\$3.018 Billion

Notes

(a) Total enrollment is the number of beneficiaries qualifying for Medicare under the ESRD Only program.

(b) Cost per enrollee and the copayment include both Medicare Part A (HI) and Part B (SMI) costs.

METHODOLOGY USED TO PROJECT THE 5-YEAR SAVINGS

To estimate the savings available, we worked with three primary factors:

- the number of ESRD enrollees beyond the first year of eligibility,
- the percentage of enrollees with EGHP coverage, and
- the annual medical costs per enrollee.

These factors and our 5-year savings estimate are discussed in the following paragraphs.

Enrollment

Information was not readily available on ESRD enrollment beyond the first year of eligibility. However, we were able to estimate the number of enrollees beyond the first year by computing an average first year enrollment and subtracting it from total enrollment projections.

Average first year enrollment was computed from statistics on new patient enrollment, patient survival rates, and enrollment growth. HCFA's Bureau of Data Management and Strategy collected and published statistics on midyear enrollment and new enrollments by month. The Bureau reported that there were 9,000 new ESRD enrollees added to the program in 1985.

The Medicare Annual Report for Fiscal Year 1983, which was the latest available at the time of our review, provided statistics on first year ESRD enrollee survival rates. From that report, we calculated that 85 percent of new ESRD enrollees under age 65 would survive their first year and that 7,650 ($9,000 \times .85$) of the new enrollees for 1985 would survive their first year. The average first year enrollment included in the total enrollment was 8,325 $[(9,000 + 7,650) / 2]$.

Total enrollment projections were obtained from the Office of Actuary. The enrollment projections, which went through 1989, were based on the Actuary's Midsession Review of Budget Assumptions. The Actuary projected that the ESRD enrollment would be about 35,000 in 1988 and increase to about 36,000 by 1989. Based on the 1989 growth rate of 3 percent, we projected that enrollment would increase to about 39,000 by 1992. (See Appendix I.)

We then projected first year enrollment for each year based on total enrollment growth since 1985. For example, since total enrollment is projected to grow from 31,000 in 1985 to 35,000 in 1988, average first year enrollment will grow to about 9,400 in 1988 $[(35,000/31,000) \times 8,325 = 9,400]$. Since savings estimates are based on enrollment beyond the first year, the enrollment subject to potential savings is 25,600 $(35,000 - 9,400)$ in 1988. Similar calculations were made for each year. (See Appendix I.)

Percentage of Enrollees with EGHP Coverage

We estimated that EGHPs provide coverage to about 56 percent of the ESRD beneficiaries. Our estimate was based on a nationwide review that was performed by the HHS Office of Inspector General titled "Medicare as a Secondary Payment Source--End-Stage Renal Disease", Control #OAI-07-86-00092.

The results of that review showed that 282 of the randomly selected 498 beneficiaries (56 percent) had EGHP coverage. The statistical sample used in the review was taken from 36 facilities in 9 randomly selected States. Using 56 percent, we estimated that 14,336 beneficiaries $(25,600 \times .56)$ in 1988 would have EGHP coverage after their first year of eligibility. Similar calculations were made for each year. (See Appendix I.)

Annual Medical Costs Per Enrollee

HCFA's Office of Actuary provided us with data to estimate annual Medicare costs per enrollee. The Actuary's midsession review, discussed earlier, included per capita costs for ESRD beneficiaries through 1989. The Actuary advised us to use the 1989 projected growth rates to project per capita costs through 1992. These per capita costs were average costs for all enrollees, including the costs when Medicare was the secondary payer during the first year of eligibility. Therefore, we had to calculate the per capita costs for the balance of the enrollment (after the first year) when Medicare is the primary payer. Based on these calculations, we estimated that annual Medicare costs per ESRD enrollee when Medicare is the primary payer would be about \$37,940 in 1988 and increase to about \$48,007 by 1992. (See Appendix I.)

Savings Estimate

The maximum savings achievable is the difference between what Medicare would pay as the primary payer and what Medicare would pay as the secondary payer for beneficiaries who are beyond the first year of eligibility.

Since ESRD enrollees incur substantial medical expenses annually, enrollees' expenses are often limited to the maximum copayment provided in their EGHP. Medicare, as a secondary payer, would generally pay the enrollees' copayment.

To estimate what Medicare would pay as a secondary payer, we used data obtained in a Department of Labor (DOL) report titled "Employee Benefits in Medium and Large Firms, 1985", dated July 1986. The DOL report provided statistics on enrollee copayments under their EGHPs. The report showed that about 77 percent of the enrollees have an annual limit. From the statistics provided and our estimate of ESRD annual medical expenses, we calculated an annual copayment per enrollee. The copayment, what Medicare would pay as a secondary payer, starts at \$2,856 per enrollee in 1988. Subtracting the copayment from the cost per enrollee, the net savings per enrollee would be \$35,084 (\$37,940 - \$2,856) in 1988. (See Appendix I.)

The savings achievable was then calculated by taking the savings for each enrollee times the number of enrollees with EGHP coverage beyond the first year. For example, savings achievable in Fiscal Year 1988 would be \$503 million (\$35,084 savings per enrollee x 14,336 enrollees = \$503 million). (See Appendix I.)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Appendix III
Health Care
Financing Administration

Memorandum

Date SEP 2 1987

From William L. Roper, M.D.
Administrator

Subject OIG Priority Audit Memorandum - Amending the Medicare Secondary Payer Provision for ESRD Beneficiaries Could Save the Medicare Program \$3 Billion Over the Next 5 Years (CIN: A-10-86-62016)

To The Inspector General
Office of the Secretary

We have reviewed the memorandum which recommends that we propose legislation that would extend the Medicare Secondary Payer (MSP) provisions indefinitely for ESRD beneficiaries covered by Employer Group Health Plans (EGHP). Currently, the secondary payer requirement for ESRD only applies to the first 12 months after entitlement. The secondary payer requirement for all other beneficiaries is not time-limited.

HCFA is concerned that an indefinite secondary payer provision might encourage insurers to drop uneconomical services, such as facility-dialysis and transplantation. If this occurred, Medicare would again be the primary payer for Medicare eligible individuals, while those not eligible would have no coverage.

The only way to protect beneficiaries under such a proposal would be to explicitly mandate that EGHPs provide coverage for facility-dialysis and transplantation services, a requirement that would be highly regulatory, unprecedented, and difficult to administer.

Consequently, HCFA would favor making Medicare indefinitely secondary for all Medicare sources other than facility-dialysis and transplantation services, as the best way to spread the cost burden more equitably without endangering beneficiary access to care. This position has been endorsed by the Secretary's Budget Review Group for inclusion in the FY 1989 budget.

We furthermore take issue with the Health Insurance Association of America's study mentioned in the report. The study does not appear to have relevance for ESRD beneficiaries. Also, the statement that "most individuals would have many years of benefits before their EGHP coverage would be exhausted" begs the question of how plans would modify coverage in response to the recommended policy.

Finally, the savings estimates provided by the OIG may be somewhat high. We would appreciate the opportunity to review the methodology used to generate the estimate.

Thank you for the opportunity to comment on this priority audit memorandum.

Appendix B

THE ESRD PROGRAM PROVISIONS OF THE FY 1990 OMB PASSBACK FOR MEDICARE SUPPLEMENTAL MEDICAL INSURANCE

Summary.

OMB's FY 1990 Passback for Medicare's Supplemental Medical Insurance Program contains two ESRD program proposals (discussed in detail below) which, if adopted, would be harmful to the Program and its beneficiaries. These proposals would:

1. endanger patients by reducing facility revenues well below the level required to provide adequate care;
2. destabilize the established network of facilities for the delivery of dialysis services, by threatening the economic viability of the entire independent facility sector; and
3. destroy the incentives for efficiency and cost reduction which are at the heart of the composite rate reimbursement system for dialysis.

It has been reported that HCFA will appeal both OMB proposals. This is consistent with the position taken by the agency and by key members of both houses of Congress during ESRD reimbursement discussions in 1988, and is necessary to preserve the integrity of the ESRD program and the wellbeing of dialysis patients. HCFA's position in opposition to OMB is the only possible responsible action, and is supported by all elements in the ESRD community. OMB should accede to HCFA's position.

Background.

From the beginning of Medicare's End Stage Renal Disease (ESRD) program in 1973, reimbursement for facility dialysis was limited by a "screen" of \$138 per treatment. By the early 1980's, virtually every independent facility was being reimbursed at the maximum, and a large proportion of hospital facilities were receiving considerably more as a result of rate exceptions.

In 1983, HCFA implemented the present composite rate reimbursement system for dialysis. This new reimbursement system combined incentives to promote home dialysis and elimination of most rate exceptions with a significant reimbursement reduction: independent facilities received \$127 per treatment and hospital facilities received \$131. These rates were in large part a product of HCFA's audit procedures, which relied on data which were 4-5 years out of date, and which eliminated approximately 17% of the real expenditures of independent facilities.

In 1986, HCFA proposed another reduction of the same magnitude. Once again, the cost data used were 4 years old, and more than 17% of independent facility costs were eliminated. This time, however, HCFA also adjusted its statistical procedures in order to manipulate the data to support a reduction. In response to public comments, HCFA modified its proposal somewhat, and finally implemented a reduction of \$6 per treatment for independent facilities and \$4 per treatment for hospitals.

In OBRA-86, Congress overturned HCFA's 1986 rate reduction and substituted a nominal \$2 per treatment reduction, leaving dialysis reimbursements at \$125 for independent facilities and \$129 for hospitals. Congress also prohibited any further cuts for a two year period, and required a study of the effects of rate reductions on the quality and accessibility of dialysis care. This study, performed by the Urban Institute and completed in December, 1987, has never been released. In OBRA-87, Congress demanded a second, more thorough study, to be carried out by the Institute of Medicine (IOM), with a completion date of December 31, 1990.

As the two year prohibition on reductions in the dialysis reimbursement rate legislated in OBRA-86 approached its October 1, 1988 expiration, a general consensus concerning ESRD reimbursement emerged among concerned members of Congress, high ranking HCFA officials, dialysis patients, ESRD providers, and involved professional organizations. Elements of that consensus, supported to a greater or lesser degree by all of these actors, included:

1. Agreement that experience since implementation of the composite rate reimbursement system in 1983 pointed to possible **serious adverse impacts of reimbursement reductions on quality of care**, as measured (for example) by patient mortality rates;
2. Agreement that the **IOM study of the ESRD program mandated by OBRA-87**, and scheduled for completion in December 1990, is the best available vehicle for resolving questions about the effects of reimbursement changes on quality of patient care, and providing guidance for future dialysis reimbursement policy; and
3. Agreement that the **results of the IOM study should be an element in any consideration of ESRD program reimbursement reductions or restructuring** - including implementation of the reimbursement rates promulgated by HCFA in 1986 and superseded by Congress in OBRA-86.

The only significant actor not subscribing to this consensus was OMB, which pressured HCFA to implement its 1986 rate reduction through the second half of 1988. HCFA resisted this pressure, with support from patients, many members of Congress, dialysis professionals and providers, and it was finally agreed

that no change in the dialysis reimbursement rate would be considered until after the Presidential transition.

OMB's Proposals.

OMB's FY 1990 ESRD program passback proposals ignore or contradict all three elements of the consensus described above, and violate the promises made to the ESRD community. OMB has proposed:

1. February 1, 1989 implementation of HCFA's previously reversed 1986 reimbursement rate, effectively reducing independent facility reimbursements by \$4; and
2. A restructuring of the composite rate methodology to save an additional \$85 million in FY 1990, by using independent and hospital facility costs to calculate a separate rate for each of the two groups of facilities.

We shall discuss these proposals in turn.

February 1, 1989 implementation of HCFA's 1986 rate.

This proposal totally ignores the 1988 policy discussion, and resulting consensus, about dialysis quality of care and its relationship to reimbursements. It preempts the findings of both the OBRA-86 and OBRA-87 studies. It flies in the face of strong Congressional sentiment. It dismisses the clear and compelling testimony of providers and patients that dialysis quality of care cannot be maintained if rates are further reduced. The simple fact is that every party to the dialysis reimbursement discussion except OMB is convinced that this proposal will put dialysis patients as a group at significant excess risk of death.

It is well established that dialysis patient mortality has increased steadily since 1983 - by about 1% of the patient population per year, and is now approaching an annual 25% rate. These increases are not fully understood, but diminished quality of care is the most plausible and best supported explanation.

Dialysis facility adaptations to reimbursement reductions and simultaneous cost increases have been of a kind which could result in quality deficits, and which certainly have destroyed the margin of safety in the effort to maintain dialysis care quality. Staff ratios have been reduced; licensed staff have been replaced by less well trained unlicensed caregivers; dialysis times have been shortened to increase productivity.

Unlike virtually every other group of providers, dialysis facilities have experienced reimbursement reductions over the past 15 years. Today's \$125 per treatment independent facility rate is equivalent to less than \$40 when discounted by inflation in the CPI-Medical since 1973. Dialysis providers have been burdened by the same cost increases as other providers.

In the last three years, health provider input prices have increased about 7% per year. But OMB wants to implement a rate reduction based upon data from 1982, and a methodology which eliminated 17% of independent provider costs in that year. OMB says it wants to use current cost data, but insists upon a reduction using data which are now 6 years old. Payments which take no account of increasing costs necessarily lead to reduced resource inputs and therefore to reduced quality of care.

Finally, it should be noted that there is no FY 1990 budgetary reason, and no FY 1989 reason either, for implementing this rate change effective February 1, 1988. OMB is advocating an unnecessarily accelerated process which would result in a rate change under cover of the Presidential transition and while Congress is out of session and unable to express its opinion.

Restructuring the composite rate methodology.

OMB proposes to save \$85 million in FY 1990 and in each successive year by separating the costs of independent facilities and hospital facilities when calculating the composite rate for each of the two groups. In support of this proposal, OMB refers to an OIG study which purportedly finds that independent facilities now receive \$30 per treatment more than their costs, while hospital facilities receive \$2 less than their costs.

The empirical base for OMB's proposal is an OIG Report, based upon dialysis facility audits for 1985, which has not yet been published and which was probably only reviewed by OMB in initial draft. A detailed discussion or critique is impossible, because the Report is not available to the public for review. But there are facts about HCFA cost audits in general, and the 1985 audits in particular, which impugn OMB's analysis.

In addition to the now standard 17-18% independent facility cost eliminations, the 1985 audits were characterized by extraordinary eliminations from the cost reports of National Medical Care, the largest independent provider. Those extraordinary eliminations, which stemmed from HCFA's misapplication of audit rules relating to costs associated with changes in NMC's ownership and structure, have already been reversed in part, and may be further reversed. OMB's claim of a \$30 spread between independent facility costs and revenues is an artifact of audit methodology, not a reflection of financial reality.

But even on its own terms, OMB's \$85 Million proposal is empirically indefensible. OMB claims a \$30 per treatment spread between revenues and costs, and therefore presumably found independent facility costs to be \$95 per treatment in 1985 (present reimbursement is roughly \$125). Assuming the typical 18% independent facility cost eliminations due to audit methodology, and 7% annual provider input price increases for each of the last three years, we can calculate 1988 facility costs.

Thus, accepting for the sake of argument the accuracy of OIG's work, and ignoring the extraordinary NMC cost eliminations, we get:

- | | | |
|----|---|----------|
| 1. | 1985 Independent Facility Audited Cost
(per OIG Report, pending) | \$ 95.00 |
| 2. | 1985 Actual Cost (adding back 18%
elimination of real costs) | \$112.10 |
| 3. | 1988 Cost (at 7% input price inflation
per year for 3 years) | \$137.32 |

In order to provide a dialysis treatment with the same level of resource inputs as a typical 1985 treatment, an independent dialysis facility would require \$137.32 per treatment in 1988 - \$12 per treatment more than it was paid! Adjustment for the extraordinary NMC audit eliminations would increase this figure.

This analysis is conservative. There is no reason to expect that dialysis facilities are immune to the input price increases which are clearly documented for every class of provider. The nursing shortage, quality assurance and regulatory compliance, and infection control in response to the AIDS epidemic have caused dialysis facilities extraordinary cost increases in the last two years. The example provides no cushion for new equipment technology, other advances in patient care, or increased staff training requirements. It is inescapable that **providers are of necessity reducing the per treatment resource input** - and that is the cause of the present serious concern about quality of care. OMB seems prepared to gamble with patients lives.

Conclusion.

OMB is pursuing reimbursement changes which have been rejected by every other participant in the ESRD policy discussion, and which would seriously endanger patients while threatening the stability of the dialysis services delivery system. The changes should be firmly and finally rejected.

The ESRD program needs reimbursement stability, and it needs a modest reimbursement adjustment to allow providers to hold resource inputs constant in the face of continued cost increases. ESRD patients and providers have evidenced their willingness to work with HCFA to identify sources of program savings which can help deal with budgetary requirements without endangering patients. Inadequate and destructive proposals such as those from OMB simply divert energy from productive policy channels.

THE WHITE HOUSE
WASHINGTON

March 6, 1989

MEMORANDUM FOR THE PRESIDENT

FROM: ROGER B. PORTER *RBP*
SUBJECT: Status Report on Education Initiatives

This responds to your inquiry about the status of our education initiatives which reflect the four principles of excellence, helping those in need, choice, and accountability.

The Department of Education submitted to OMB on Friday, March 3, a draft Omnibus Education Act covering the six legislative initiatives announced by you on February 9:

- o Merit Schools
- o Magnet Schools
- o Alternative Certification of Teachers
- o President's Award for Excellence in Education
- o National Science Scholars
- o Endowment Funds for Historically Black Colleges and Universities

Our other two initiatives do not require legislation. The request for increased funding for experimentation and innovation in schools will be part of an OMB formal budgetary amendment. The accountability study is to be undertaken by the Secretary of Education.

The omnibus legislation is scheduled to be cleared by March 17. We are in the process of determining congressional sponsors in a Working Group I have established to push our education initiatives.

In addition to the proposed legislation, we are moving forward on an executive order to initiate the Bush Administration program of support for Historically Black Colleges and Universities. This executive order is scheduled to come to you for review by March 9.

We are now planning a series of events for an education week later this month. The plan includes, among other events, transmitting the omnibus legislative package and signing the HBCU executive order.

EDUCATION: KEY PRINCIPLES

1. EXCELLENCE:

Excellence and **success** in education should be recognized and rewarded.

2. NEED:

Federal funding should be **targeted** to those who **need it most**.

3. CHOICE:

Choice and flexibility -- for educators, parents and students -- are important to educational reform and to achieving excellence.

4. ACCOUNTABILITY:

Greater **accountability** is needed in the education system to assure that students are actually receiving the highest quality education. Success should be rewarded; programs which do not work should be changed.

BUSH ADMINISTRATION
EDUCATION INITIATIVES

- o Merit Schools: This initiative provides recognition of schools whose students make significant educational progress over time. Special emphasis will be placed on schools enrolling substantial numbers of disadvantaged students who show significant educational progress. For FY 90, \$250 million is requested, with growth projected to \$500 million in FY 93.
- o Teachers' Awards: The President's Award for Excellence in Education (\$5,000 cash) will be presented to top teachers in every state. For FY 90, \$8 million is requested.
- o National Science Scholars: Outstanding high school students in mathematics and science -- each selected by a Congressman, Senator, or the President -- will receive up to \$10,000 annually for four years in scholarship awards. For FY 90, \$5 million is requested, rising to \$20 million in FY 93.
- o Magnet Schools: An annual fund of \$100 million in new appropriations is requested to assist in the creation and development of magnet schools which offer students and parents enriched educational choices.
- o Alternative Certification for Teachers and Principals: This initiative will assist those states interested in developing or enhancing programs to bring individuals with excellent subject area knowledge into the classroom, and proven managers into school management. For FY 90, \$25 million is requested.
- o Experiments for Educational Achievement: The pursuit of excellence requires experimentation, innovation, and better data; support will be provided to the best innovators with the best ideas. For FY 90, \$13 million is requested.
- o Historically Black Colleges and Universities: A special fund of \$60 million -- over four years -- will be developed to build, through matching grants, the endowments of Historically Black Colleges and Universities.
- o Accountability in Education Programs: The Secretary of Education will review Federal education programs and implement improvements in accountability systems. The Federal government should be a model in assuring that its programs are successful.

Relationship of Initiatives to Principles

	<u>Excellence</u>	<u>Target To Need</u>	<u>Choice</u>	<u>Accountability</u>
1. Merit Schools	Rewards progress toward excellence	Dollars weighted to schools with high proportions of disadvantaged .	---	Encourages setting measurable goals and meeting them.
2. Teachers Awards	Rewards excellence	---	---	Encourages higher standards for teachers.
3. National Science Scholars	Rewards excellence	---	---	Indirectly encourages schools to monitor their science/math programs.
4. Magnet Schools	Magnet schools are generally superior & encourage district-wide improvements	Some special consideration is given to low-income students.	Magnet schools serve broad geographic areas, and thus promote choice .	Competition for students encourages accountability and results.
5. Alternative Certification	Broadens recruitment pool of teachers, thus upgrading quality		Provides administrators greater choice in personnel selection.	---
6. Experiments	Supports innovation which leads to excellence	---	Experiments in choice are eligible for support	---
7. Accountability Study	Promotes excellence by emphasizing quality outcomes.	Most Federal dollars for education are targeted to needy.	---	The Federal government should set the example for accountability in education.
8. HBCUs	Strengthens HBCUs to enhance quality	HBCUs are in particular need .	Strong HBCUs broaden educational choice for Blacks.	---

THE WHITE HOUSE

WASHINGTON

March 30, 1989

MEMORANDUM FOR GOVERNOR SUNUNU
BRENT SCOWCROFT

FROM: ROGER B. PORTER *RBP*

SUBJECT: Meeting with Japan's Deputy Foreign Minister

I met today with Michihiko Kunihiro, Japan's Deputy Minister for Foreign Affairs (Economics). Minister Kunihiro, whom I have known for many years, is also the Prime Minister's personal representative to the Economic Summit. He said that the Prime Minister had asked him to make the following points:

1. We must not lose sight of the underlying importance of the US-Japan bilateral relationship.

The minister observed that our bilateral agenda is becoming too dominated by individual sectoral issues. This maximizes friction and minimizes the possibilities for solution. We need to keep in mind our broad common interests and the need for close cooperation. In that regard, Japan is using its foreign aid resources to support the Brady debt initiative and to help particular countries important to the United States.

2. The US should be cautious in using its new Super 301 authority to open foreign markets.

The US would undercut support for the Uruguay Round if it initiated Sec. 301 actions against many countries. In Japan, Sec. 301 action would jeopardize progress already being made on structural adjustment, such as on tax reform and opening the distribution system.

3. Other Summit countries will be looking for policy leadership from the US Sherpas at the upcoming April 7-9 Sherpa meeting.

Other countries will be particularly interested in the US Sherpas' appraisal of prospects for agreement with the Congress on a budget package that significantly reduces the deficit.

4. Managed trade is not the answer.

In the minister's view, the semiconductor agreement is a bad precedent since it focuses attention on a market-share figure that masks real progress. He emphasized that managed trade is

not a useful basis for reducing bilateral trade imbalances. He specifically noted Japanese opposition to the recommendations on managed trade in the report by the Advisory Committee on Trade Negotiations.

I told Minister Kunihiro that, in my opinion, it will be extremely important at the Paris Economic Summit for the Heads of State to provide a strong reaffirmation of support for an open world trading system. Without this support, there is a real risk that the benefits the post-war system has brought to all countries will be lost.

cc: Secretary Baker
Secretary Brady
Secretary Mosbacher
Ambassador Hills

THE WHITE HOUSE

WASHINGTON

April 5, 1989

THE CHIEF of STAFF
has seen

MEMORANDUM FOR GOVERNOR SUNUNU

FROM: ROGER B. PORTER *RBP*
SUBJECT: AIDS-related Discrimination

Today the AP wire carried a story with the lead, "President Bush is prepared to propose a bill to ban housing and job discrimination against people infected with the AIDS virus if a current survey of state laws shows federal legislation is needed."

The story reported on a response given at a Congressional hearing by James Allen, acting director of the National AIDS Program Office in the Public Health Service at the Department of Health and Human Services.

Background

When the President's AIDS Commission issued its report last June, then-Vice President Bush issued a statement that included the following:

"I am particularly pleased that the Commission recognizes the need for patient notification and wide-spread testing as a means to limit the spread of AIDS. Such programs will be ineffective without being coupled with strict confidentiality and anti-discrimination provisions."

Also, in a paper on health care released by the campaign, the position taken with respect to AIDS was "George Bush believes we must ensure against discrimination, particularly in our schools and the workplace."

Yesterday's Testimony

Rep. Henry Waxman chairs the House Energy and Commerce's Health and the Environment subcommittee, the subcommittee most interested in AIDS.

Yesterday he quoted several statements from speeches the President made during the campaign about the need for compassion towards individuals with AIDS.

Then he asked: "What are you doing about confidentiality and discrimination?"

Allen replied that HHS has a contract with the Intergovernmental Health Policy Project to assemble information about such laws in each state. He said that HHS is planning to look at the results of this study.

Waxman then asked whether HHS would then be prepared to propose confidentiality and discrimination legislation.

Allen replied that based on the results of this study, they would, if it is appropriate.

HHS staff say that Allen took this position on his own; during the briefing sessions he was reminded that the Justice Department has the lead on the discrimination issue.

Future Action

Attorney General Thornburgh is about to sign a memorandum announcing the creation of a Working Group on Health Policy of the Domestic Policy Council, which Bill Roper will chair. Issues surrounding AIDS will be among the first topics the working group will consider.

File -

~~cc David Bates~~

THE CHIEF of STAFF
has seen

April 5, 1989

MEMORANDUM TO: DAVID BATES
ASSISTANT TO THE PRESIDENT AND CABINET
SECRETARY

FROM: CONNIE HORNER
HHS



This morning you asked about Dr. James Allen's testimony on AIDS yesterday before Congressman Henry Waxman. The AP reported that Dr. Allen had said he believed President Bush would support Federal anti-discrimination legislation if a state survey indicated states were not solving problems of discrimination.

In fact, in a Q&A Dr. Allen testified that:

. a state survey was being done by HHS, and

*_____ pursuant to
Law*

. President Bush had made a statement in support of anti-discrimination during his campaign.

Dr. Allen drew no connection between these two assertions and did not commit the President to any legislation.

THE WHITE HOUSE

WASHINGTON

May 1, 1989

THE CHIEF of STAFF
has seen

MEMORANDUM FOR GOVERNOR SUNUNU

FROM: ROGER B. PORTER *ABP*

SUBJECT: Aldicarb on Potatoes and Bananas

Aldicarb is an insecticide applied to about 40 percent of the U.S. Potato crop and about 3 percent of the bananas imported into this country from Central America. It is recognized that large doses of Aldicarb have the potential to cause flu-like symptoms. There is no concern about cancer or other long-term health risks. Although EPA has no information showing anyone has ever become sick from eating potatoes or bananas treated with Aldicarb, a draft staff report -- using experimental methodology -- raised the theoretical possibility that a small number of children could experience flu-like symptoms which would quickly disappear. This draft document was leaked to the press before scientific peer review, which caused aldicarb hysteria, as well as anger with some legislators on the Hill.

In response to concerns raised by those in Congress, EPA's Acting Deputy Administrator, John Moore, circulated a letter (attached) last Friday which "unequivocally state(s) that the public should not be alarmed about possible risks from Aldicarb residues in the diet." Moore goes on to explain that in the case of Aldicarb, the agency employed a new and "innovative" approach to figure the theoretical risk calculations. The draft document which resulted from this experiment, says Moore, was prematurely leaked to the NYT and resulted in an "unfortunate and mistaken impression among the public." EPA's potential new method of calculating risks is scheduled to be reviewed by an independent group of scientists on May 9th. Depending on the outcome of this review, states Moore, a need may be identified for changes in Aldicarb use -- "not because our current foods are suddenly unsafe to eat, but to be sure that our regulatory practice continues to provide an ample margin of safety, i.e., to judiciously improve upon an already safe food supply."

In his letter, Moore apologizes for the Aldicarb "leak", and promises to emphasize to EPA staff that such action "can interfere with our goal of protecting public health and the environment and may be grounds for discipline."

The Assistant Administrator-designate for Pesticides and Toxic Substances plans to review EPA's present methods of implementing the laws regulating pesticides and to work to find ways to more efficiently and judicially enforce any legal provisions.

THE WHITE HOUSE

WASHINGTON

May 2, 1989

THE CHIEF of STAFF
has seen

MEMORANDUM FOR GOVERNOR SUNUNU

FROM: ROGER B. PORTER *RBP*

SUBJECT: Assessing the Economy

As we often observe, economists are accustomed to speaking "on the one hand, on the other hand" language. Our Associate Director for Domestic Economic Policy, Larry Lindsey, is no different as is evidenced by the attached memorandum assessing our current economic situation.

His conclusion is a happy one: we are seeing a cooling in the consumer sector and a rise in the investment and export sectors. Let's hope he is right.

Attachment

cc: Larry Lindsey

THE WHITE HOUSE

WASHINGTON

May 1, 1989

MEMORANDUM FOR ROGER PORTER

FROM: LARRY LINDSEY *L*
SUBJECT: Economic Situation

Today's Wall Street Journal ran the following side-by-side headlines on page 2:

"Principal Gauge of Economy Declines 0.7%"

"Economy Picked Up Steam Last Month"

Is the economy going up? Is it going down? Is it going sideways? Or is it going up and down at the same time?

With apologies to the laws of physics, "up and down at the same time" seems the best answer. Some sectors of the economy are doing quite well while others are doing less well.

A quick scan of the Leading Indicators (the index that declined 0.7 percent) shows that some 80 percent of the decline was in just two areas -- orders for consumer goods and building permits. These are highly interest sensitive sectors which are feeling the pinch from higher interest rates.

On the other hand, plant and equipment spending was actually a positive factor in the leading indicators. The National Association of Purchasing Managers reported the economy picking up steam. They report that it was new export orders which caused the rise.

These data suggest a cooling in the consumer sector and a rise in the investment and export sectors. Declining consumer spending was also indicated by the March personal consumption data which showed an increase of only 0.2 percent. Personal income rose 0.8 percent, thus pushing the personal saving rate to 6.3 percent, the highest since the recession. The export sector has risen 34.6 percent in real terms from the end of 1986 through the end of 1988, compared to only 8 percent for the whole economy. This trend should continue.

This substitution of investment and export goods for consumer goods is essential for sustained growth. Often such transitions of economic leadership from one sector to another are not successfully made without an economic downturn. The data so far suggests that we are making this transition fairly smoothly.

THE WHITE HOUSE

WASHINGTON

May 4, 1989

MEMORANDUM FOR GOVERNOR SUNUNU

FROM: ROGER B. PORTER *RBP*

SUBJECT: Major Presidential Initiatives

An updated version of the Major Presidential Initiatives document is attached.

Attachment

May 4, 1989

MAJOR PRESIDENTIAL INITIATIVES

1. Comprehensive Budget Plan

February 9, 1989

Budget Agreement between Administration and Congress reached on April 14.

- o Realistic plan for FY90 Budget.
- o Meets GRH targets through FY 1993.

Based on that agreement, the House Budget Committee approved a Budget Resolution with a FY90 deficit of \$99.7 billion on April 27. The Senate Budget Committee completed action on a similar resolution a week earlier.

Both House and Senate began debate on these resolutions on May 3.

2. Financial Institutions Reform, Recovery, and Enforcement Act of 1989

February 22, 1989

333-page bill transmitted to Congress. Extensive testimony by Administration officials.

- o Assures financial integrity of deposit insurance by raising annual premium rate for both commercial banks and S&Ls.
- o Resolves status of existing insolvent banks in orderly fashion by creating Resolution Trust Corporation.

Legislation similar to the President's proposal passed the Senate on April 20.

The House Banking Committee approved legislation which now must go to the House Judiciary and Ways and Means Committees.

- o Improves supervisory control; S&Ls brought up to the same standards applied to commercial banks.
- o Separates FSLIC from Federal Home Loan Bank Board and attaches it administratively to the FDIC. Creates one strong independent insurer.
- o Enhances enforcement of bank fraud provisions.

3. Minimum Wage

March 3, 1989

House and Senate conferees agreed on a minimum wage bill on Tuesday, May 2. That bill will raise the minimum to \$4.55 with a 60 day training wage.

- o Increases minimum wage over three years to \$4.25.
- o Implements a minimum training wage at \$3.35 rate for all workers on the job for up to six months.
- o Increases tip credit from 40 percent to 50 percent.
- o Raises small business exemption from \$362,500 to \$500,000 and extends to all small business.

4. Working Family Child Care
Assistance Act of 1989

March 15, 1989

- o Provides a new child tax credit of up to \$1000 per child under 4 for low and moderate income working families.
- o Makes the existing Dependent Child Tax Credit refundable.

Legislation transmitted to Congress. Presidential meeting held with key congressional sponsors. The alternative proposal, the ABC Bill, was marked up in the Senate Labor and Human Resources Committee on March 15. It includes a Head Start increase of \$250 million.

The Senate Democratic leadership has indicated floor consideration will follow the budget resolution in late May.

5. Head Start

March 15, 1989

- o Increases authorization by \$250 million for FY90.
- o Pays for up to 95,000 more children in Head Start.

Legislation transmitted to the Congress. Presidential meeting held with key congressional sponsors. Authorization passed the House on a voice vote on March 21. Senate provision included in ABC (see discussion above).

6. Capital Gains Proposal

March 14, 1989

- o Establishes a 45 percent capital gains exclusion for qualified capital gains and a maximum 15 percent capital gains tax rate.
- o Eliminates capital gains tax completely for families with incomes under \$20,000.

Treasury testimony on Administration proposal before Senate Finance Committee.

- o Gradually increases holding period to qualify for favorable capital gains tax treatment from one year to three years.

7. Excellence in Education

April 5, 1989

- o Omnibus bill with seven key elements:
 - Presidential Merit Schools
 - Magnet Schools of Excellence
 - Alternative Certification of Teachers and Principals
 - President's Awards for Excellence in Education
 - National Science Scholars Program
 - Drug-Free Schools: Urban Emergency Grants
 - Endowment Initiatives for Historically Black Colleges and Universities (HBCUs)

Omnibus education legislation incorporating administration education proposals transmitted to the Congress, April 5. Senate bill, S.695, has 36 cosponsors. House bill, HR1675, has 84 cosponsors. Senate hearings begin on June 13. No House activity scheduled.

8. Vocational Education Reauthorization

April 7, 1989

- o Focuses on the four Bush education principles.
- o Emphasizes acquisition of basic skills.

Administration bill transmitted by Secretary Cavazos to Congress on April 10. House floor vote potentially scheduled for May 9.

- o Increases flexibility for the states to address vocational education needs of special populations, accompanied by strengthened accountability measures.
- o Enhances choice in vocational education.

9. Medicaid Act Amendments

April 18, 1989

Administration bill transmitted by Secretary Sullivan on April 18. Presidential statement issued. Introduced May 3 by Senator Dole with four cosponsors in the Senate and by Representative Michel with five cosponsors in the Senate.

- o Expands population of low income women and children which states must cover.
- o Focuses on facilitating immunization of children.
- o Finances expansions through lowering federal match rates for administration services.

10. Ethics Reform Legislation

April 7, 1989

Ethics Commission Report completed and transmitted to the President. Meeting with Ethics Commission members on March 14. Legislation transmitted to Congress on April 12.

- o Extends to all federal employees prohibition against taking actions that affect their financial interests.
- o Allows waivers from conflict of interest statute.
- o Bans on honoraria for all federal employees; caps on earned income.
- o Extends one-year post employment cooling-off period to judicial and legislative branches.

11. Enterprise Zones Legislation

March 22, 1989

Secretary Kemp testified before House Ways and Means Committee on March 22. HUD, Treasury, OMB, and White House meeting to refine Administration proposal.

- o Provides tax and regulatory incentives for encouraging work, investment, and entrepreneurship in depressed areas.

12. Clean Air Act Amendments

Late-May/Early-June, 1989

Administration officials (EPA, Energy, OMB, White House) have undertaken extensive consultations with Senate and House Republicans and Democrats during Domestic Policy Council process of developing comprehensive administration legislation.

- o Reduces acid rain through controls on sulfur dioxide and oxides of nitrogen emissions.
- o Addresses areas of the country not meeting the health standards for ozone and carbon monoxide.
- o Improves the cumbersome and ineffective regulatory program for addressing hazardous air pollutants.

Roger Porter has chaired 15 policy meetings to develop clean air proposals. The DPC has scheduled six meetings to shape policy recommendations for the President.

13. Youth Entering Service

Mid-April, 1989

Office of National Service is developing legislative proposal.

- o Calls for private funds to match federal dollars for promotional, informational, organizational and administrative expenses the pilot phase.
- o YES provides an umbrella organization to encourage volunteer organizations and schools.

Withdrawal/Redaction Sheet

(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
03. Memo	From Roger Porter to POTUS Re: Global Poverty Reduction Act (2 pp.)	5/17/89	P-5	

Collection:

Record Group: Bush Presidential Records
Office: Chief of Staff to the President, Office of the
Series: Sununu, John, Files
Subseries: White House Offices File
WHORM Cat.:
File Location: Policy Development (1989) [3]

Open on Expiration of PRA
(Document Follows)
By gf (NLGB) on 12/12/07

Date Closed: 12/1/2004	OA/ID Number: 29181-001
FOIA/SYS Case #: 1998-0004-F[1]	Appeal Case #:
Re-review Case #: 2005-0426-S	Appeal Disposition:
P-2/P-5 Review Case #:	Disposition Date:
AR Case #:	MR Case #:
AR Disposition:	MR Disposition:
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Presidential Records Act - [44 U.S.C. 2204(a)]

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

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(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

Information

THE WHITE HOUSE

WASHINGTON

1989 MAY 18 AM 9:40

May 17, 1989

MEMORANDUM FOR THE PRESIDENT

FROM: ROGER B. PORTER *RBP*
SUBJECT: Global Poverty Reduction Act

This responds to your request for my comments on the Global Poverty Reduction Act which President Carter wrote to you about. In short, while the goals of the legislation are admirable, its approach is inconsistent with our current policy which emphasizes market-based development as the most efficient means to alleviate poverty.

Background

The Carter Administration approach to foreign aid aimed at providing for basic human needs such as nutrition, health, and shelter. By contrast, the Reagan Administration approach emphasized overall economic growth. Since Congress earmarks most of our foreign assistance funds, the current aid program is a hybrid of the two approaches.

You have not formally considered the direction you wish our aid programs to take. AID Administrator Alan Woods wrote to the Congress on May 1 criticizing the Global Poverty Reduction Act on the grounds that an attack on the symptoms of poverty will not make the structural changes necessary to cure poverty. The Woods letter notes that the most progress in reducing poverty is being made in developing countries with the highest rates of economic growth.

Details of the Legislation

The Global Poverty Reduction Act begins with a long "findings" section outlining the poverty-related goals various international organizations have set and the seriousness of the problem.

The legislation calls for the President to develop a plan to ensure that United States development assistance contributes to eradicating the worst aspects of absolute poverty. The plan is to include specific measurable goals and target dates for reaching them. The goals are to include the three goals outlined in the Carter letter: (1) reduce infant mortality to 70 per 1,000 live births; (2) increase female literacy rates to 80 percent; and (3) reduce each country's population in absolute poverty to less than 20 percent of the total.

The proposed legislation requires the President in preparing the plan to consider the ecological sustainability of growth, to submit annual reports on the status of the report's goals, and to host a conference of the heads of government of donor and recipient countries to conclude an international agreement on eliminating the worst aspects of absolute poverty.

Outlook and Next Steps

The Global Poverty Reduction Act was introduced by Senator Boschwitz in the Senate where it has 32 cosponsors (22 Democrats and 10 Republicans) and by Representative Mel Levine in the House where it has 195 cosponsors (147 Democrats and 48 Republicans).

The House Foreign Affairs Committee and the Senate Foreign Relations Committees are considering revisions to the foreign aid statutes. While there is growing appreciation in the Congress of the importance of broad-scale economic growth, it is likely that the Global Poverty Reduction Act approach of direct assistance targeted on basic human needs will be reflected in the congressional effort to structure our assistance programs.

The Administration will be reviewing its Third World development strategy as part of an upcoming NSC assessment of the international affairs budget.

★
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JIMMY CARTER

April 15, 1989

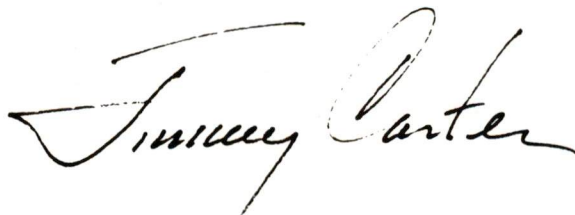
To President George Bush

As you may know, we at The Carter Center are involved in some humanitarian programs in the Third World. It would make a great impact in other countries if our government could make clear its commitment to some specific goals. I write to encourage your support of the Global Poverty Reduction Act (HR 594 and S 369). The three goals of this legislation are to:

- Reduce the rate of infant mortality under 5 years to 70 per 1,000 live births
- Increase female literacy rates to 80%
- Reduce the number of people living below the absolute poverty level to 20%

The United States cannot afford to remain idle in a world where more than 40,000 people (many of them children) die each day of hunger related illnesses. I hope that you will take this opportunity to make our country an example to the rest of the developed world by crafting a foreign policy targeted at eliminating the worst aspects of absolute poverty by the year 2000.

Sincerely,



The Honorable George Bush
President of The United States
Washington, D.C. 20500

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON DC 20523

THE ADMINISTRATOR

May 1, 1989

IDENTICAL LETTER SENT TO MEL LEVINE

The Honorable John Miller
House of Representatives
Washington, D.C. 20515

Dear Congressman Miller:

During the House Foreign Affairs Committee hearing on the FY 1990 foreign assistance request, you asked that I provide you with my views on H.R. 594, the Global Poverty Reduction Act.

Let me begin by saying that I believe we share a sense of frustration about how little progress has been made in some of the developing countries. I know that you are as appalled as I am by the degree and extent of poverty that exists in these nations.

As regards the sentiment expressed in the title of the bill you have introduced, namely, that poverty in the developing countries must be reduced, I am in full agreement. That having been said, I hasten to add, however, that I do believe programs which address the symptoms of poverty necessarily result in poverty reduction.

As my recent report, Development and the National Interest: U.S. Economic Assistance into the 21st Century, points out, only those developing countries that have adopted sound economic policies and allowed private enterprise to respond to market signals are making real inroads on poverty. Along with rising incomes, we are seeing significant improvements in measures of human welfare in these countries. Human welfare measures are improving in other countries too, partly as a result of scientific and technical breakthroughs -- but their progress is nowhere near as dramatic, nor as sustainable, as that which is occurring in countries where economic growth is proceeding apace. Where there is economic stagnation, income levels are eroding and government programs that focus on human welfare are contracting. In these countries, we anticipate that prior gains on human welfare measures may vanish as well.

When an earlier version of the Global Poverty Reduction Act failed to acknowledge the fundamental link between economic growth and improvements in human welfare, I reacted strongly in a letter to Congress. That version of your bill, by precluding work aimed at encouraging economic growth, would have taken A.I.D. out of the poverty reduction business.

Problems remain with the current version of the bill, but it also has good features. Through the sentiment expressed in its title, it puts the spotlight on the persistence of poverty in the developing countries -- and on the need to do something about that fundamental problem. In this regard, the bill is helpful -- as are the many editorials spawned in its wake.

Secondly, the bill suggests using performance measures, instead of resource allocations, to assess the foreign assistance program. This recommendation is offered explicitly in the House Foreign Affairs Committee Task Force Report on Foreign Assistance. It is a concept with which I agree. I also agree with the HFAC Task Force recommendation to place the responsibility for defining performance measures in the Executive Branch, where there is greater familiarity with the problems of measuring progress in a developing country context.

In that regard, I would note that some of the specific measures of poverty reduction cited in the bill, as well as its targets, are less than helpful. Only one of the three performance measures offered focuses directly on the reduction of poverty. The others focus on the severity of narrow symptoms of poverty. Given a prominent place in the law, these measures -- while not being without value -- could take on too prominent a role, shifting resources and talent away from other humanitarian programs and dampening efforts to focus our energy on the central problem of reducing the number of people who remain poor. In addition, by specifying global, rather than country-by-country targets, and by setting a rapid timetable for their achievement, the bill as currently written is unrealistic -- an exercise in programmed failure whose targets would not be met.

Despite the problems we have with the current draft of the Global Poverty Reduction Act, I believe that we are trying to reach the same broad goal -- the reduction of poverty in the developing countries. That fact is more important by far than any small differences we may have about how to write legislation that keeps the foreign assistance program trained on this fundamental objective.

I believe, as you do, in the poverty reduction goal you have identified. I look forward to working with you in crafting a new foreign assistance act that fully integrates our shared concern about poverty reduction, human welfare and economic growth.

Sincerely,


Alan Woods

TALKING POINTS

1. I believe we share a common objective -- bringing people out of poverty in the developing countries.
2. Your bill points to the fact that levels of poverty remain high in these countries -- and that is helpful. It is the same point I made in my report, Development and the National Interest.
3. As I look at the developing countries, I see several things:
 - o The only countries that are making significant and sustained gains on poverty -- in family income and human welfare terms -- are those in which economic growth is occurring.
 - o Where there is economic stagnation and negative growth at the national level -- family incomes are falling, and government services are contracting.
 - o Broad based economic growth -- that benefits everyone, not just a few -- is the flip side of poverty reduction. As the record shows, you simply can't achieve one without the other.
4. Last year's version of the Global Poverty Reduction Act failed to acknowledge that linkage -- and I objected strongly. By precluding work on economic growth, that version of your bill would have taken us out of the poverty reduction business.
5. The current version of the bill does not preclude work to promote economic growth -- but neither does it encourage it.
 - o I believe that work must be encouraged.
 - o That's one of the reasons I liked the HFAC Task Force Report -- it acknowledges the importance of economic growth for the advancement of human welfare in the developing countries, and
 - Recommends that broad based economic growth be a central objective of a new foreign assistance bill..
 - o It would be helpful if your bill moved further in that direction.

6. At the same time -- there are ideas that the HFAC discussion draft might take from your work.

- o I appreciate your use of the term poverty reduction -- instead of poverty alleviation -- which suggests that we are trying to make poverty bearable -- rather than eliminate it, to the degree possible.

7. As regards performance indicators and targets:

- o I think that both your bill and the HFAC Task Force Report are moving in a useful direction by suggesting that the foreign assistance program be held accountable for results -- rather than monitored on how it allocates resources.
- o In contrast to your bill -- the HFAC Task Force Report suggests that such performance indicators and targets as are needed to assess our performance against the broad goals of the foreign assistance program should be identified by the Executive Branch. I concur with that view.
- o The Executive Branch has the experience with developing countries that is needed to define how to measure progress in a developing country context.
- o I do not envision the process of defining appropriate indicators for legislative goals as a unilateral one. Consultations with Congress would be in order should a shift to performance based monitoring be incorporated into a new foreign assistance act.