

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	Linda Tyler to the Honorable William J. Clinton re: phone number (partial) (1 page)	02/11/1999	P6/b(6)
001b. letter	Linda Tyler to the Honorable William J. Clinton re: phone number (partial) (1 page)	02/11/1999	P6/b(6)
002a. memo	Mildred Alston to the President (2 pages)	05/07/1999	P6/b(6)
002b. letter	Abbey Meyers to Kathy McClanahan (1 page)	04/29/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20147

FOLDER TITLE:

POTUS Notes [Folder 3]

2012-0463-S

rc815

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 advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

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

RR. Document will be reviewed upon request.

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

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

Bill Clinton 3-4-99

C. Jennings

I have some
ideas about the
the murder
advice.

Boe

Copied
C. Jennings
COS

President of the United States

UNINSURED IN U.S. SPAN MANY GROUPS

Health Coverage Experts Take Further Look at Solutions

By PETER T. KILBORN

WASHINGTON, Feb. 25 — Who are all these 43.4 million Americans, at the Census Bureau's last count, who do not have health insurance? Who runs the least risk in going without it? (Children.) Who runs the most, medical and financial? (Sick people approaching 65.) Who is most likely to have it? (People over 65.) Not to have it? (Adults who work for low wages.) Who doesn't care? (Invincible youth.)

For more than a decade, an average of a million Americans a year have either lost their health insurance or failed to obtain insurance for which they became eligible. The reasons vary: prohibitively priced premiums, reduced employer coverage, the welfare overhaul.

But whatever the causes, the growth in the number of uninsured is a startling anomaly in an economy that has been able to subdue inflation, unemployment and budget deficits. Much to the dismay of advocates for the uninsured, the United States, despite its bounty, stands almost alone among industrial nations in not providing free basic health care for all.

"The number is going in absolutely the wrong direction," said Grace-Marie Arnett, president of the Galen Institute, a conservative health and tax policy organization. "It shows something is wrong with the system."

And with the rise in the cost of insurance and health care outrunning wage gains, said Paul Fronstin,

Continued on Page A14

NEWS SUMMARY

A2

Business Day C1-17
Editorial, Op-Ed A20-21
International A3-9
National A10-15
New York A16-19
SportsFriday C19-24
Weekend (2 Parts) B1-32; B33-46

Obituaries C18 Weather C23

Classified Ads A19 Auto Exchange A19

Updated news: www.nytimes.com

JEWISH WOMEN/GIRLS LIGHT SHABBAT
candle today 18 min. before sunset. In NYC 5:25 PM.
Info 718-774-2060. Outside NYC 718-774-3000. In
merit of Raizel Gutnick, OBM — ADVT.

Shift in

All of the 1
made the Sat.
Motors one
prominent ex
tions have be
union membe
ers chose nev
vocated a me
close relation
er's managen

Busine



An Unexpe

A storm just o
coasts. By yes

Struggle

By MIC

LVIV, Ukrain
this graceful bu
have a message
over your money

Just a decade
was part of the
was a prime sup
tanks, bombsights
tronics. When the
ished, so did Lviv
scores of thousand
and then, bit by b
for a capitalist fut

The question no
Mayor, Vasyl Kuy
the capitalists war
about it. And what
West does not help
factories to nonmil
"Either we fir

Americans Without Health Insurance Run the Gamut

Continued From Page A1

an analyst at the nonpartisan Employee Benefit Research Institute, "this is going to get worse unless something is done about it."

The what to do about it, long primarily the concern of liberals, is now being weighed by officials across the political spectrum. The proposals, still evolving, range from expansion of government insurance programs to tax breaks helping more people buy coverage.

But while there is debate on how to help the uninsured, few experts disagree on who they are.

To begin with, not many are among the elderly or the seriously disabled, most of whom are covered by Medicare. Another group, some five million to six million, have family incomes exceeding \$75,000 a year and can usually afford the insurance that, for any number of reasons, they do without.

Almost 11 million are children, from families that range from indigent to well off. But children are a less compelling concern to many health system analysts than are large numbers of the other uninsured. First, they are generally healthier than adults and less expensive to treat. And second, alone among the uninsured, they have already been singled out for help, under a \$24 billion, five-year program for non-Medicaid-eligible children approved by Congress in 1997.

That leaves the rest of the uninsured, those who need coverage most: 25 million to 30 million people who have the greatest chance of becoming ill and cannot pay for care when they do. Demographically, they run the gamut.

"Some work, and some don't," said Katherine Swartz, an associate professor at the Harvard School of Public Health. "Some don't work because they're sick. Some are very young adults not covered by their parents' health insurance. They take jobs serving latte in coffee shops that are not likely to have health insur-

ance. They just don't think about the risks."

The income of many is so low that they cannot afford to buy insurance, Professor Swartz said, but not so low that they qualify for Medicaid. Others may qualify but fail to apply, because of ignorance, language barriers or a general sense of intimidation.

Most of the uninsured in the greatest need of coverage "are working adults who are not quite in the middle class," said David B. Kendall, health policy analyst at the Progressive Policy Institute. "They are the folks who don't have a job that's going to be there for a lifetime."

Minority groups account for a disproportionate number of the uninsured, Mr. Kendall said. Hispanic Americans, nearly half of whom under 65 lack insurance, are only 11 percent of the population but 21 percent of all the uninsured. Experts say there are several reasons, among them that Hispanic immigrants tend to be healthy and in addition may be intimidated by language and cultural barriers from applying for Medicaid or other assistance.

The travails of the uninsured are often dismissed because the law assures them the last-resort, safety-net care of emergency rooms, says Drew E. Altman, president of the Kaiser Family Foundation. But by the time they call the ambulance, Mr. Altman notes, many have gone without the preventive care that might have averted the crisis.

A survey of adults under 65 by Kaiser and the Commonwealth Fund found that in a single year, 24 percent of the uninsured declined to fill a prescription that had been given them by a doctor, compared with 6 percent of those who had insurance. Fifty-one percent had encountered difficulty obtaining care, as against 10 percent of the insured. And 42 percent had not seen a doctor during the prior year, compared with 17 percent of the insured.

As a result, the uninsured are sicker than others, according to research last year by the Center for Studying

Health System Change, a group supported by the Robert Wood Johnson Foundation. The study found that 16.3 percent of uninsured people under 65 were in fair to poor health, compared with 10.6 percent of all people under 65.

One explanation for the rise in the uninsured is the shift of people from welfare to work. More than six million have left the welfare rolls in the last five years, many for low-wage jobs with employers that do not offer any insurance or that charge a lot for it. For these workers, there is help for a while from Medicaid, the Fed-

A trend 'going in absolutely the wrong direction.'

eral-state insurance program for the poor, which is automatically granted welfare recipients. In most states, families can remain on Medicaid for a year after leaving the cash-assistance rolls.

But then, said Ronald F. Pollack, executive director of Families U.S.A., a consumer advocacy group, "their reward is the loss of health insurance."

Another reason for the swelling in the number of uninsured is the rising cost of health care — for hospital stays, visits to the doctor and prescription medicine alike. It is climbing faster than workers' wages, and, on top of the general increase in the cost of care, employers are asking workers to pay a larger share of that cost.

In 1985, nearly two-thirds of all businesses with 100 or more employees paid the full cost of a worker's care, a study by the Kaiser Family Foundation found. A decade later only a third did so. Kaiser also says employers who ask workers to pay part of the cost through payroll deductions had raised the workers'

share to 22 percent on average by 1996, from 13 percent in 1988.

As a result, a survey by the Federal Agency for Health Care Policy and Research found, one in four workers who were offered employer-subsidized insurance in 1997 declined to sign up. A decade ago, only one in ten declined.

These changes, analysts say, have spawned the largest segment of the uninsured, the working poor.

Young adults — some poor, some not — are another large group of the uninsured. Of 65 million up to 34 years old, nearly 25 percent are uninsured (compared with 13 percent of the rest of the population), and they account for nearly 40 percent of all the uninsured.

Of the youngest among them, those 19 to 24, the Center for Studying Health System Change says, 30 percent are not offered insurance through their jobs. Of those who are offered it, typically for a few hundred dollars a year, 30 percent turn it down. Some who reject it are working poor and cannot afford it. Others, feeling invincible, simply spend the money on something else.

However much some young adults feel they can do without insurance, the nation has an incentive to help them buy it, analysts say. Like safe drivers who never have accidents and yet are required to buy car insurance, these young people, by paying health insurance premiums, would help defray the cost of care for people who are frailer and older. This process of subsidizing one group whose purchases then serve to subsidize others is called cross-subsidizing.

Among the beneficiaries of cross subsidies would be a not so obviously needy group of the uninsured: the poorer and sicker, often retired and homebound, among the 23 million Americans who, age 55 to 64, are not yet eligible for Medicare.

According to the Center for Studying Health System Change, people in that age group have average family incomes of \$45,800 a year, about \$4,000 more than the average for all

SNAPSHOT

The Uninsured

Percentage of Americans without health insurance in 1997, by ...

SEX

Men 18%
Women 15%

AGE

Under 18 15%
18 to 24 30%
25 to 34 23%
35 to 44 17%
45 to 64 14%
65 and over 1%

RACE AND ETHNICITY

White 15%
Asian 21%
Black 22%
Hispanic 34%

WORK

All full-time workers 17%

Full-time workers with incomes below the poverty line 49%

All people who did not work 26%

*May be of any race.

Source: Census Bureau

The New York Times

families and enough to permit nearly 90 percent of them to pay the age group's high premiums of close to \$3,000 a year, even if the employer pays no share.

But the three million among them who are uninsured earn an average of only \$18,000. The center reports that a third of them are in particularly perilous straits: these one million are in ill health and have average incomes of just \$9,600, which puts private coverage far out of reach.

the tenure track should they take maternity leave.

The com: what is ter: Though the of talented men to wor the way to l example, ur try majors o Yet there we uate student male profes blames the women from at MIT. "We call it microdiscrimination, the feeling of not having your work valued as much as other colleagues," she says. "Those things kind of mount up. . . . Many women along the line have said, 'Why bother?'"

Slippery footing. Such discriminatory practices take place unconsciously, the MIT report found. Virginia Valian, a professor of psychology and linguistics at Hunter College in New York and author of *Why So Slow? The Advancement of Women*, says people in academia tend to favor males for advancement. Though men and women may start their careers on equal footing, men are more likely to be promoted faster and to receive plum assignments. When asked to pick leaders or rising stars, she says, senior faculty will most often select a male over a female because "they see a man as somebody who looks right for the job, who's in charge of things." It's a kind of discrimination found even in liberal arts departments, where the male-female ratio is less skewed, says Martha West, a member of the AAUP committee and a law professor at the University of California-Davis.

But the situation is not hopeless, Valian adds, pointing to the Johns Hopkins University department of medicine as a success story. Between 1990 and 1995, the number of female associate professors grew from four to 26, mainly because senior faculty were encouraged to advise women on the school's promotion criteria—a service previously performed almost exclusively for men. At MIT, modest change is underway, and the School of Science will increase the number of tenured female faculty by 40 percent this year—although even at this rate it will take 40 years before 40 percent of the school's faculty is female. Administrators and committee members alike say they also hope the publicity surrounding the report will make pleading ignorance impossible. Says Lotte Bailyn, MIT's faculty chair: "By making it explicit, by making people aware, people can't still deny it exists."

Copied
Jennings
Podesta

to
l.
ds
of
ig
or
s-
3.
d-
e-
m
ig
rs

No time for the poor

Physicians dependent on managed care provide less assistance to the uninsured

to leverage their - Be



DAVID BUTOW—SABA

Free clinics struggle to provide care to the uninsured.

BY JOSEPH P. SHAPIRO

The more doctors depend upon managed care for their income, the less likely they are to fill their traditional role of providing free care to the poor. That conclusion comes as no surprise to critics of managed care. Evidence of the trend, documented in a new survey of nearly 10,000 doctors, is striking, even though the fraying of the health care safety net cannot be blamed on managed care alone.

Doctors who get at least 85 percent of their income from managed care provide 40 percent less charity care than those who get no more than one fifth of their income from managed care, according to a study published last week in the *Journal of the American Medical Association*. The majority of doctors—77 percent—still provide some free or reduced-fee care, averaging 10 hours a month. But the report's author, Peter Cunningham of the Center for Studying Health System Change, says that "the holes in the safety net may be getting bigger."

Indeed, there are 45 million Americans without health insurance, and their ranks are growing by 1 million a year. At the same time, doctors are struggling to

dize the care of others.

More affordable. For its part, the managed-care industry says that it has lifted many people from the ranks of the uninsured by making health care more affordable. One 1997 study concluded that up to 5 million more Americans would be uninsured today if not for managed care's success in keeping prices down. Still, managed care can do only so much, says

HEALTH CARE

Karen Ignagni, president of the American Association of Health Plans, the industry's Washington lobby. The traditional sources of indigent care—free clinics, and public and teaching hospitals—also have limits. They could not serve everyone before, and are even more burdened now. The uninsured, Cunningham has found in a second study, are less likely to get free care if they live in communities where the number of people without insurance is relatively high.

Cunningham and Ignagni agree that it will take renewed political will to reduce the number of the uninsured. A *JAMA* editorial accompanying Cunningham's article suggests one solution: a tax on managed-care companies and other insurers to create a government-managed pool of money to cover the cost of ministering to the uninsured.

THE PRESIDENT HAS SEEN

3-2-99

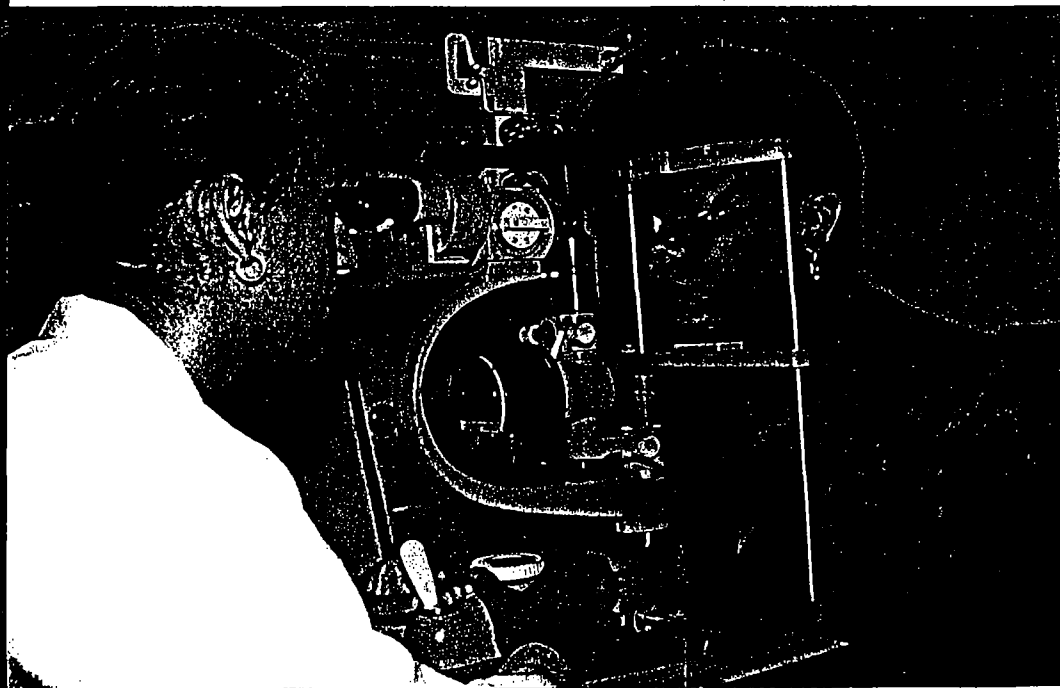
C Jennings
Su M M. Thru

copied
Jennings
Podesta

Be

*A university-centered
eye institute dedicated to
excellence in research,
education, and culturally
appropriate clinical services to
preserve and restore vision
for underserved, minority,
and socio-economically
disadvantaged populations,
and for the whole of society.*

THE LOS ANGELES EYE INSTITUTE



South Central Los Angeles: A Community in Need

Current treatments of eye diseases are capable of reducing new blindness and visual impairment in this country by at least one-third. Such treatments could prevent or cure two-thirds of the blindness observed in African Americans.

Yet more than 25% of the population of South Central Los Angeles—350,000 people—have no health insurance and are unable to afford the cost of eye care services.





South Central Los Angeles County has over 1.4 million residents, of whom approximately 80% are African American and Latino and 13% Asian and Pacific Islander. Nearly half of this population lives below the federal poverty level. This population profile is typical of our inner cities: predominantly socioeconomically deprived members of minority groups.

The eye care needs of individuals living in South Central Los Angeles are profound. Several scientific studies have established that rates of blindness and vision impairment in African American populations are twice those in Caucasian Americans. African Americans are also six times more likely to suffer blindness from unoperated cataracts, and seven times more likely to be blind due to complications from glaucoma. (Comparable population-based data on Latinos and Asian Americans are not available.)

The effectiveness of current treatment in preventing vision impairment depends upon the timely identification of the problems and the implementation of the appropriate medical intervention. At present, access to effective eye care programs by the uninsured working poor, the unemployed, and homeless children and adults in South Central Los Angeles is severely limited.

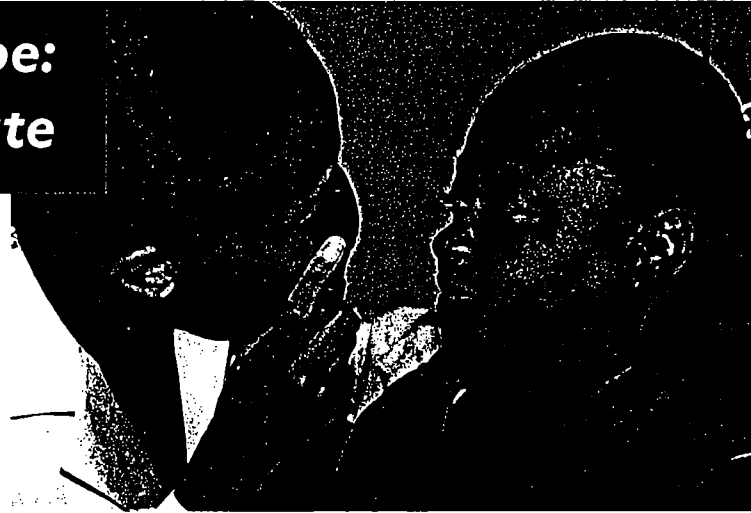


The primary comprehensive multi-subspecialty eye care provider in this community (the Division of Ophthalmology at the Charles R. Drew University of Medicine and Science located in the Martin Luther King, Jr. General Hospital) operates within the physical constraints of a 1,200-square-foot facility. The four- to five-month-long waiting period for services at the above clinic (due to extreme demand) discourages many residents from seeking routine care. Instead, they inappropriately use the emergency room at the hospital as their primary source for eye care, often presenting with end-stage eye disease.

Creating a beacon of hope: The Los Angeles Eye Institute

*The Los Angeles Eye Institute
will be dedicated to providing access
to high-quality eye care programs
for children and adults who would
otherwise have no place else
to turn for such care.*

*The formation of this Institute
offers a unique opportunity to go
beyond providing just a stopgap
program of services. It will
provide the same excellence
in eye care as that offered to
Americans who have access
to eye care.*



THE SOLUTION to this crisis proposed by the Division of Ophthalmology of the Charles R. Drew University of

focused solely on minority and socioeconomically disadvantaged populations. As such, it will create new paradigms

to eye care.

THE SOLUTION to this crisis proposed by the Division of Ophthalmology of the Charles R. Drew University of Medicine and Science is the creation of The Los Angeles Eye Institute, which would be located in the South Central community. The Los Angeles Eye Institute will be dedicated to providing high-quality eye care programs for children and adults who would otherwise have no place else to turn for such care. The Institute will also conduct research and education programs to support the delivery of clinical services. These programs will establish The Los Angeles Eye Institute as a significant resource for policymakers, health care professionals, and communities interested in expanding the delivery of care to underserved and medically indigent populations.

The creation of the Institute represents a longstanding passion of the founding members, who have amassed more than 50 years of dedicated service to this community. The Institute is born from their deep commitment to the medically indigent children and adults living in this community. Each founding member offers his or her specialized training and professional expertise to serve those who have no other place to turn for such care.

The formation of this Institute offers a unique opportunity to go beyond providing just a stopgap program of services. The Institute will be created by minority professionals and

focused solely on minority and socioeconomically disadvantaged populations. As such, it will create new paradigms for the delivery of care and offer important information for the development of more far-reaching health care policies concerning these populations.

The Institute will serve to assemble an impressive array of talent and mobilize the resources of the Los Angeles community by providing a vehicle for the philanthropy of corporations, foundations, and individuals in support of vital eye care services.



It will utilize the experience of the directors of other major eye care centers around the nation and the dedication of its founders to realize a vision whose time has come—to establish a beacon of hope to which the underserved and medically indigent may look in their quest for excellence in eye care services.

CURRENT LEGAL STATUS

The legal formation of The Los Angeles Eye Institute is currently in progress and will result in the creation of a 501(c)(3) non-profit, public benefit corporation. Glenville A. March, Jr., M.D. will assume the position of Founding Director of The Los Angeles Eye Institute. Formal resource development activities will begin soon to establish the physical operations of the new entity.

Proposed Programs and Services

*The clinical services to be offered at
The Los Angeles Eye Institute are
designed to maximize the quality and
efficiency of ophthalmic care through a
delivery system capable of providing
comprehensive preventive, primary,
secondary, and tertiary eye care to the
underserved and medically indigent.*



These services will include ...

These services will include . . .



COMMUNITY-BASED EYE CARE DELIVERY SYSTEM

to provide a broad spectrum of eye care services from eyeglasses to specialized medical and surgical treatment of disease for people in the primary catchment area of South Central Los Angeles.

VISION REHABILITATION CENTER

to offer multidisciplinary vision rehabilitation services to people who are visually impaired due to diabetes, glaucoma, birth defects, and trauma. Center services will include orientation and mobility training, support groups and counseling, vocational training and placement, and visual aids and assistive devices that will allow individuals to live independent and productive lives.



COMPREHENSIVE DIABETIC EYE CENTER AND A GLAUCOMA EYE CENTER

to provide state-of-the-art ophthalmic treatment for these diseases and offer outreach education and screening programs that focus on prevention and early detection. Research and clinical trials will support these programs and create the ongoing ability to more effectively address the specific needs of these minority populations.

TELEOPHTHALMOLOGY CENTER

to provide urban areas and other remote locations, both nationally and internationally, with satellite access to the Institute's clinical expertise and educational programs.



CHILDREN'S EYE CENTER

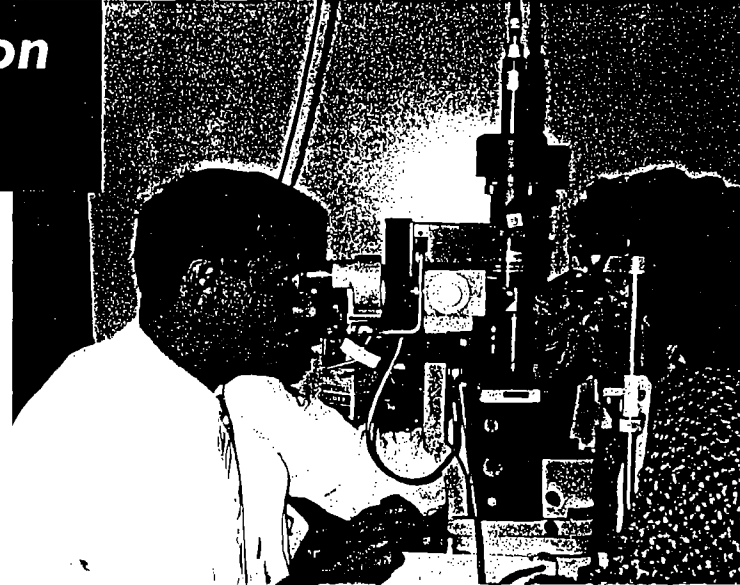
to identify and address eye problems related to birth defects and diseases of childhood and to mitigate their impact on cognitive and behavioral development of affected children.

TRAUMA AND RECONSTRUCTIVE SURGERY CENTER

to provide computer simulation technology and state-of-the-art equipment and procedures for structural and functional restoration in severely traumatized patients.

Research and Education

The ongoing assessment and improvement of the clinical service programs will depend upon the creation of a rigorous and scholarly research program that will address a wide range of issues related to the diagnosis, treatment, and management of ophthalmic conditions specific to minority populations.



Potential areas of research include the following ...

CLINICAL RESEARCH

to investigate such topics as disease prevention, diagnosis, eti-

allow the Institute to provide the most effective eye care possible to the population of South Central Los Angeles and will

CLINICAL RESEARCH

to investigate such topics as disease prevention, diagnosis, etiology, epidemiology, and disease management of ophthalmic conditions that disproportionately affect minorities and the medically indigent.

HEALTH SERVICES RESEARCH

to determine how to optimize the delivery of care to the populations that the Institute will serve, since the "mainstream" approaches often fail. For example, individuals may be reluctant to travel even a short distance to receive care at the Institute if they have to cross gang lines.

BEST PRACTICES RESEARCH

to determine how to optimize treatment approaches for low-income and linguistically and culturally diverse populations. For example, restricting access to specialty care is normally important to controlling costs. In underserved communities, facilitating access to specialty care may be important to controlling costs. In addition, the Institute may also serve as a vehicle for identifying best practices in patient-provider communications among non-English-speaking and culturally diverse populations.

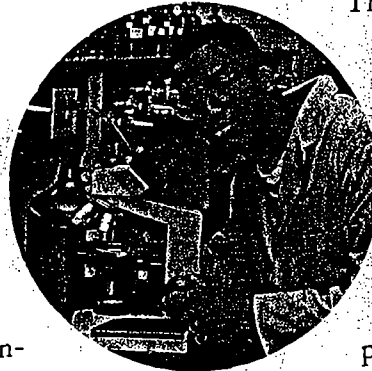
COST-EFFECTIVENESS RESEARCH

to determine how best to allocate constrained resources. This research will employ an integrated approach to problem solving, combining the expertise of medical doctors, social scientists, and basic researchers. Outcomes from this research will

allow the Institute to provide the most effective eye care possible to the population of South Central Los Angeles and will add to a growing body of knowledge that could have profound implications in preventing and curing blindness and visual impairment in minority populations. By disseminating the scientific knowledge gained from this research to other practitioners in the field, the Institute will be able to improve service delivery systems across the country and become a national resource for the vision care of minority populations.

EDUCATION

The Institute has a tremendous opportunity to serve as a training site for medical professionals and community members committed to the delivery of high-quality eye care services to minority populations and the medically indigent. It will develop educational curricula to sensitize health care providers to the extensive and unique cultural needs of these target populations. By educating the general public, allied health professionals, physicians, and eye care providers, the Institute will accomplish its objective of increasing not only the numbers of those providing vital eye care interventions but also their effectiveness in doing so. Furthermore, these educational programs will provide an immediate outlet for the dissemination of results and outcomes derived from the research activities described above.



Los Angeles Eye Institute Founders and Advisors

BOARD OF DIRECTORS

MELINDA MCINTYRE-KOLPIN, CHAIRPERSON

President and CEO, First Professional Bank

RICHARD S. BAKER, M.D.

Director, Research Centers in Minority Institutions
Charles R. Drew University of Medicine and Science

CABRINI T. MARCH, M.D.

Medical Director, Los Angeles Eye Institute

GLENVILLE A. MARCH, JR., M.D.

President/CEO, Los Angeles Eye Institute

NICHOLAS MCCLURE, M.B.A.

CEO, Commercial Capital, LLC

HARRY VOSS

CEO, Diamond Packaging

ADVISORY COMMITTEE

The following individuals are currently participating in the

GLENVILLE A. MARCH, JR., M.D.



obtained his medical degree at the University of Rochester, completed his residency at the Charles R. Drew University of Medicine and Science, and completed Fellowships at Harvard University/ Massachusetts Eye and Ear Infirmary in Neuro-Ophthalmology and at UCLA's Jules Stein Eye Institute in Orbital and Ophthalmic Plastic Surgery.

RICHARD S. BAKER, M.D.



obtained his medical degree in a joint program at Harvard University and Massachusetts Institute of Technology, completed Fellowships in Ophthalmic Epidemiology at the Joslin Diabetes Center/Harvard Medical School, and in Epidemiology and Biostatistics at the University of Minnesota, and completed his residency at the Charles R. Drew University of Medicine and Science. He is currently Director of Research Centers in Minority Institutions at Drew.

RICHARD CASEY, M.D.



obtained his medical degree at Harvard University, completed his residency at Massachusetts Eye and Ear Infirmary, and a Fellowship in Cornea and External Diseases at the same institution. He is currently the Chief of the Division of Ophthalmology at the Charles R. Drew University of Medicine and Science.

CHARLES W. FLOWERS, JR., M.D.



obtained his medical degree from Cornell

CEO, Diamond Packaging



and Science.

Chief of the Division of Ophthalmology at
the Charles R. Drew University of Medicine

ADVISORY COMMITTEE

The following individuals are currently participating in the formation of the Institute in an advisory capacity:

BRADLEY STRAATSMA, M.D.

Founding Director of the Jules Stein Eye Institute;
Editor in Chief, *American Journal of Ophthalmology*

BARTLEY MONDINO, M.D.

Director, The Jules Stein Eye Institute

RONALD E. SMITH, M.D.

Director, The Doheny Eye Institute; Chairman
of the American Board of Ophthalmology

CARL KUPFER, M.D.

Director, National Eye Institute

HON. YVONNE BRATHWAITE BURKE

County Supervisor, Los Angeles

ROBERT BROOK, M.D.

Vice President of Health, RAND Corporation

HON. THERESA HUGHES

California State Senator

HON. KEVIN MURRAY

California State Assemblyman

HON. MAXINE WATERS

U.S. Congresswoman

GARNETT L. MARCH, SR.

Vice President, Priority Records, Los Angeles

YOLANDA D. KING

CEO, Higher Grounds Productions; Board of Directors,
Martin Luther King Jr. Center for Non-Violent
Social Change

HON. JUANITA MILLENDER-MCDONALD

U.S. Congresswoman

CHARLES W. FLOWERS, JR., M.D.



obtained his medical degree from Cornell University, completed his residency at the Charles R. Drew University of Medicine and Science, and completed a Fellowship in Cornea and Refractive Surgery at USC's Doheny Eye Institute. He is currently the Director of the Refractive Surgery Service.

CABRINI T. MARCH, M.D.



obtained her medical degree at UCLA/Drew University, completed her residency at the Charles R. Drew University of Medicine and Science, and completed a Fellowship in Ophthalmic Pathology at UCLA's Jules Stein Eye Institute.

M. ROY WILSON, M.D., M.S.

obtained his medical degree at Harvard University, completed his residency at Massachusetts Eye and Ear Infirmary/Harvard University, and completed a Fellowship in Glaucoma at Harvard University. He is former Dean of the Medical School at Charles R. Drew University; and is currently serving as Dean of the Medical School at Creighton University.

The Los Angeles Eye
Institute: a beacon of
hope to which the
underserved and
medically indigent may
look in their quest
for excellence in eye
care services.

The
Los Angeles
Eye Institute
12012 S. Compton Ave.,
Suite 2-216
Los Angeles, CA 90059
ph. 310.668.5152
fax 310.638.3278





KATHY SALAZAR
Board Member

1425 W. Victoria
Montebello, California 90640
office: 213-728-0100
fax: 213-888-0836
pager: 213-506-7128

The Bond Between Cops and Kids

323

DRAWING UP PLANS TO PAY FOR PILLS FOR THE ELDERLY

ISSUE FOR 2000 ELECTION

Washington Stage Set for Fight
to Add Prescription Drugs
to Medicare Coverage

A1

By ROBIN TONER

WASHINGTON, May 9 — Prescription drugs were not a major issue when Medicare was created in 1965, and thus never included as a benefit. But 34 years later, medicine has been transformed by new drugs to treat the ills of old age, from osteoporosis to heart disease, and many of the elderly are struggling to pay the bill.

The issue has great and growing power at the grass-roots level, politicians and health care advocates say, and with the goad of an election just over the horizon, lawmakers in both parties on Capitol Hill are suddenly working on a variety of proposals to do something about it. The debate will be fully joined in a matter of weeks when the Clinton Administration produces its plan to overhaul Medicare, which is expected to propose a major new drug benefit.

Yet there is also widespread agreement that it will be very hard to actually pass legislation on the issue, and not simply because of partisan politics. Medicare, the Federal health insurance program for the elderly and the disabled, already has problems paying for benefits over the long term; because of that, many politicians say, any expansion of benefits must be tied to a broader restructuring of the program, an extremely divisive prospect.

As Senator John B. Breaux, the Louisiana Democrat who headed a Federal advisory commission that deadlocked over how to restructure Medicare, put it: "People want the goodies. They want dessert. But you've also got to reform the system to make it work."

More than a third of the 39 million people on Medicare have no coverage for prescription drugs they use outside hospitals, and many others with some form of private coverage have substantial out-of-pocket costs.

It was not hard to start a conversation about the issue at the Berkeley Senior Center in Martinsburg, W. Va., last week.

"My medicine bill was almost \$200 last month," said Edith Dennison, 82, a retired millworker who says she pays that bill out of her Social Security check. Dorothy Baker, a friend who is also 82, said her bill was more than \$100. Judy Knuck pulled out a list of her medications, pointed to one and declared, "This is the one that

kills me — \$145 for 30 at the Wal-Mart."

Social workers at Berkeley Senior Services, a private, nonprofit agency that operates the center, say they have become expert at getting the low-income elderly onto drug-company programs that provide free medication, and patching together other forms of assistance.

Heather Triplett, a Berkeley outreach worker, said: "A lot are embarrassed or ashamed to admit that they can't afford their prescriptions. So they go from month to month and never let anyone know what a dire situation they're in. Sometimes their kids call us."

The cost can be to a patient's health as well as pocketbook. Addressing that concern, Roni Mather, a registered nurse, recently gave a talk at the senior center about the importance of patients' taking medication as directed, and not trying to economize by stopping short when they feel better.

"Cost really comes into play with our patients," Ms. Mather said.

Medicare beneficiaries who do have some drug coverage get it in several ways. About a fourth of all beneficiaries had coverage through employer-sponsored plans in 1995, according to the National Academy of Social Insurance, a research group, while less than a tenth bought supplemental Medigap insurance with a drug benefit, which is substantially more expensive than a standard Medigap policy.

The rest of those with coverage are either members of health maintenance organizations that provide drug benefits, or qualify for Medicaid, the insurance program for the poor. Thirteen states have programs to help the lower-income elderly who are not poor enough for Medicaid.

Medicare does cover prescriptions for its beneficiaries in hospitals.

Besides the third of all Medicare beneficiaries with no drug coverage at all, what worries some analysts are the signs of erosion in private coverage. The number of large companies offering their retired employees such benefits is declining, according to the Administration. Meanwhile, some health maintenance organizations are putting new limits on how much they will cover for prescription drugs. And some of the elderly have lost their drug benefits because their health maintenance organizations have pulled out of the Medicare market.

"I went through a period toward the end of last year when four of the eight H.M.O.'s that treat seniors pulled out of my area," said Representative Benjamin L. Cardin, Democrat of Maryland. "So I had a town hall meeting and a huge crowd showed up." They were "panicked," he said, over the loss of prescription drug benefits.

With coverage limited, advocates say, the out-of-pocket costs for the elderly are substantial, because of both the rising prices of drugs and the greater use of them. Spending on outpatient pharmaceuticals this year is expected to average \$942 per Medicare beneficiary, roughly half paid by insurers and half paid by the beneficiaries, according to the National Academy of Social Insurance. About 29 percent have out-of-pocket expenses of more than \$500 a year.

Dr. Jerry Avorn, a geriatrician and expert on drugs at Brigham and Women's Hospital in Boston, said a Medicare patient today might be a woman in her 70's, on medication for osteoporosis, cholesterol, high blood pressure and depression.

"She could easily end up with bills

of three or four thousand dollars a year, primarily to prevent the occurrence of disability in future years," Dr. Avorn said. "In that light, we're really in a new era of pharmacological therapy for the elderly."

In contrast, Dr. Avorn said, "When Medicare was first created back in the mid-60's, our understanding of drugs was quite different. They were primarily used to treat acute illness and made up a small part of the health care budget. In the three-plus decades since, medicine has become not just about the treatment of acute disease but about ongoing management of chronic illness, and even more about the lowering of risk status for things like hypertension."

As a result, many advocates argue, the lack of prescription drug coverage raises important questions of equity.

The issue has quickly caught fire on Capitol Hill, with both parties promising action. But the enthusiasm masks the serious difficulties in its path. Among the biggest questions: Should a new prescription drug benefit cover everyone on Medicare, or just the lower-income? And how should it be paid for?

An analysis of five possible drug benefits by the National Academy of Social Insurance showed them adding \$17 billion to \$24 billion in the first year to Medicare, which has total spending of about \$200 billion a year.

Lawmakers are keenly aware that one of the last major efforts to expand Medicare benefits was disastrous: a 1988 law intended to provide additional coverage for catastrophic illnesses and for prescription drugs that was financed, in part, by a surtax on the elderly. The backlash was

**Prescription drugs
are at the center of
the Medicare debate.**

so intense that it was repealed the following year, before the drug benefit even began.

Moreover, all the current maneuvering is taking place in the shadow of the 2000 elections, in which the House, where Republicans have only a thin majority, is considered up for grabs. Some Republicans suggest that the Democrats are less interested in passing legislation than in creating a campaign issue.

Republican leaders say they will offer a more responsible approach to the problem. "Republicans are working on a prescription drug plan for seniors that will not bankrupt Medicare," Representative Bill Thomas, Republican of California and chairman of the Ways and Means Subcommittee on Health, said last week. "The Democrats' bill is a poison pill," he added.

Add to that some powerful lobbies, notably the Pharmaceutical Research and Manufacturers of America, which is fiercely opposed to any Medicare prescription drug plan that would involve government price controls, asserting it would hinder research.

For all of that, many analysts say that sooner or later, the Medicare benefit package must be retrofitted for the changing medical needs of the elderly.

Dr. Christine K. Cassell, chairman of the geriatrics department at Mount Sinai Medical Center, said, "If you were to look at the current Medicare population, living as long as they do, and say, 'Let's design a cost-efficient but effective health care plan,' you'd do it very differently."

The New York Times

MONDAY, MAY 10, 1999

Good
Breed
and her low
of the low
5-11-99

C. Jennings

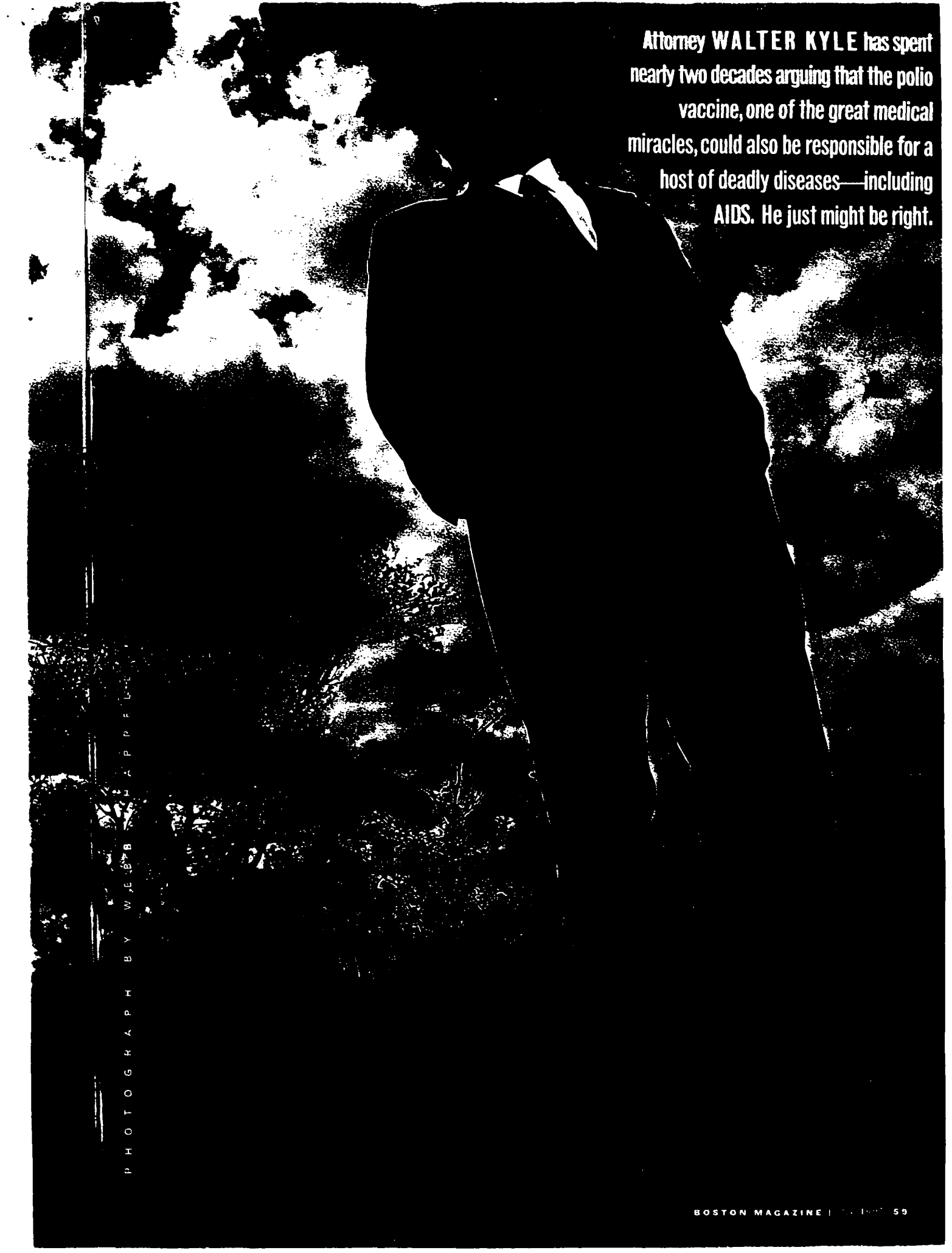
5-18-99

↳ This is an
important issue & think
Walter Kyle (see
article attached) brought it
to me - see # below & I need
to follow up

Walter Kyle
SOS-428-1115

copied
Jennings
Podesta

Kyle strongly believes
parents should have
informed choice, esp.
those in the high
category - women who
should not be forced
to vaccinate their kids
to get in school -
Rebecca Whitman



Attorney **WALTER KYLE** has spent nearly two decades arguing that the polio vaccine, one of the great medical miracles, could also be responsible for a host of deadly diseases—including **AIDS**. He just might be right.

PHOTOGRAPH BY W. E. B. DUBOIS

THE LONELY CRUSADE OF WALTER KYLE

By Debbie Bookchin and Jim Schumacher

DIRECTLY ABOVE THE GIFTED HAND, an upscale antiques and crafts store in the center of Hingham, a black and gold sign neatly mounted on the white clapboard of an immaculately kept Colonial house announces the offices of Walter S. Kyle, Attorney at Law. At first blush, Walter Kyle seems to blend perfectly into the backdrop of Hingham's amalgam of suburban chic and historic elegance. He is a handsome and affable 47-year-old Arkansas transplant whose soft-spoken and gentlemanly bearing suggest ease and comfort. His tidy office is tastefully turned out: a small cherry desk adorned with an antique brass faux-gas lamp, leather chairs, striking vermillion drapes, newly hung Williamsburg Collection wallpaper, and Persian-style rugs covering polished pine floors.



THE CURE: Almost everyone born before 1955 remembers the swath of terror that polio cut through the American psyche.

On a glass-encased shelf sits a gold-framed, inscribed photograph of Kyle and his son Robert standing with President Clinton in the Oval Office; nearby sits another of Kyle standing directly behind Clinton as he gives a speech in New Hampshire during the 1992 primary. Clinton, who told *Boston Magazine* he has known Walter Kyle "most of his life" and is "grateful for his friendship," tapped Kyle to serve as his New Hampshire field director during the 1992 presidential race. Dressed in a conservative blue suit that fits snugly over his athletic frame, Kyle could easily be mistaken for a smooth and prosperous lawyer, at home in the corridors of power.

Yet Kyle has devoted most of his career to a single-minded and iconoclastic pursuit that has earned him no love in Washington or in the boardrooms of America's pharmaceutical giants: attacking the polio vaccine. The vaccine is one of modern medicine's most revered miracles; but Kyle has borne witness to its darker side. Not only can the vaccine itself cause paralysis and death by infecting recipients with polio, but Kyle says there is plenty of reason to believe that it may be the repository for a variety of monkey viruses that can cause disease in human beings. That is because all polio vaccine produced for consumption in this country is grown on the kidney tissues of monkeys, which are notorious reservoirs for all kinds of viruses. He believes that federal health regulators have at times allowed contaminated batches of vaccine to be distributed to infants and children in this country. He has even hypothesized that one possible source of the AIDS virus was through contaminated polio vaccine.

The Food and Drug Administration (FDA) counters that the vaccine is free of all known monkey viruses. Kyle believes he has evidence to prove otherwise. In three undisclosed locations in the Boston area, Kyle, in the course of 20 years of litigation, has collected more than 100,000 pages of internal drug company memoranda and government documents. He says the internal memos paint a damning picture of a vaccine production process rife with contamination problems and a government that doesn't seem to care. "Why would anyone think it's okay to give American kids a vaccine that might be contaminated with monkey viruses?" says Kyle. "But that's exactly what's been going on with the polio vaccine. For 40 years they've been engaged in a massive experiment with our children. Every parent should be angry."

TODAY IT IS EASY TO FORGET how deeply the fear of polio gripped the nation during the first half of this century. But almost everyone born before 1955 remembers the swath of terror the disease cut through the American psyche. Parents would reach into a crib to pick up their infants and, to their horror, find that overnight their legs had turned limp and lifeless. Polio could take the most robust and athletic children and reduce them to weakened cripples, condemned to a lifetime on crutches or worse, entombment in an iron lung. Polio didn't single out the poor and sickly; it struck healthy, middle-class kids and adults too. It was unpredictable. No one seemed to know how the disease was spread, so no one knew how to avoid it. In the epidemic of 1916, the first of almost four straight decades of annual epidemics in this country, 27,000 people were paralyzed and 6,000 died. As recently as 1952, 58,000 people contracted the disease. Every summer, as polio epidemics worsened throughout the 1940s and early 1950s, parents prayed their children would be spared. Polio had become a national scourge. Deliverance from it could not come soon enough.

When after extensive research in the early fifties a young, unknown Debbie Bookchin and Jim Schumacher are freelance writers who live in Vermont.

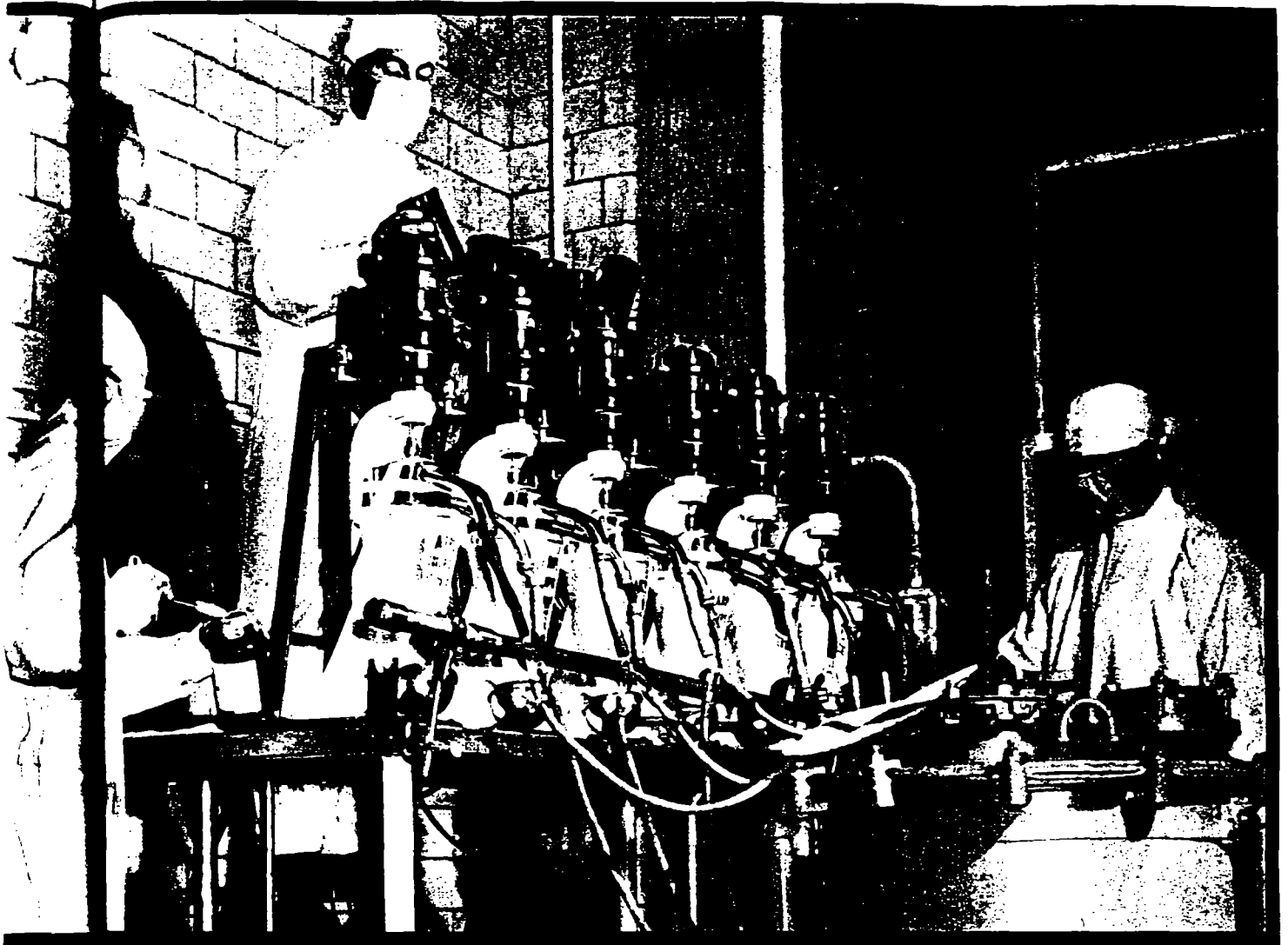
"ASK ANY MOTHER if she would approve of her child being given a vaccine that was potentially contaminated with monkey viruses," Barbara Loe Fisher says of the polio vaccine. "I think she would tell you, 'No, thank you.'"

microbiologist from the University of Pittsburgh named Jonas Salk developed a vaccine, he became an instant American hero. On April 12, 1955, the 10th anniversary of the death of Franklin D. Roosevelt, perhaps the most famous American polio victim, church bells rang throughout the land to celebrate the success of the trials of Salk's vaccine and its availability for massive immunization. Between the inactivated Salk vaccine and later Albert Sabin's "live" oral vaccine, polio was completely eradicated in this country by the late seventies. The success of the polio vaccine has stood as a singular achievement that is universally regarded as an unparalleled triumph of American know-how over what was as close to a plague as this country had ever known.

In 1977, when Walter Kyle was preparing to take the Arkansas bar exam, the last thing on his mind was the polio vaccine. The second in a family of overachievers (his two sisters both practice law, one in Texas, the other in Arkansas; a brother is a neurosurgeon) and a proficient pilot, Kyle had planned to pursue aviation law. He recalls that he used to fly seaplanes for Chalk's International to Bimini (before Gary Hart made it famous with Donna Rice aboard the yacht *Monkey Business*) after graduating from the University of Miami in Coral Gables. At Miami, Kyle received degrees in mechanical and electrical engineering, and then spent two years testing autopilot systems by pushing planes to their maximum speeds and taking them into a dive to see if they would crack up before he could recover.

After he'd had his fill of engineering feats, Kyle returned home to attend law school at the University of Arkansas in Fayetteville, where his old friend Bill Clinton and Bill's new wife, Hillary, were two of his professors. (Kyle recalls that the future First Lady was "more intimidating" in the classroom than her husband.) Two weeks after graduating, Kyle took the bar exam, skipping the lengthy bar preparation course most students consider prerequisite. He already had a job lined up with a law firm in Ft. Lauderdale.

Then the wife of one of his plane mechanics suddenly became paralyzed—a victim of what doctors call "contact" polio. Like almost 3 million Americans each year, she had brought her infant son to his pediatrician for a routine polio immunization. And like those other Americans she had no idea that her son's ingestion of the live oral vaccine held any danger for her or her child. But three weeks after he received the vaccine, she became permanently paralyzed from the waist down. The statistical risk of paralysis from the vaccine is considered negligible, but each year 8 to 10 people in the United States contract polio after receiving the oral vaccine or, as in the young mother's case,



PANDORA'S BOX: Above, workers in 1955, processing the polio vaccine. Kyle believes the continued use of monkey tissue in making the vaccine has exposed millions of Americans to many simian viruses.

after being exposed weeks later to the poliovirus in the stools of a recently vaccinated child. In 1963, the United States had switched from an inactivated injected vaccine and began to use the live virus vaccine. One reason the country began using the live vaccine was to increase the number of people being immunized in this fashion.

When Kyle learned that government policy included this kind of deliberate exposure of care givers to the deadly virus, he was outraged. "These people were innocents whose lives were ruined all because of a massive government program to inoculate people with a live virus without their consent," he says. "I thought it was a travesty." One day after passing the bar exam, he signed up his first case, agreeing to represent the woman and her family against one of the world's largest drug manufacturers, Lederle Laboratories, now known as Wyeth-Lederle Vaccines and Pediatrics, in Radnor, Pennsylvania, the nation's only manufacturer of live polio vaccine.

Kyle took his paralysis case to a well-known tort attorney, Henry Woods, now an Arkansas federal judge. On the day they were to start the trial, the two men won a sizable settlement from Lederle for their client. As far as Woods was concerned, the case was over. Not so Kyle. In 1979 he filed suit against the federal government on behalf of his paralyzed client, claiming not only that the government had failed to follow its own regulations to ensure that the vaccine was safe for people in close proximity to those inoculated, but that it was an invasion of a constitutional right to privacy for the U.S. gov-

ernment to expose people to the virus without their knowledge or consent. When the U.S. Court of Appeals for the Eighth Circuit, in St. Louis, agreed with Kyle that the government could be held liable

on certain claims just like any private citizen, Kyle significantly advanced the rights of anyone harmed by vaccines to sue the government for negligence. Since then he has been involved in nearly 100 claims on behalf of vaccine-damaged clients.

Far from prospering from these claims, Kyle has often not been paid for his vaccine work and has found that he has to devote increasing amounts of his time to more garden variety tort law to make ends meet. But even if they haven't made him rich, his vaccine litigations have secured him a minor place in legal history. In 1988, the United States Supreme Court cited his 1981 case in a landmark decision recognizing the rights of any vaccine-damaged individual to sue the federal government for failure to follow its own regulations. "He has touched a lot of people through his work," says Clinton. "He has always been hard working, determined, and compassionate."

IT WAS DURING HIS INITIAL case that Kyle received his first big batch of internal documents from Lederle. (Continued on page 93)

Walter Kyle

(Continued from page 61)

In his discovery requests, Kyle had asked for Lederle's neurovirulence-testing data—the tests that ensure the vaccine won't cripple anyone. In response, he received a flood of documents and noticed that many contained references to “adventitious agents.” Memo after memo documented Lederle's problem with the agents. Says Kyle, “It became obvious that what they were talking about was unwanted live monkey viruses that they couldn't get rid of.” The realization piqued his curiosity.

Kyle started setting aside every document that mentioned adventitious agents. When he later turned to analyze them, he realized that the memos were describing a witch's brew of contaminants, including simian measles, foamy viruses, simian virus 40 (SV40), adenoviruses, and simian cytomegalovirus, known to scientists by its acronym SCMV. The Lederle memos dated from the early sixties to 1987 show that these adventitious agents had been plaguing the process of manufacturing vaccine for decades, forcing Lederle to discard what would have become millions of doses of vaccine.

Kyle cites a 1983 memo describing an internal company study of 13 years of vaccine production. The memo documents that Lederle was forced to junk almost half—43 percent—of all vaccine-in-production largely because of viral contamination problems. The memos show Lederle also had other contamination issues. A 1977 memo reports that even though the vaccine manufacturing process was supposed to be sterile, bacterial contamination forced the rejection of a large amount of vaccine-in-production. An internal company investigation found that mold, yeast, and strep were living in the company's air duct system.

As Kyle continued to collect Lederle memos, he realized that they mentioned one specific “adventitious agent” again and again: simian cytomegalovirus. According to Kyle's documents, simian CMV and CMV-like agents have proved to be a chronic problem for Lederle, which frequently had difficulty keeping the virus out of monkey-kidney-tissue preparations—the so-called harvests of poliovirus-containing fluids from the kidney tissues. Kyle believes the virus or its DNA has almost certainly made it beyond the vaccine-in-production stage and into some doses of the final vaccine released to the public, a charge that Lederle denies.

SCMV is a member of the herpes virus family. Its human counterpart, human cytomegalovirus, can cause retinal and gastrointestinal disorders and malaise. It is considered quite dangerous to infants or people with compromised immune systems. HCMV easily infects if it is ingested orally. If SCMV were present in oral polio vaccine, something offi-

cial from the Food and Drug Administration adamantly deny, it would be, they acknowledge, a cause for serious concern.

Lederle, which sells 16 million to 20 million doses of the vaccine each year, most of it to the U.S. government, insists all monkey tissue it obtains is tested and screened for adventitious agents before it is used for vaccine production and that it “strictly adhere[s]” to FDA regulations. Doug Petkus, a Lederle spokesman, asserts that the screening process used by Lederle is designed to insure that the vaccine be free of all foreign viruses, including SCMV. Another Lederle spokesperson, Audrey Ashby, maintains that “monkeys contaminated with cytomegalovirus have never been used for oral polio vaccine production.”

But internal company memos from 1972 suggest that for many years SCMV-infected monkeys were used. In August 1972, Ronald

Kyle believes that the simian counterpart to HIV, or possibly even an HIV progenitor, may have been released in millions of doses of polio vaccine in the seventies.

Vallancourt, a veterinarian who was head of Lederle's polio production, described a study the company had undertaken with the FDA to examine how widely SCMV contaminated monkey tissue. In a memo titled “Cytomegalovirus Contingency Plan,” Vallancourt noted that the joint study had found all 11 monkeys examined harbored the virus. Worse, he noted, 7 of the 11 infected monkeys “would have passed our existing test standards,” an acknowledgment on Vallancourt's part that the monkeys would have been found suitable for vaccine production. Vallancourt concluded that the 1972 study suggested that SCMV “has been present in our environment for at least as long as the poliovirus vaccine has been produced. Therefore, all substrate [kidney tissue] used to this date have conceivably been ‘contaminated.’”

The possibility of vaccine contamination was apparently of no concern to federal health officials at the time. As far back as 1968, a Lederle official had boasted that Roderrick Murray, the head of the federal agency then charged with vaccine safety, had “agreed” with the company “that the adventitious agents . . . are of little consequence for an oral preparation in that such a large experience exists with the use of oral polio vaccine without any evidence of trouble related to these agents.” Kyle's memos indicate that government health officials never followed up on the joint SCMV study. In one 1972 memo,

Vallancourt even observed: “Cytomegalovirus . . . is not being tested for at this time. For a manufacturer, and especially a regulatory agency, to accept this situation can only be judged a dichotomy but it has its basis in the fact that this agent is extremely cell-associated and cannot end up in the final vaccine.” Kyle disputes Vallancourt's conclusion, focusing instead on Lederle's failure to test for SCMV. “If they weren't testing for this virus at least until after 1972, and they admit the monkeys were all contaminated, then Americans got contaminated vaccine,” he says.

In 1973, Vallancourt informed his superiors at Lederle that federal officials had never again raised the subject of the SCMV contamination since the completion of the joint study the previous year. In another 1973 memo, he predicted that “our CMV problem will be pushed further and further into the background.” Vallancourt was right, as underscored by the resignation of a government scientist named Kendall O. Smith, an electron microscopist, who in 1968 had first discovered widespread SCMV contamination of commercial African green monkey kidney tissues—the exact type used for polio vaccine manufacture. In a 1969 paper published in the *Journal of the National Cancer Institute*, Smith noted that SCMV often escaped detection by conventional methods and warned that existing testing protocols were inadequate. Smith quit the FDA in disgust over the agency's failure to react to the virus. In 1972, he told the journal *Science* that he found it “unforgivable” that federal regulations governing polio vaccine production had not been changed to ensure more thorough screening against the virus. Those regulations are essentially unchanged today.

BARBARA LOE FISHER is a five-foot-one-inch, 49-year-old Washington, D.C., mother-turned-activist who heads the National Vaccine Information Center (NVIC), headquartered in Vienna, Virginia. From the organization's airy, second-story office just outside the Beltway, she and co-founder Kathi Williams have long pushed for greater government disclosure of the little-studied deleterious effects of vaccines upon some recipients and for parents to be allowed to make informed decisions about what vaccines their children receive. The notion of live monkey viruses in the polio vaccine strikes Fisher as alarming and par for the course, at the same time. “Our organization is very concerned that there seems to be so little interest on the part of the government about the issue of exposing millions of children to viruses and other biological agents from other species,” she says. “Nobody knows what the long-term impact might be.”

Fisher notes that as recently as 1995, Swiss scientists found evidence that the live

Walter Kyle

measles-mumps-rubella vaccine, grown on cell cultures of chicken embryos, might be contaminated with avian leukosis virus, which can cause a leukemia-like illness in birds. As long as the polio vaccine and a handful of others are to be mandated for every child, the government has an obligation to prove they are free of contaminants, she says. "Ask any mother if she would approve of her child being given a vaccine that was potentially contaminated with monkey viruses," she says of the polio vaccine. "I think she would tell you, 'No thank you.'"

Cecil Fox was a senior scientist with the National Institutes of Health for 18 years until 1991. There he did cancer research and became a prominent AIDS researcher who discovered that the virus that causes AIDS could live outside the bloodstream and in the lymph nodes. Fox has been concerned about the polio vaccine for many years. He takes issue with Vallancourt's 1972 assertion that since SCMV is "cell-associated" it could not end up in the final vaccine, arguing that fluids containing CMV-infected cells are notoriously difficult to clean up. "Saying it's cell-associated is taking a great leap of faith," he says. "There's no good way of cleaning up a cultured medium or liquid in which a fair amount of CMV has been present. You may be able to filter out all the infected cells, but that doesn't mean that the liquid is no longer infectious."

Although he remains a supporter of the oral polio vaccine, he cautions that continued reliance on monkey kidney tissues for vaccine production carries risks. "There's no way to ensure purity. All you need is one virus in one cell," he says. The use of monkeys, he says, is "a Pandora's box: The risk is that there are still monkey viruses that have not yet been discovered that can be transmitted to humans."

Fox is particularly concerned about the inactivated vaccine, which he believes holds far greater risk than the oral vaccine for transmitting monkey viruses to humans, because it is injected directly into the body. Fox's concern is of renewed interest because the Centers for Disease Control and the Massachusetts Department of Public Health have recently recommended using inactivated vaccine for some of the four recommended childhood doses of polio vaccine in response to concerns about polio caused by the live vaccine. Fox stresses that for many years the original Salk vaccine—an injected vaccine—may have been contaminated with up to 60 different monkey viruses, which he has referred to as the "crabgrass" of the polio vaccine.

At least one of these viruses, simian virus 40 (SV40), was not always killed by the formaldehyde used to inactivate the Salk vaccine. Between 1954 and 1963, up to 98 million Ameri-



MEDICAL MIRACLE: Jonas Salk created the vaccine that freed the world from the horrors of polio.

cans were exposed to SV40 through the polio vaccine. By 1963, all vaccine manufacturers had switched to African green monkeys, a species that is not infected with SV40; and all stocks of contaminated polio vaccine were no longer on the market. Long presumed harmless, SV40 genetic material has recently been discovered in some human brain, bone, and lung cancers. Scientists speculate that it is an oncomavirus, a cancer-causing virus, but that it may take years to cause certain cancers. Fox, who now heads a Gaithersburg, Maryland, research firm, says SV40 highlights the dangers associated with monkeys. "When you inject ground-up monkey guts into children, all kinds of things can happen."

Kyle speculates that the government was reluctant to get tough on Lederle's SCMV problem because it feared running out of vaccine. In fact, Vallancourt noted in his "Cytomegalovirus Contingency Plan" that the company held all the cards should the government decide to crack down on CMV: "Unless and until Pfizer's Diplovax [a rival vaccine] is in abundant supply, the FDA cannot risk Lederle being off the market."

Kyle also believes that Lederle's SCMV problems likely did not end 25 years ago. The 1983 memo, which had documented that the company had tossed almost half of its vaccine-in-production because of contamination problems, cited SCMV as the top culprit. Kyle has also collected hundreds of pages of Lederle's

monthly reports on poliovirus harvests. The reports document that SCMV continued to torment the vaccine manufacturer well into the 1980s. From October 1980 to March 1981, SCMV was particularly vexing, forcing the company to reject 65 percent of its harvests. A January 1981 report complained: "Rejections of harvest produced in October, November ... and December ... have been very high—11 in a row ... and 13 of 14 overall. An unidentified viral agent, strongly resembling or presumed to be cytomegalovirus, is the cause."

In 1986, Lederle was forced to scrap 16 percent of all harvests because of SCMV. As recently as 1987, the last year for which Kyle has information, Lederle documented that it had discarded 30 percent of all its poliovirus harvests during the first half of the year, 8 percent because of SCMV contamination.

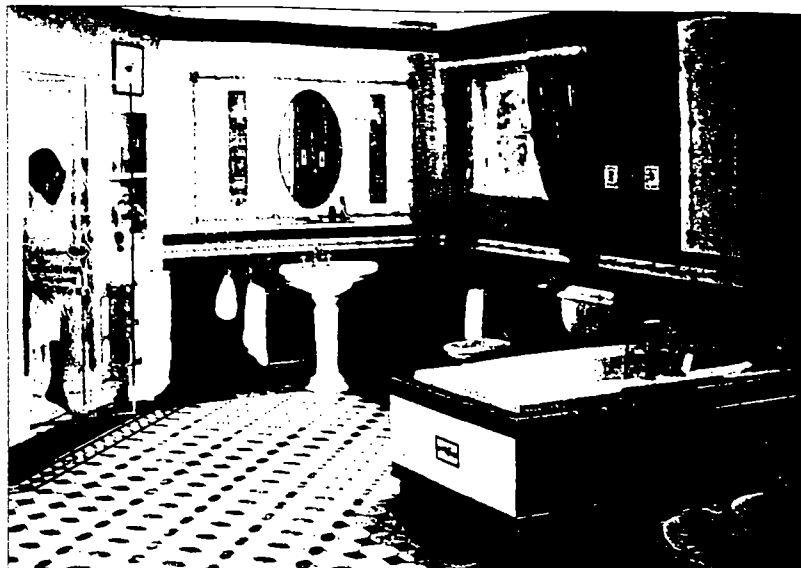
FDA OFFICIALS DISMISS the possibility that the polio vaccine released to the public could be contaminated by SCMV or any other known monkey virus. In a lengthy interview, William Egan, a chemist and deputy director of the FDA's Office of Vaccines Research and Review, and two of his subordinates asserted that the oral polio vaccine is, and has been, free of foreign viruses since SV40 contamination ended in 1963. But as a senior FDA official later clarified: "We can't screen for something we don't know about. We maintain it's free of viruses we

know how to protect from." Many of the scientists contacted for this article who work with monkeys, including Ronald Desrosiers, professor of microbiology and molecular genetics at Harvard Medical School and chairman of the microbiology division of New England Regional Primate Research Center, believe that only a small fraction of the viruses harbored by monkeys have been identified. Desrosiers once described use of monkey tissue in polio vaccine preparation as "a ticking time bomb waiting to explode."

According to Peter Reeve, a virologist and associate director of the FDA's division of viral products, the FDA ceased its own testing for viral contaminants more than 15 years ago. "There was no more point in putting time or effort into getting negative results," Reeve said. "It became clear that it was not necessary to repeat the [manufacturer's] tests because there was a lot of time and money involved." Lederle continues to check for viral contaminants according to the FDA requirements, which place the obligation of testing products on the manufacturer. The FDA itself conducts only routine virulence tests in its effort to minimize vaccine-associated polio.

Kyle says the disclosure that the FDA has suspended its own testing is an example of what he characterizes as the "incestuous relationship" between the agency and the drug companies it regulates. Fisher from the NVIC is also angered by the news, which she says proves her point that the polio vaccine receives little scrutiny because of its sacred-cow status. "They're supposed to be the watchdogs," she says. "But the reality is that they have such a cozy relationship with the drug companies that they are much too lax in regulating the vaccine. They have no business allowing manufacturers to use any sort of animal tissue if they can't guarantee its safety."

Could monkey viruses from the oral polio vaccine have infected people? W. John Martin, a professor of pathology at the University of Southern California, announced in 1995 that he had isolated a virus that was closely related to SCMV from the brains and peripheral blood of two people with neuropsychiatric diseases. Writing in a peer-reviewed journal, *Clinical and Diagnostic Virology*, he posited that the likely source was contaminated doses of the oral polio vaccine. Gary Hayward, a renowned herpes virus expert at Johns Hopkins University, has confirmed that the genetic sequences Martin has sent him are very close to those of an African green monkey cytomegalovirus. "The virus he's working with is not from baboons, or chimpanzees or rhesus. It's definitely from an African green monkey-like species," says Hayward. Martin's work has not been replicated and no one knows today whether Martin's hypothesis—that SCMV or an SCMV variant could be related to chronic fatigue syndrome and other immune-depressive diseases—has



Tiles by Original Style

Voted "Best of Boston™ 1996"
Boston Magazine

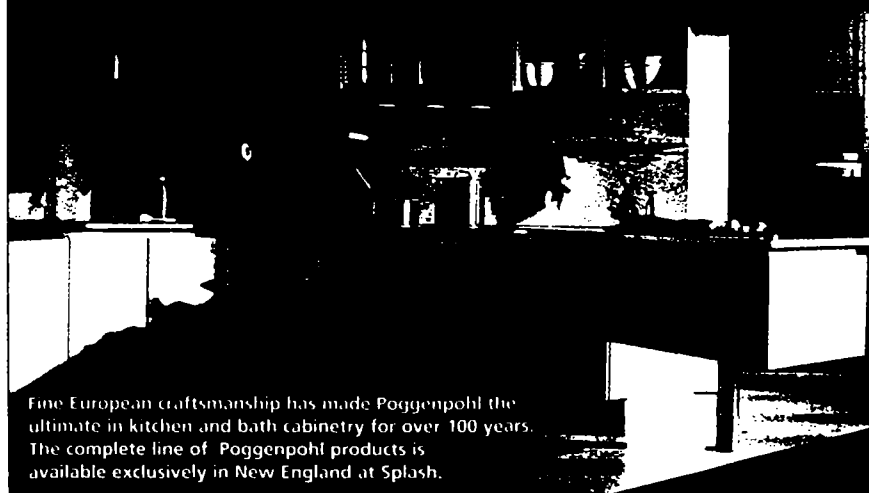
Roma Tile

55 Mount Auburn Street (Route 16)

Watertown, MA (617) 926-7662

See our ad in the NYNEX yellow pages

Visit Splash/Spritzo at <http://www.splashnet.com>
Call The Kitchen Store at Splash for an appointment 800 696 6662



Fine European craftsmanship has made Poggenpohl the ultimate in kitchen and bath cabinetry for over 100 years. The complete line of Poggenpohl products is available exclusively in New England at Splash.

poggen

pohl and Splash---

we are often imitated but never surpassed! **THE KITCHEN STORE AT**

**BEST OF
BOSTON
1996**

SPLASH

244 Needham St. Newton, MA 617 332 6662
MTWTF 9:30-5 TH 9:30-8:30 SAT 10-4

Walter Kyle

any basis.

Martin says his belief that monkey viruses could be playing a role in human disease stems from his own experience testing vaccines at the FDA in the late seventies. He recalls being suspicious of viral DNA in a batch of vaccine and seeking permission from his superior to test it further. Permission was denied, and the agency released the batch containing millions of individual doses.

Martin's story is confirmed by a colleague from the time, G.S. Aulakh, a scientist who recalled that his superiors at the FDA rejected Martin's efforts to test the contaminant. "Nobody tested to see if it was harmful or not," Aulakh recalls. He adds that he has not seen or spoken to Martin since the two men worked together nearly 20 years ago, but his memory of his boss's brush-off is the same. "They told me the testing would scare the people, and it's not in the interest of the American people and this organization to do it," Aulakh says. A postscript: A few years later Martin's superior retired from the FDA and took a job as a senior vice-president with American Cyanamid, the parent company of Lederle.

HARLAND WINTER is a pediatric gastroenterologist who holds multiple staff positions at Children's Hospital, Massachusetts General, and Boston Medical Center. He is an associate professor at the medical schools of Harvard and Boston University. In his home, Winter has a reproduction of an ancient Egyptian papyrus drawing of a person with a polio-withered leg, a reminder that polio has afflicted mankind for millennia. Now polio is near extinction worldwide. But he echoes other clinicians when he says that fear of monkey viruses shouldn't scare people from the vaccine. "I think it would be terrible if people became so concerned about taking vaccines that polio would return," he says.

Susan Lett, medical director of the immunization program of the Massachusetts Department of Public Health, explains that even though the Western Hemisphere was declared polio free in 1991, the possibility of exposure to the virus always exists until the disease is wiped out. "The risk for that happening is declining based on rapid advances in other countries," Lett says, but she adds that people should continue to make sure their children are vaccinated. She says the CDC has never provided her with any data indicating the current vaccine contains dangerous contaminants. "We are all committed at every level to having the safest vaccines available," she says.

For his part, Kyle contends he is not anti-vaccine. What bothers him is the pattern he feels his memos reveal. "There's no reason American kids should be exposed to danger-

ous viruses because of government sloppiness and indifference," he says. Kyle believes that lax regulation of the vaccine has not only exposed Americans to SCMV and other monkey viruses but possibly to a far greater danger—AIDS. He believes that SIV (the simian counterpart to HIV, the human virus that causes AIDS) or possibly even an HIV-progenitor may have been released in millions of doses of polio vaccine in the seventies.

SIV infects up to 50 percent of African green monkeys in the wild. But since it is asymptomatic in the monkeys, Kyle believes infected African greens would not have been excluded from vaccine production prior to the discovery of the virus in 1985. Since then, all monkeys used to make vaccine have been tested for the virus.

Kyle focuses principally on one lot—2 million to 3 million individual doses—of vaccine

"It's in the best interests of the drug companies not to do anything," says a prominent scientist. "Until somebody like Walter Kyle raises enough hell, it's going to continue that way."

released in 1977. The FDA was so concerned about the lot that its release was delayed for an unprecedented 20 months. FDA scientists had discovered the batch, listed as "Lot 3-444," might contain retroviruses (SIV and HIV are retroviruses). Although no one at the time knew about the existence of AIDS, the possibility the vaccine could contain retroviruses prompted the agency to send micrographs—photographs taken through an electron microscope—of suspected viral material found in the batch to three electron microscopists at the National Institutes of Health for review.

Though the scientists were unsure about the identity of the material, the FDA decided the lot was free of contaminants and released it for public consumption. Kyle says that far from making a definitive determination concerning the vaccine's safety, one NIH scientist, in a memo to the FDA, worried about the possibility of retroviruses in the vaccine and warned of the potential for cross-species transfer of viruses. Kyle speculates that Lot 3-444 and perhaps others may have been contaminated with SIV or an HIV progenitor.

It was after he had received and reviewed the extensive documentation on Lot 3-444 that Kyle began research that led him to posit an alternative source for AIDS in North America. In the seventies, some clinicians were administering repeated doses of the oral vaccine to gay men in California and New

York as an unorthodox cure for herpes lesions. Kyle believes that the live virus, which normally would pass through the gut in children without adverse effect, found access to the bloodstream in gay men as a result of the open lesions and sexual activities. Kyle believes that when the HIV-like virus entered the bloodstream, it began its deadly work.

Kyle's theory, far from being dismissed, was published in 1992 by *The Lancet*, one of the most prestigious medical journals in the world. Partially in response to Kyle's claims, this past year FDA scientists tested samples from 12 lots of old polio vaccine for the presence of HIV and SIV. The results, they say, were negative. Howard Urnovitz, a Berkeley microbiologist who is founder and science director of the Chronic Illness Research Foundation, has reviewed the FDA study. He says even if HIV or SIV were not found, the finding of other markers associated with nonpolio viruses is significant. "What's shocking is that there is a polymerase DNA [an enzyme characteristic of a retrovirus]," Urnovitz says. "Because these are vaccines that should only contain [the poliovirus which is] an RNA virus. What it tells us is that they have no idea what's spilling over into the vaccine."

John Coffin, a Tufts professor of molecular biology and microbiology who serves as a senior editor of the highly respected *Journal of Virology*, feels Kyle's AIDS theory "doesn't make a great deal of sense." Like many other scientists, Coffin believes the likely source for the AIDS virus in humans is chimpanzees, not African green monkeys. He observes that the polio vaccine has a 40-year safety record that is "well established" and believes that the vaccine is completely safe as far as retroviruses are concerned. Nonetheless, Coffin says, there is always a possibility of cross-species viral contamination when animal tissues are used. "By continuing to grow the vaccine on monkey tissues, there clearly is a discernible risk," he says. "It would make a lot of sense to move away from monkey tissue."

That view is shared by a number of scientists, including Jonathan Allan, a virologist and internationally known AIDS researcher at the Southwest Foundation for Biomedical Research in San Antonio, Texas. Allan is a supporter of the polio vaccine and says he has no reason to believe it is contaminated. But he agrees that continued use of monkey kidney cells for polio vaccine production is foolhardy.

"There's a lot of scientific evidence that points to the possibility that monkey viruses that typically cause little or no disease in their natural hosts can have disastrous consequences when they jump ship into humans," says Allan, who was a vocal dissident on an FDA panel that approved the baboon bone marrow transplant for AIDS patient Jeff Getty in 1995. In a 1996 *New York Times* op-ed essay, he castigated the FDA and CDC for "muddled" priorities, saying,

"Once a virus invades the human population it is nearly impossible to eradicate it." Allan, like many other scientists interviewed for this article, believes the United States should abandon the use of monkeys and join countries such as Great Britain and Canada that have used more expensive cloned human cells to produce oral and inactivated polio vaccine for many years.

RECENTLY, WALTER KYLE has begun to turn his attention to the many new unexplained diseases that have arisen in the second half of this century. What if some are connected with viral contaminants in vaccines? In Kyle's very first vaccine case, Lederle argued that his client had become paralyzed by a polio vaccine that would not have affected any normal person because she was immuno-compromised in some fashion. Kyle says it was the other way around, and he was angered that the drug company engaged in what he calls a classic "blame the victim strategy." His client was fine until she was exposed to the vaccine. "My thought was there was some agent—monkey viral contaminant—that transmitted transient immune deficiency," he says. "That's why she got paralyzed."

Now Kyle is having tissues and blood samples from clients who have unexplained immune system disorders tested, searching for clues that they may be harboring in their blood monkey virus sequences that came from the polio vaccine. Kyle admits it's a chilling idea that millions of Americans could be walking around with monkey viruses, but given what he knows, it hardly seems far-fetched. What is scarier to him is the continued use of monkeys to manufacture the polio vaccine and continued government indifference. "Why do we continue to take risks with our children when the rest of the world abandoned monkeys a long time ago?" he asks in frustration. "When are we going to wise up?"

Today, even as more and more scientists recognize that there are safer alternatives, Americans continue to have no choice when it comes to polio vaccine: both the oral and injected vaccines available in this country are exclusively grown on monkey kidney cells. Pasteur Mérieux Connaught manufactures an inactivated vaccine from monkeys for U.S. consumption but produces the vaccine on clean cloned human cell lines for Canadian use. Cecil Fox maintains that, despite all the problems associated with monkeys, there is no financial incentive for vaccine manufacturers to give them up.

"It's easy. We've done it for a long time, so we keep on doing it," he says. Fox doubts that U.S. policy will change in the near future, even though the technology exists to readily make a vaccine safe from all contaminants. "It's in the best interests of the stockholders of these companies not to do anything," he says. "Until somebody like Walter Kyle raises enough hell, it's going to continue that way." **B**

Face FACTS

The fact is, the surgeons at Massachusetts Eye and Ear Infirmary specialize exclusively in facial plastic surgery and are faculty members at Harvard Medical School.

And that's good to know, because, when it comes to choosing the right surgeon for your face, you need facts you can trust. Our highly trained surgeons are dedicated solely to enhancing the face through face, neck, and eye lifts; nose, chin, and ear reshaping; laser removal of fine lines and wrinkles; facial liposuction; chemical peel and dermabrasion; and scar revision. For more facts about facial plastic surgery at Mass Eye & Ear, or for a private consultation, please call, *Dr. Richard G. Goss* 617 • 573 • FACE (3 2 2 3) MASSEYE&EAR

THE VACCINE REACTION

"When it happens to you or your child, the risks are 100%"

Special Report

Published by the National Vaccine Information Center
Barbara Loe Fisher, Editor

September 1998

HEPATITIS B VACCINE: THE UNTOLD STORY

Parents Question Forced Vaccination As Reports of Hepatitis B Vaccine Reactions Multiply

In increasing numbers, parents across the country are contacting the National Vaccine Information Center (NVIC) to report opposition to regulations being enacted by state health department officials that legally require children to be injected with three doses of hepatitis B vaccine before being allowed to attend daycare, kindergarten, elementary school, high school or college. Simultaneously, as more schools and employers bow to pressure from government health officials and require individuals to show proof they have been injected with hepatitis B vaccine before being allowed to get an education or a job, reports of serious health problems following hepatitis B vaccination among children and adults are multiplying.

The National Vaccine Information Center (NVIC) maintains that federal and state public health officials are promoting forced vaccination with hepatitis B vaccine without truthfully informing the public about the risks of hepatitis B disease in America or the known and unknown risks of hepatitis B vaccine. Without being provided with accurate and complete information about disease and vaccine risks, citizens cannot exercise informed consent, which becomes a human right when an individual considers undergoing a medical procedure that could cause injury or death.

Following is a general overview of what is and is not known about hepatitis B disease, the hepatitis B vaccine and the politics of hepatitis B vaccination.

HEPATITIS B NOT HIGHLY CONTAGIOUS - Unlike other infectious diseases for which vaccines have been developed and mandated in the U.S., hepatitis B is not common in childhood and is not highly contagious. Hepatitis B is primarily an adult disease transmitted through infected body fluids, most frequently infected blood, and is prevalent in high risk populations such as needle using drug addicts; sexually promiscuous heterosexual and homosexual adults; residents and staff of custodial institutions such as prisons; health care workers exposed to blood; persons who require repeated blood transfusions and babies born to infected mothers.

According to *CDC Prevention Guidelines: A Guide to Action* (1997), a book written by federal public health officials at the U.S. government Centers for Disease Control (CDC), "the sources of [hepatitis B] infection for most cases include intravenous drug use (28%), heterosexual contact with infected persons or multiple partners (22%) and homosexual activity (9%)." According to *Harrison's Principles of Internal Medicine* (1994), mother to child transmission of hepatitis B "is uncommon in North America and western Europe."

Although CDC officials have made statements that hepatitis B is easy to catch through sharing toothbrushes or razors, Eric Mast, M.D., Chief of the Surveillance Section, Hepatitis Branch of the CDC, stated in a 1997 public hearing that: "although [the hepatitis B virus] is present in moderate concentrations in saliva, it's not transmitted commonly by casual contact."

HEPATITIS B NOT A KILLER FOR MOST - Symptoms of hepatitis B disease include nausea, vomiting, fatigue, low grade fever, pain and swelling in joints, headache and cough that may occur one to two weeks before the onset of jaundice (yellowing of the skin) and enlargement and tenderness of the liver, which can last for three to four weeks. Fatigue can last up to a year. According to *Harrison's*, in cases of acute hepatitis B "most patients do not require hospital care" and "95 percent of patients have a favorable course and recover completely" with the case-fatality ratio being "very low (approximately 0.1 percent)."

Those who recover completely from hepatitis B infection acquire life-long immunity. Of those who do not recover completely, fewer than 5 percent become chronic carriers of the virus with just one quarter of these in danger of developing life threatening liver disease later in life, according to *Robbins Pathologic Basis of Disease* (1994), a medical college textbook.

The Guide to Clinical Preventive Services (1996), written under the supervision of the U.S. Department of Health and Human Services (DHHS), states that the risk of developing a chronic hepatitis B infection is higher in infected infants than in infected older children and adults: "Infections during infancy, while estimated to represent only 1-3% of cases, account for 20-30% of chronic infections." Because infants born to infected mothers are at highest risk for developing chronic hepatitis B infections, routine screening of pregnant women for hepatitis B infection is one of the most important public health measures that can be taken to prevent chronic hepatitis B carriers. *The Merck Manual* (1992), a major medical reference used by physicians, notes that "postexposure vaccination is recommended for newborn infants of hepatitis B positive mothers."

HEPATITIS B LOW IN U.S. - The U.S. and western Europe have always had among the lowest rates of hepatitis B disease in the world (0.1% to 0.5% of the general population) compared to countries in the Far East and Africa, where the disease affects 5-20% or more of the population. According to *Guide to Clinical Preventive Services*, in the U.S. "the greatest reported incidence [of hepatitis B] occurs in adults aged 20-39" and "the number of cases peaked in 1985 and has shown a continuous gradual decline since that time."

Even though hepatitis B disease is uncommon in the general population in the U.S., it continues to be high among those engaged in high-risk behaviors, especially IV drug use. *Guide to Clinical Preventive Services* states that "In recent years, a growing number of injection drug users have become infected; currently, between 60% and 80% of persons who use illicit drugs parenterally (through the skin such as with a needle stick) have serologic evidence of [hepatitis B] infection."

In 1991, there were 18,003 cases of hepatitis B reported in the U.S. out of a total U.S. population of 248 million. According to the October 31, 1997 *Morbidity and Mortality Weekly Report* published by the CDC, in 1996 there were 10,637 cases of hepatitis B reported in the U.S. with 279 cases reported in children under the age of 14 and the CDC stated that "Hepatitis B continues to decline in most states, primarily because of a decrease in the number of cases among injecting drug users and, to a lesser extent, among both homosexuals and heterosexuals of both sexes."

CDC RECOMMENDS ALL INFANTS GET HEP B VACCINE - Even though hepatitis B is an adult disease, is not highly contagious, is not deadly for most who contract it, and is not in epidemic form in the U.S. (except among high risk groups such as IV drug addicts), in 1991 the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) recommended that all infants be injected with the first dose of hepatitis B vaccine at birth before being discharged from the hospital newborn nursery. A similar recommendation was also made by the Committee on Infectious Diseases of the American Academy of Pediatrics (AAP). This, despite the fact very little is known about the health and integrity of an individual baby's immune and neurological systems at birth.

In 1991, media reports generated by the CDC used hepatitis B disease statistics that were not anchored in documented fact but are still used today to promote mass hepatitis B vaccination. Most of the inflated disease statistics originate with statements generated by the Centers for Disease Control. In the 1991 ACIP Recommendations calling for mass vaccination with hepatitis B vaccine published in the *Morbidity and Mortality Weekly Report*, the CDC states that there are an "estimated 1 million-1.25 million persons with chronic hepatitis B infection in the United States" and that "each year approximately 4,000-5,000 of these persons die from chronic liver disease" and that "an estimated 200,000-300,000 new [hepatitis B] infections occurred annually during the period 1980-1991." The CDC gives no scientific reference for this data other than the CDC.

Just one year before the government's call for mass vaccination, hepatitis B vaccine maker SmithKline Beecham in their 1990 hepatitis B vaccine product insert stated, "The CDC estimates that there are approximately 0.5 to 1.0 million chronic carriers of hepatitis B virus in the U.S. and that this pool of carriers grows by 2% to 3% (12,000 to 20,000 individuals) annually."

FEDERAL RECOMMENDATIONS BECOME STATE LAWS - Because vaccination requirements are controlled by states and not the federal government, in order for federal health officials to achieve their goal of a 100 percent vaccination rate with new vaccines marketed by drug companies, they must persuade states to turn federal vaccine policies into state law. And, because during the past 50 years, most state legislatures have completely turned over the power to mandate vaccines to state health department officials, very infrequently do state legislators take a vote to approve the mandating of a new vaccine such as hepatitis B. So, while American children born in 1948 were only required by state health officials to show proof of smallpox vaccination to enter school, American children born in 1998 are required by most states to be injected with 33 or 34 doses of 9 or 10 different viral and bacterial vaccines to enter school, including three doses of hepatitis B vaccine.

FEDERAL HEALTH OFFICIALS GIVE STATE HEALTH OFFICIALS MONEY TO FORCE HEP B VACCINATION - Following the 1991 CDC recommendation for universal use of hepatitis B vaccine by all children, state health department officials began issuing mandates requiring children

to show proof they have been injected with three doses of hepatitis B vaccine in order to attend daycare or school. By the end of 1997, 35 states had regulations on the books requiring children to get 3 doses of hepatitis B vaccine and, yet, only 15 states had passed laws requiring prenatal screening of pregnant mothers for hepatitis B infection.

To encourage states to mandate use of hepatitis B vaccine by all children, federal health officials at the Centers for Disease Control give grants and other financial incentives to state health departments to reward them for promoting mass vaccination. Since 1965, the CDC has given state health departments hundreds of millions of dollars through categorical grant programs to promote mass use of federally recommended vaccines. At the same time, if state health officials do not show federal health officials proof they have attained a certain vaccination rate in their state, federal grants to state health departments can be withheld.

In 1993, the Comprehensive Childhood Immunization Act of 1993 was passed giving the Department of Health and Human Services (DHHS) the authority to award more than \$400 million to states to set up state vaccine registries to tag and track children and enforce mandatory vaccination with federally recommended vaccines, including hepatitis B vaccine. The Performance Grant Program rewards a state with either \$50, \$75 or \$100 per child who is fully vaccinated with all federally recommended vaccines, including hepatitis B vaccine and, in 1995, DHHS Secretary Donna Shalala gave the states the power to approve a newborn's social security number in order to set up vaccine tracking registries in more than half the states. The CDC plan is to hook up the state vaccine tracking registries in order to create a de facto centralized electronic database containing every child's medical records.

PHARMACEUTICAL INDUSTRY ALSO FUNDS FORCED HEP B VACCINATION -

In addition to federal grants, many states get money from the Robert Wood Johnson Foundation (Johnson & Johnson), which operates All Kids Count, to set up vaccine tracking systems to enforce state vaccination mandates. (In 1989, Merck & Co., the U.S. manufacturer of the measles, mumps, rubella (MMR), chicken pox and hepatitis B vaccines, joined with Johnson & Johnson to form Worldwide Consumer Pharmaceuticals Co. with the goal of becoming "one of the premier worldwide consumer products companies." Merck's 1997 vaccine sales reached 1 billion dollars.)

All Kids Count is a project of the Task Force for Child Survival and Development headquartered at The Carter Center (former President Jimmy Carter) in Atlanta, which is directed by former CDC director Dr. William Foege. The Task Force is supported by the World Health Organization, World Bank, Rockefeller Foundation, United Nation's Population Fund and vaccine manufacturers, entities which also sponsor the Children's Vaccine Initiative (CVI). The CVI, headquartered in Geneva, was launched in 1990 at the World Summit for Children and promotes "the development and utilization" of vaccines by all of the world's children.

Forced vaccination with hepatitis B vaccine is also promoted in states by non-profit organizations such as Every Child by Two, founded in 1991 by former First Lady Rosalyn Carter and Betty Bumpers, wife of Arkansas Senator Dale Bumpers. Every Child by Two is funded in part by grants from Merck, Lederle and Connaught, the three largest U.S. vaccine manufacturers.

The non-profit CDC Foundation, which began operation in 1995, has raised more than \$15 million in the past four years to augment the CDC's campaign to enforce mass vaccination. The CDC Foundation, the Task

Force for Child Survival & Development and vaccine manufacturers funded the recent National Immunization Conference held in Atlanta.

The five-year-old non-profit Immunization Action Coalition operates the Hepatitis B Coalition, which nationally promotes hepatitis B vaccination for all children. Funding comes from private donations, including a grant from SmithKline Beecham, manufacturer of the hepatitis B vaccine, and a new \$750,000 grant from the Centers for Disease Control. A newsletter produced by this group contains the assurance that "Everything herein is reviewed by the Centers for Disease Control and Prevention for technical accuracy (unless it is an opinion piece written by a non-CDC author)."

PHARMACISTS NOW VACCINATE - SmithKline Beecham, through the American Pharmaceutical Association, has also funded a nationwide campaign called "Pharmacy-Based Immunization Advocacy" which allows pharmacists to vaccinate children and adults. As of 1998, the Hepatitis B Coalition reports that 23 states have passed laws giving pharmacists the right to sell and administer hepatitis B and other vaccines.

FAMILIES PENALIZED FOR REFUSING HEP B VACCINE - As state health departments accumulate power and money to force vaccination with all federally recommended vaccines, including hepatitis B vaccine, child and adult citizens are punished by both federal and state health officials with economic sanctions for refusing to comply. Refusal to be injected with hepatitis B vaccine can result in citizens being denied an education, including enrollment in daycare, elementary school, high school, college and graduate school; denial of health insurance; denial of employment; denial of federal entitlement benefits for poor children including food under the Women, Infants and Children (WIC) program and medical care under Medicaid. In some states, like Texas, a needy family loses \$25 per month per child in state health benefits if all children have not received all federally recommended vaccines, including hepatitis B vaccine.

HEP B VACCINE LICENSED BY FDA WITHOUT ADEQUATE PROOF OF LONG TERM SAFETY - In 1986, the FDA gave Merck & Co. a license to market the first recombinant DNA hepatitis B vaccine, which replaced the old hepatitis B vaccines made from blood taken from human chronic hepatitis B virus carriers. In awarding Merck & Co. and, later, SmithKline Beecham Pharmaceuticals, licenses to market their genetically engineered hepatitis B vaccines in the U.S., the FDA allowed both drug companies to use "safety" studies which only included a few thousand children monitored for only four or five days after vaccination to check for reactions. As "proof" their hepatitis B vaccine is safe to be used in children, Merck & Co. stated in their 1993 product insert that "In a group of studies, 1636 doses of RECOMBIVAX HB were administered to 653 healthy infants and children (up to 10 years of age) who were monitored for 5 days after each dose."

Merck & Co. found that injection site and systemic complaints, such as fatigue and weakness, fever, headache and arthralgia (joint pain), were reported following up to 17 percent of all hepatitis B injections. Because the FDA did not require drug companies to provide scientific evidence that hepatitis B vaccine does not compromise the immune and neurological systems of children and adults over weeks, months or years post-vaccination, Merck & Co. warns in the 1996 product insert that "As with any vaccine, there is the possibility that broad use of the vaccine could reveal adverse reactions not observed in clinical trials" and SmithKline Beecham (1993) has a similar warning that "it is possible that expanded commercial use of the vaccine could reveal rare adverse reactions."

Another warning in the Merck 1996 product insert is "it is also not known whether the vaccine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity" and "it is not known whether the vaccine is excreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when the vaccine is administered to a nursing woman."

And, although doctors routinely inject hepatitis B vaccine into children along with many other vaccines such as DPT, HIB, MMR and chicken pox vaccine, Merck & Co. state in the 1996 product insert: "Specific data are not yet available for the simultaneous administration of RECOMBIVAX HB with other vaccines."

HEP B VACCINE EFFICACY ALSO QUESTIONED - All vaccines stimulate only an artificial, temporary immunity, and the length of immunity conferred by the hepatitis B vaccine and the future need for more "booster" doses later in life is still not clear. Merck & Co state in their 1996 hepatitis B vaccine product insert that "the duration of the protective effect of RECOMBIVAX HB in healthy vaccinees is unknown at present and the need for booster doses is not yet defined."

In the *CDC Prevention Guidelines: A Guide to Action* (1997), the CDC states "The duration of protection [of hepatitis B vaccine] and need for booster doses are not yet fully defined. Between 30% and 50% of persons who develop adequate antibody after three doses of vaccine will lose detectable antibody within 7 years but protection against viremic infection and clinical disease appears to persist." If immunity only lasts 7 years, babies vaccinated with hepatitis B vaccine may be candidates for more shots at age seven.

IOM REPORT REVEALS LACK OF ADEQUATE SCIENTIFIC STUDIES - In *Adverse Events Associated with Childhood Vaccines* published in 1994 by the Institute of Medicine, National Academy of Sciences, observations about the limitations of hepatitis B vaccine studies included the statements that "it is important to note that individual trials usually involved a few hundred subjects for study...when larger vaccination programs were monitored, observations of adverse events were necessarily less detailed and less accurately reported" and "the studies were not designed to assess serious, rare adverse events; the total number of recipients is too small and the follow-up generally too short to detect rare or delayed serious adverse reactions."

The IOM report also noted that no controlled observational studies or controlled clinical trials have ever been held to evaluate repeated reports that hepatitis B vaccine can cause Guillain-Barre syndrome; arthritis; transverse myelitis, optic neuritis, multiple sclerosis and other central demyelinating diseases of the nervous system (degeneration of the myelin sheath of the brain that helps transmit nerve impulses); or sudden infant death syndrome (SIDS).

A major conclusion of the Institute of Medicine report was that almost no basic science research has been undertaken to define at the cellular and molecular level the biological mechanism of vaccine-induced injury and death. The report concluded that "The lack of adequate data regarding many of the adverse events under study was of major concern to the committee...the committee encountered many gaps and limitations in knowledge bearing directly or indirectly on the safety of vaccines. These include inadequate understanding of the biologic mechanisms underlying adverse events following natural infection or immunization, insufficient or inconsistent information from case reports and case series...and inadequate size or length of follow-up of many population-based epidemiologic studies...."

MEDICAL LITERATURE CITES IMMUNE SYSTEM/BRAIN DAMAGE - During the

past decade, there have been many reports in the medical literature (primarily in international medical journals rather than U.S. medical journals) that hepatitis B vaccination is causing chronic immune and neurological disease in children and adults, including *lupus*: Tudela & Bonal (1992); Mamoux & Dumont (1994); Guiserix (1996); *arthritis, including polyarthritis and rheumatoid arthritis*: Christan & Helin (1987); Hachulla et al (1990); Rogerson & Nye (1990); Biasi et al (1993),(1994); Vautier & Carty (1994); Hassan & Oldham (1994); *Rheumatic Review* (1994); Gross et al (1995); Pope et al (1995); Cathebras et al (1996); Soubrier et al (1997); *Guillain Barre Syndrome GBS*: Shaw et al (1988); Tuohy (1989); *demyelinating disorders such as optic neuritis, Bell's Palsy, demyelinating neuropathy, transverse myelitis and multiple sclerosis*: Shaw et al (1988); WHO (1990); Reutens et al (1990); Herroelen et al (1991); Nadler (1993); Brezin et al (1993); Mahassin et al (1993); Kaplanski et al (1995); Baglivo et al (1996); Marsaudon & Barrault (1996); Berkman et al (1996); Waisbren (1997); *diabetes mellitus*: Poutasi (1996); Classen (1996); *chronic fatigue*: Salit (1993); Delage et al (1993); *vascular disorders*: Fried et al (1987); Goolsby (1989); Cockwell et al (1990); Poullin & Gabriel (1994); Mathieu et al (1996); Graniel et al (1997); and others.

In 1996, Burton A. Waisbren, M.D., a cell biologist and infectious disease specialist, who is a founding member of the Infectious Disease Society of America and past President of the Infectious Disease Society of Milwaukee, pointed out in the *Wisconsin Medical Journal* that "there is an increasing number of reports in the refereed medical literature about demyelinating diseases occurring after an individual has received the hepatitis B vaccination...since the hepatitis B virus itself has been reported to cause autoimmune problems, should we not be wary of giving antigens that seem to have triggered these problems?" Waisbren, in a presentation before a 1996 Institute of Medicine Vaccine Safety Forum, warned that genetically engineered hepatitis B vaccines contain polypeptide sequences that are present in human neurologic tissues such as myelin and that, by a mechanism called molecular mimicry, these polypeptides can act as autoantigens which can induce autoimmune demyelinating diseases of the brain such as multiple sclerosis.

In that same year, Montinari et al published a study in Italy evaluating 30 children and adults, the majority aged 3 to 9 months, who suffered central nervous system disorders, such as seizures and autism, following hepatitis B vaccination. The purpose of the study was to investigate whether there is an immunogenetic basis (autoimmune type) responsible for the demyelination process in the brain that can occur following recombinant hepatitis B vaccination. The authors concluded "autoimmune diseases are more frequent in nations where vaccines are widely used, the so called "clear" communities" and they identified several potential genetic markers that "may visualize risk patients for autoimmune diseases following hepatitis B vaccination.

Montinari's work to identify genetic factors for predisposition to hepatitis B vaccine reactions is important in light of the study in 1989 by Alper et al to identify genetic factors for those who do not respond to hepatitis B vaccination. In that study, the authors concluded that there was genetic predisposition to failure to respond to the vaccine. They stated: "These results support our hypothesis that the production of anti-HBsAg [vaccine-induced antibodies] is a dominant trait and that the inability to produce high titers of anti-HBsAG after adequate immunization is a recessive trait..." The authors concluded that the genetic markers they identified are most prevalent in caucasians of European descent "and is associated with a wide variety of diseases with autoimmune features in this population, including Type I diabetes mellitus..."

In 1996, Barthelow Classen, M.D., CEO of Classen Immunotherapies Inc., published an epidemiologic study in the *New Zealand Medical Journal* and reported that there was a 60 percent increase in Type I diabetes (juvenile diabetes) following a massive campaign in New Zealand from 1988 to 1991 to vaccinate babies six weeks of age or older with hepatitis B vaccine. His analysis of a group of 100,000 New Zealand children prospectively followed since 1982 showed that the incidence of diabetes before the hepatitis B vaccination program began in 1988 was 11.2 cases per 100,000 children per year while the incidence of diabetes following the hepatitis B vaccination campaign was 18.2 cases per 100,000 children per year.

VACCINE INJURIES REPORTED AT NVIC CONFERENCE ON VACCINATION -

At the First International Public Conference on Vaccination sponsored by the NVIC on September 13-15, 1997 in Alexandria, Virginia, physicians and scientists from around the world gathered to speak about vaccine-induced chronic illness. Canadian physician Byron Hyde, M.D., Chairman of the Nightingale Research Foundation, and an internationally recognized authority on myalgic encephalomyelitis (also known as chronic fatigue syndrome), spoke about the data he has accumulated on more than 200 cases of serious immune and neurological dysfunction following hepatitis B vaccination. Dr. Hyde said:

"There was a nurse in Wisconsin who had had two immunizations against hepatitis B. After the second, she started to complain. They insisted that she have three more [shots], full dosage. They gave her the first, she complained of headaches, pain, and they told her this was anxiety neurosis. They gave her the fourth and fifth and she lost I.Q., measurable loss of intelligence, measurable loss in stamina, all of the things you see in the worst cases of ME or chronic fatigue syndrome.....A lot of these cases that we've looked at suggest demyelinating disease, disseminated myelitis, localized injuries, three unexplained deaths...the problem with all of this is that nobody has ever seriously studied it...."

Dr. Hyde was particularly critical of the poor science and medicine that hurts patients. He concluded "Almost all of these people who had adverse reactions after the first immunization, after the second immunization were individuals who had immunological side effects and who told their physicians and the physicians did nothing about it but continued to proceed with immunization... I think part of the problem is the pharmaceutical companies and the governments themselves have attempted to say 'Here, take this sugar pill, it is danger-free, it is a wonderful thing, it has no risk, no problems' and doctors have become lazy and actually believed this dangerous philosophy put out by the pharmaceutical companies and the governments."

HEP B VACCINE INFANT DEATHS REPORTED IN VAERS - Even though fewer than 10 percent of all doctors report health problems following vaccination, there are more than 16,000 reports of hospitalizations, injuries and deaths following hepatitis B vaccination that have been reported to the U.S. government Vaccine Adverse Event Reporting System (VAERS) since July 1990. There are reports of deaths in infants under one month of age following hepatitis B vaccination in VAERS, with most of the deaths being classified as sudden infant death syndrome (SIDS), even though SIDS is not historically recognized in the medical literature as occurring in babies under two months of age.

One of those death reports was made for a 15-day old baby boy who died within 48 hours of his first dose of hepatitis B vaccine. His father testified at a 1995 Institute of Medicine Vaccine Safety Forum workshop. He described what happened:

"For the first 13 days of his life, Nicholas was no different than any other baby. He ate well. When he slept, he slept well. He acted just like my first son acted when he came home from the hospital." Nicholas was given a hepatitis B shot at his regular check up at the pediatrician's office on the 13th day of his life. His father said:

"That night when I got home from work, I noticed that Nicholas was crying a lot more than usual. In fact, he was screaming some of the time. He was acting differently, but because we had just taken him to the doctor for a checkup and they told us he was a big healthy boy, we thought everything was OK. When he was just acting fussy, like babies sometimes do, we didn't know anything about vaccines or that they can cause problems for some babies."

"Nicholas cried on and off for most of the night. When I got up and went to work the next day, he was still crying on and off. He continued during most of the day and into the evening. The next morning, his mother found him dead in his crib. From the way he looked, he had been dead for several hours."

An autopsy was done the next day. A couple of weeks later, our pediatrician told us over the phone that the autopsy showed Nicholas had died of sudden infant death syndrome. He told us Nicholas was one of the healthiest babies he had ever seen.... What I didn't know then but I know now is that the pediatrician had made a report within 17 days of Nicholas' death to the government's Vaccine Adverse Event Reporting System, VAERS. In VAERS, Nicholas' death is listed as SIDS. Even though I didn't know anything about vaccines or SIDS, something told me that there was a reason why Nicholas died, and I had to find out why."

After seeing an article in the *Washington Post* about the Institute of Medicine report on adverse events associated with childhood vaccines, Nicholas's father called the National Vaccine Information Center and began talking to experts and researching infant death and vaccines. Eventually a clinical professor of pathology, who had reviewed Nicholas' medical records, autopsy and slides, stated in writing that Nicholas did not die of SIDS but died a cardiac death, caused by passive congestive changes with pulmonary edema and hemorrhage caused by the active immunization with hepatitis B vaccine. The pathologist stated "I do not believe this was a sudden infant death syndrome death. Sudden infant death syndrome is the most abused diagnosis in pediatric pathology. In this particular case, the infant was two weeks old. Sudden infant death at two weeks old is so rare as to be virtually unheard of."

The pathologist went on to say that Nicholas was at high risk for congestive heart failure because his mother had gestational diabetes, but that he would definitely have survived were it not for the stress induced by the hepatitis B vaccination.

Nicholas's father, in his testimony before the Institute of Medicine, asked "How many other newborn babies are dying from the effects of hepatitis B vaccine, but are being wrongly diagnosed as SIDS and no one ever knows the difference? I looked at the computer printouts of VAERS reports at the National Vaccine Information Center, and I saw there were other reports of babies just a few days or weeks old, who have died shortly after hepatitis B vaccination. Many are listed as SIDS deaths, but are they?"

ADULTS REPORT HEP B VACCINE INJURY AND DEATH TO NVIC - As hepatitis B requirements force more adults to get vaccinated as a condition for getting a higher education or working in the health care field, NVIC is receiving more and more reaction reports like this one from a disabled nurse, who recently wrote in:

"24 hours after my first [hepatitis B] shot, I had muscle pain in legs and arms - was told this was 'normal.' Same thing after 2nd shot. Six weeks after 2nd shot I had my first episode of Raynauds [temporary loss of blood flow to fingers resulting in tingling, throbbing, swelling, intense pain] and also began having rashes on arms and neck. At this point it was minor and not constant. I asked if it had anything to do with the vaccine and was told no.

"Six months after the 1st shot, I received the booster. From then (1995) to today, I have constant daily fevers up to 100.5, tormenting rashes and prickling on arms, hands, neck and legs, muscle degeneration, joint pain with restricted movement, difficulty swallowing and Raynauds has become severe.

"I was perfectly healthy until the hepatitis B vaccinations and still all the doctors tell me it has nothing to do with my illness. I had reactions to two of the drugs they tried to treat me with. I am on total disability because of these symptoms. I am an RN but was taught that the vaccines were perfectly safe."

PARENTS OPPOSE HEPATITIS B VACCINE MANDATE IN ILLINOIS - In the spring of 1997, a suburban Chicago mother of two daughters, ages 9 and 11, became concerned when she received a notice from the school system stating that her older daughter had to be vaccinated with hepatitis B vaccine by September 1997 or she would be barred from attending school. Although both of Kathy Rothschild's daughters were fully vaccinated with all other childhood vaccines, she didn't know anyone with hepatitis B and couldn't understand why her daughter had to get the vaccine. Her research led her to a public library and then to NVIC.

With the help of Kathy Rothschild's State Senator, Kathy Parker, an agreement by the Illinois Department of Health to not voice opposition, and with support from NVIC members around the state, a bill passed the Illinois Senate 52-2 on March 20, 1997, allowing parents the right to philosophical exemption to vaccination. The bill also created a Task Force and required the Board of Health to hold public hearings to review how Illinois public health employees add new vaccines to state vaccination laws and how they implement those laws.

After the bill overwhelmingly passed the Senate, the Illinois Department of Health went back on its pledge not to oppose the bill and vigorously fought against the bill in the House, successfully killing it in committee before it had a chance to come to a floor vote. However, the health department did agree to roll back the hepatitis B mandate for one year (until September 1998) and to hold three public hearings, which resulted in testimony from physician expert witnesses and parents and reinforced the dangers of hepatitis B vaccine and the need for informed consent rights to be established within state vaccine requirements.

DOCTOR, MOTHERS SAY VACCINE SAFETY DATA POOR - In a December 1997 public hearing in Chicago before the Illinois Board of Health, Mayer Eisenstein, M.D., M.P.H., who is board certified in public health and preventive medicine, quality assurance utilization review, by the National Board of Medical Examiners and has recently completed a law degree, testified against the proposed hepatitis B mandate. He said: "The idea of giving this vaccine to a one-day old baby, a newborn, is preposterous. There is no scientific evidence for this. In fact, I called up the [hepatitis B vaccine] manufacturer and I had [a representative] come to St. Mary of Nazareth Hospital, where I am Chairman of the Department of Medicine, and I asked him: 'Show me your evidence on one-day old infants as to side effects [from the hepatitis B vaccine]' - we have none. Our studies were done on 5 and 10 year olds....As a father, grandfather,

a physician, as a lawyer, I want the option of not giving it to my children unless I believe the scientific evidence is there."

Later during the public hearing, a mother whose child reacted to the hepatitis B vaccine testified that "We were told unless we had the shot our children were not getting into school. In the past, I got the shots for my children. So I went and got the [hepatitis B] shot. First shot, my daughter got slightly sick. We didn't associate it with the shot. We associated it with possible flu. Her legs hurt. Her back hurt...."

"The second shot, within two days of this shot, my daughter's symptoms went from mild to severe abdominal pain around the clock. She couldn't eat. She couldn't sleep. Her legs hurt. She broke out in a rash. She had eczema over most of her body. Going to the doctor, we were told it was in her head, that she needed a psychiatrist. Then we decided we would find out for ourselves.

"It was the people who gave me [information on the vaccine], the list that I should have gotten first that said what the reactions were, including severe abdominal pain, eczema, rash, hair loss. My doctor didn't tell me that. I was given a piece of paper that said reactions would be a minimum, maybe a small fever. She had a fever the whole time.

"I never knew any of this existed, and this is \$18,000 later, a child who [had to be] out of school for the first three months and was tutored at home. I don't want to see other kids go through this. I think there should be more testing done. I think the parents should know that this shot isn't for something that's easily picked up. This is for sexual transmission or drug use. My child is ten years old. She plays with Barbie dolls and paints her fingernails. She doesn't know about this stuff. I don't want to give her a shot to protect her from something and someplace she's not at yet."

CITIZENS MAKE PLEA FOR INFORMED CONSENT - Before testifying at a Board of Health public hearing held in Springfield on March 26, 1998, NVIC held a press conference in the State Capitol building. Then, along with scores of Illinois parents who traveled to Springfield to make public comment, NVIC President Barbara Loe Fisher Reverend Robert VandenBosch, President of the American Research Foundation, and Bonnie Dunbar, Ph.D., professor of cell biology at Baylor College of Medicine in Houston, presented formal testimony.

Fisher told the Board of Health "There is a six year old girl named Katherine lying in a bed in Skokie, Illinois unable to lift her head off her pillow or walk to the bathroom. Just 13 weeks ago, Katherine was an ice skater with boundless energy and a dream of going to the Olympics. Her mother didn't want her to get the hepatitis B shot but her pediatrician told her it was a political issue like AIDS and the American Academy of Pediatrics (AAP) was going to mandate the vaccine soon. Katherine got that hepatitis B shot and now she may never skate again. Where were her informed consent rights? And where will the doctors from the state health department and the CDC and the AAP be when her mother carries her up the stairs to the bathroom? And will the state of Illinois pay her medical bills when her insurance runs out after DHHS and the Justice Department oppose giving her federal compensation?"

During limited public comment time, all of the parents asked the Board of Health to allow citizens to follow the judgement of their conscience when making vaccination decisions for their children, including the right

to exercise informed consent to vaccination without suffering harassment and punishment at the hands of state health and school officials. Some, like a young man who was kicked out of an Illinois college in the middle of the semester because of his sincere religious beliefs, asked for the right to follow his religious convictions without being punished by doctors employed by the state. He said:

"They have refused to give me credit for this semester and have told me not to attend class and have cancelled my appointment with my advisors. I applied for a religious exemption. Both my parents wrote letters identifying my objection. We were refused on the grounds that, in order for a religious exemption to occur, I must identify 'a recognized church or religious organization.' I don't believe that anyone has a right to judge my religion. How does recognition of my belief by another human being make it more or less? I am confused by the word 'organized.' How does the number of people or the structure under which they operate validate my beliefs? This is a violation of my Constitutional right to religious freedom."

Rev. Robert VandenBosch, an ethicist, warned that "The First Amendment [of the U.S. Constitution] clearly defines the free exercise of religious beliefs and the moral rights of individuals to obey the judgement of their conscience in matters of life and death. The Ninth Amendment of the Constitution guarantees that governmental authority cannot override individual rights of conscience. It states: 'The enumeration of the Constitution of certain rights shall not be construed to deny or disparage others retained by the people.' One of the rights retained by the people is the right of conscience."

PROFESSOR OF CELL BIOLOGY INVESTIGATES HEP B VACCINE DAMAGE -

Professor Bonnie Dunbar, Ph.D., who has a distinguished 25 year career in academic and laboratory science and has been honored by the U.S. National Institutes of Health (NIH) for her pioneering work in contraceptive vaccine development, presented at the March 26 Illinois Board of Health hearing and described disabling reactions to hepatitis B vaccine suffered by her brother and a research assistant.

"Three years ago my brother, who is a geologist Ph.D. agronomist with four college degrees, came to work with me at Baylor College of Medicine to work on a collaborative project in molecular genetic engineering of wheat proteins. He was required to take the hepatitis B vaccine. Within 24 hours to four days after the first injection, he had fever and severe fatigue for one week. Two to four weeks after that injection, he ended up with a whole series of symptoms that now 15 doctors have said are clearly symptoms of an adverse reaction to this vaccination. Even workman's compensation for the state of Texas is compensating him for over \$300,000 worth of medical expenses."

"At about the same time, a 21-year old girl, a medical student, came to work in my lab for the summer. She, too, had to get the hepatitis B vaccine. After the first injection, she had fever and fatigue. Three weeks following her second injection, she lost vision in her one eye but, after 6 months, regained most of her sight. She was reluctant to get the third dose of vaccine, and talked with her doctor and he told her this [hepatitis B] vaccine is the safest, there's no problem. After the third injection, she ended up in the hospital for two months extremely ill and she has lost all of her eyesight in one eye."

Dr. Dunbar went on to explain to the Board of Health members that during the past three years of collecting data on the hepatitis B vaccine, she has been contacted by hundreds of doctors and patients around the world who have reported severe autoimmune and neurological complications to hepatitis B vaccination in previously

healthy children and adults, including serious rashes, fever, joint pain, chronic fatigue, multiple sclerosis and lupus-like symptoms, rheumatoid arthritis and neurological dysfunction. As a basic science researcher with expertise in cell and molecular biology, she is investigating the possibility that molecular mimicry or other autoimmune mechanisms may be the reason why the genetically engineered hepatitis B vaccine "tricks" the immune systems of genetically susceptible individuals into attacking their own bodies, causing debilitating autoimmune disorders.

After analyzing the data she has accumulated, Dr. Dunbar, in collaboration with colleagues at other academic and medical institutions, applied for a NIH research grant to investigate the role that genetic factors may play in hepatitis B vaccine reactions and in vaccine failures. Their goal is to identify genetic markers so high risk children and adults could be screened out of the mass vaccination program and spared injury and death. The grant was turned down twice by the government in July 1997 and July 1998 but Dr. Dunbar and her colleagues are in the process of refiling the grant, along with additional data.

HEP B VACCINE VICTIMS IN FRANCE SUE - An article in the July 31, 1998 issue of *Science*, an American scientific journal, reports that French attorneys representing 15,000 French citizens filed a lawsuit against the French government "accusing it of understating the vaccine's risks and exaggerating the benefits for the average person." One French physician has reportedly collected data on more than 600 people suffering from serious immune and neurological dysfunction following hepatitis B vaccination, many with symptoms resembling multiple sclerosis. *Science* quotes a World Health Organization official as saying "These fears [of the hepatitis B vaccine] are quite unfounded" and reveals that CDC employee Robert Chen, who is responsible for monitoring vaccine safety for the U.S. government, has a simple explanation for the growing number of reports of hepatitis B vaccine associated injury and death in the U.S., Canada and Europe. His scientific analysis leads him to believe that "It's human nature to attribute cause to almost anything that precedes a tragedy."

HEP B VACCINATION CAN MEAN A POSITIVE HEP B BLOOD TEST - A little known fact about hepatitis B vaccine is that those who are vaccinated can test positive for hepatitis B on some routine blood tests. NVIC has received calls from adults who report that, after getting hepatitis B vaccine, they are testing positive for hepatitis B when they undergo routine blood tests in doctor's offices. The Red Cross maintains that more sensitive lab tests used by blood banks can differentiate between hepatitis B antibodies produced by disease and those produced by the vaccine.

HIV vaccines now being tested in humans also produce positive tests for HIV. As noted in a September 1997 *Washington Post* article about HIV vaccine trials: "Foremost among the worries of many would-be volunteers is the problem of forever testing positive for AIDS antibodies...although sophisticated laboratory tests can usually tell the difference between AIDS antibodies caused by a vaccine and those that indicate a real HIV infection, few laboratories are equipped to make that distinction. Moreover, as vaccines get better by more closely mimicking the real infection, it will become more difficult to distinguish between the two."

IS FORCED HEPATITIS B VACCINATION PAVING WAY FOR FORCED VACCINATION WITH AIDS VACCINE? - Hepatitis B is the first disease transmitted not by casual contact like smallpox or polio, but by high risk behavior such as IV drug use and sexual promiscuity, that has been mandated for use by all children. With the identical transmission routes as HIV, there are

strong indications that forced vaccination of infants and children with hepatitis B is a trial run for forced vaccination with an AIDS vaccine when it is put on the market in the next few years. AIDS vaccines are currently in human trials as a race to bring them to market intensified after a call last year by President Clinton to make the creation and use of an AIDS vaccine "a national mission."

CDC PLANS FOR MASS VACCINATION OF ALL CHILDREN WITH AIDS VACCINE

- In a February 12, 1997 meeting of the CDC's Advisory Committee on Immunization Practices (ACIP), Neal Halsey, M.D., chairman of the American Academy of Pediatrics (AAP) Committee on Infectious Diseases, AAP liaison member of the ACIP and Director of the Institute of Vaccine Safety at John's Hopkins University, reminded HIV vaccine researchers and developers at the meeting that the CDC plans to target 11 to 12 year old children for "universal application" of an HIV vaccine. Halsey told them:

"One of the things that's happened in the past with vaccines is that sometimes the manufacturers have developed them and tested them primarily in an age group or a population which may not be the final target population that this committee has considered. Over the last few years we have developed a statement on adolescent immunization and it probably would be worth your reading that, and others, because we really see age 11 to 12 as the target age for introduction of vaccines for prevention of sexually transmitted diseases. And I know that, at this time, you are really studying adults and you're also some distance away from the actual - having a [HIV] vaccine in hand that might be licensed and approved - but at least it would be nice if there were studies that were planned in parallel when you move another step in the direction of actually having a candidate vaccine, realizing where WE think we would want to use universal application of such a vaccine. And so I think maybe [you should get] a copy of the adolescent immunization statement."

With the Children's Vaccine Initiative (CVI) and pharmaceutical industry setting up the mechanism for global mass vaccination of children and adults, including the creation of national and international vaccine tracking systems, countries with low HIV rates like the U.S. and Europe will be forced to use an HIV vaccine in order to pay for the vaccination of populations in Asia and Africa where HIV infection rates are skyrocketing. In 1996, HIV vaccine developer Stanley Plotkin, M.D., of Pasteur Merieux Pharmaceuticals (who developed the rubella vaccine and has been a vaccine policymaker member of the AAP Committee on Infectious Disease and AAP liaison member of the ACIP) explained why mandatory vaccination in rich countries like the U.S. help deliver vaccines to Third World markets:

"The keystone of the [global mass vaccination] system is that the research costs [of drug companies] are recouped in North America and Europe and the vaccines are sold in the developing world at much, much lower margins...the relatively high rate of childhood vaccination seen lately in most parts of the world is the result of that system," explained Plotkin.

CDC TELLS CONGRESS ABOUT FUTURE VACCINES - In testimony before the U.S. Senate Committee on Labor and Human Resources in 1997, CDC official Walter Orenstein, M.D., made a bid to persuade Congress to reauthorize 288 million dollars for the CDC's Immunization Grant Program in the \$427 million 1998 DHHS budget request for immunization activities. In a review of the history of vaccination, Dr. Orenstein recounted that, although almost a century passed between the development of the smallpox vaccine in 1796 and that of the rabies vaccine in the 1880's, by the middle of the 20th century there were nearly two dozen vaccines on the market.

Painting a picture of the future, Orenstein said: "On the horizon are vaccine technologies that would have been considered science fiction just a decade ago, but are now reported at scientific meetings. Snippets of synthetic DNA have worked as experimental vaccines in animals. Edible plants have been bioengineered to become vaccine factories....vaccines have been enclosed in microscopic capsules, permitting them to be released slowly over time..."

Orenstein reminded legislators that "Every day about 11,000 babies are born in this country. Each of these children starts with immunization coverage of zero. There is why our responsibility to our Nation's children never ends: it must be sustained every day of every year....completing state-based immunization registries is the cornerstone of assuring disease prevention."

VACCINE REGISTRIES TO TAG, TRACK, FORCE VACCINATION -

Even though CDC officials admit that there is already a 96 percent vaccination rate in the U.S. with federally recommended vaccines, they are setting up state vaccine tracking registries and plan to link them together to create a de facto national electronic tracking system to ensure mass compliance with federal vaccine policies. Citizens will be tagged with a number at birth and tracked even when moving from state to state.

In 1995, DHHS Secretary Donna Shalala appropriated the social security numbers assigned to newborns to allow states to enter all babies in state vaccine tracking systems. In 1996, the Health Insurance Portability and Accountability Act (HIPAA), also known as the Kennedy-Kassebaum legislation, outlined plans for a "unique health care identifier" number, which is an alternative to the social security number, to be assigned to citizens at birth and electronically monitor their medical records, including vaccination records.

In a 1998 CDC publication entitled *Initiative on Immunization Registries*, the CDC states that "we see [vaccine] registries as a possible first step in the development of an electronic pediatric record" and "computerized registries will eventually be capable of capturing immunization for individuals of all ages" and "until a unique personal identifier can be established on a national basis, multiple means of identification must be used [in state vaccine registries]." Core data that is now collected in many state vaccine tracking systems include a citizen's name, address, phone number, social security number, birth date, sex, race, primary language, patient birth order, patient birth registration number, patient Medicaid number, mother's name (including maiden name) and social security number and father's name and social security number.

Most often state officials automatically enroll newborns into the vaccine registry without informing parents or giving them the right to "opt-out" of the registry. In the state of Texas, PROVE, a parent group led by Dawn Richardson, worked to get legislation passed in 1997 requiring the state health departments to obtain a parent's prior written consent to enroll a child in a vaccine registry.

The CDC goes on to state that one of their main goals is "establishing a target date to achieve the goal of establishing immunization registries in every community in the Nation" and "promoting the inter-operability of registries with other developing medical information systems" and "promoting the automated exchange of immunization records between registries."

WHAT YOU CAN DO - If you want to make informed, voluntary decisions about hepatitis B vaccination, there are several actions you can take to educate your community and protect your informed consent and privacy rights.

Circulate this newsletter in your community among your family, friends, and neighbors. Get reprints by sending in the enclosed reprint order card. Reprints are available for \$1.25 each. Bulk pricing is available. Give copies to your doctors, lawyers, teachers, school principals, nurses and others. Send a copy to your favorite newspaper, radio and TV station. Send a copy to your state and federal legislators with a personal letter.

Report vaccine reactions by calling NVIC at 1-800-909SHOT or accessing NVIC's website at www.909SHOT.com.

If you are pregnant, get tested for hepatitis B disease. If you are infected, your baby is a candidate for vaccination.

Stand up for your informed consent rights. If you do not test positive for hepatitis B; do not fall into one of the high risk categories described in this newsletter; and decide you do not want your newborn vaccinated before leaving the hospital newborn nursery, you can amend the "consent for medical treatment" forms you sign upon entering the hospital before giving birth by writing on the form that you do not give consent for hepatitis B vaccination of your baby in the hospital. Check to see if your state has a vaccine tracking system and, if you do not want your baby enrolled in a tracking system, find out how you can exercise your informed consent rights.

Get more information, including checking your state vaccination laws for requirements and exemptions. Hepatitis B vaccine is required in 35 states. There are medical exemptions in all states, religious exemption in all but two states (West Virginia and Mississippi) and philosophical exemption in 16 states.

Don't let anyone intimidate or coerce you into taking action before you have had the opportunity to become fully informed about all your options and are comfortable with your vaccination decision.

THE VACCINE REACTION

The National Vaccine Information Center
512 W. Maple Avenue, #206
Vienna, VA 22180
(703) 938-DPT3
<http://www.909shot.com>

NON-PROFIT ORG
U.S. POSTAGE
PAID
Permit No. 39
Vienna, VA

Published by The National Vaccine Information Center. NVIC is a national, non-profit organization dedicated to preventing vaccine injuries and deaths through public education. Subscriptions are \$18 annually. All rights reserved.

Barbara Loe Fisher
Co-Founder and President

Kathi Williams
Co-Founder and Director

800-909-SHOT to order
(703) 938-5768 to fax.
VISA/Mastercard Honored

Do Not Forward
Address Cor-Return Guar



SAVARD

S Y S T E M S

P.O. Box 515, Wynnewood, PA 19096

THE PRESIDENT HAS SEEN

11-12-99

*Clemens
Interesting letter
Pls do my number
BS*

President William Jefferson Clinton
The White House

*copy to
Jennings
Podell
Clemens
Berkowitz
(for copy)*

4-12-99

 **SAVARD**
SYSTEMS

April 8, 1999

President William Jefferson Clinton
The White House

Dear President Clinton,

On the eve of your signing *The Patient Bill of Rights and Responsibilities* (and the opportunity to have this letter delivered to you by my close friend, MMM) I am moved to thank you most sincerely for unfurling the banner of patient rights. I am deeply grateful for all your work in the area of patient rights and health care reform and thank you sincerely.

I am a general internist, champion of both women and patient rights, and sometimes doctor to Marijorie Margolies Mezvinsky. I say "sometimes" because the corporatization of health care and the subsequent weakening of the doctor-patient bond has broken my spirit and forced me to leave my role as full-time practitioner.

I am now committed to teaching people how they can be partners with their doctor by assuming much more responsibility for their health and health care. To this end, I have created a patient-held medical record that teaches people how to ask for, organize and store all their test results, doctors summaries and other medical record information as the first step to collaboration. The patient record will be published by Time-Life, Inc. next spring. Patients and doctors alike can change the paradigm of medicine.

I look forward to a future when the all-knowing physician as the authority figure in a white coat is abandoned. In its place will be a new era in which patients routinely archive their medical records, have confidence in their instincts, exercise their rights (thank you President Clinton), shoulder more responsibility for prevention and compliance and enter into a fruitful partnership with their doctors. Only then will we move beyond the current health care crisis and go on to achieve optimum well-being as a nation.

I dedicate much of my work to you.

Sincerely,



Marie A. Savard, M.D.

4-12-99

After you have seen
we will send original
to Burkhardt -



COMMONWEALTH OF WOMEN

Volume 1 Number 3 Newsletter of the Pennsylvania Commission for Women October 1998

TAKING RESPONSIBILITY FOR YOUR HEALTH CARE

Most of us do not know how to begin to take responsibility for our own health-care decisions...or even realize we should!

Women have more reasons to visit the doctor including their children, elderly parents and their spouse. Women have more chances to ask questions, hoping the doctor knows what he/she is doing. Do you sometimes ignore your doctor's advice rather than discuss it with him/her? Who, if anyone, calls you with your test results? Do you see the same doctor each visit? Does he/she remember your medical history? Were your medical records ever misplaced or lost? Who is really in charge? It has to be you!

Doctors are no longer the only experts -- you are. Today, patients are much more sophisticated and informed about their medical conditions thanks to the media and Internet, and are often as informed as their doctors about the benefits and risks of treatment. As we approach the 21st century, we are headed into a new era of medicine and health care. Early in this century, the doctor-patient relationship formed the

(CONTINUED ON PAGE 4 - BACK COVER)



*Making the Connection Conference
Dr. Marie Savard leads Health breakout session*

Continued from Page 2

bond that led to healing. The trusted family doctor, who took care of you from birth to death, Marcus Welby, MD, has disappeared. The past few decades have seen incredible advances in technology and treatments, weakening the personal bond between doctors and patients. As more and more options in diagnosis and treatments become available, the relationship needs to change from a "doctor-knows-best," to one where the patient's voice is loud and clear.

Unfortunately, changes in the structure and financing of health care have silenced the patient and to some extent, the doctor. The new source of paternalism, the insurance companies and payors of health care, may not always consider our personal needs first and foremost. Patients more than ever need to be informed and involved in all aspects of their decisions. As doctors become more and more specialized, doctors will differ in their medical knowledge, medical training, awareness of new technology, drugs, tests and procedures. Most importantly, doctors differ in their knowledge of you, the patient. Medical research by Sherrie Kaplan PhD, MPH; Sheldon Greenfield MD; Barbara Gandek MS confirms "Patients who ask questions,

elicit treatment options, express opinions and state preferences about treatment during office visits with physicians have measurably better health outcomes than patients who do not." The research confirms that shared decision-making with your doctors really works.

The reality of the situation is that the medical profession is shifting from an expert to an advisory role just as lawyers, CPA's and financial advisors. Ultimately, the medical decision is the patient's; the physician simply guides the patient based on his/her expertise. In today's health care industry, there is an abundance of specialists,

testing, technology and preventative health needs that contribute to making medical records fragmented, incomplete and unorganized. Most are owned by large medical group practices. Multiple entities, including payors and insurance companies, demand access to records. The voice of the patient is absent. Therefore, it is more important than ever for patients to establish a relationship of equality with their doctor and take responsibility for their health.

(Feature Article Submitted by Pennsylvania Women's Commissioner Dr. Marie Savard)

7 STEPS TO TAKING CHARGE

- 1) *Request copies of your medical records.
(Patients are entitled to copies of their medical records if requested)*
- 2) *Take your medical record with you.*
- 3) *Be prepared. Bring a list of questions and concerns.*
- 4) *Ask questions, use common sense and don't assume anything.*
- 5) *Record and save your doctor's findings and advice.*
- 6) *Request copies of and review all test results, no new is no news.*
- 7) *Remember you are your own best expert.*

Durable Power of Attorney
Living Will ☐ Yes ☐ No

Relationship
Telephone

Name

Emergency Contact

Address

Telephone

Name

Primary Care Provider/Family Doctor

Flu

Tetanus
Pneumovax

Date of Last Immunization and Blood Type

Significant Family Medical Conditions



This is a snapshot of your
important health information.
Carry it with you at all times.

Health at a Glance

Name

Date of Birth

Address

Telephone

Medical Conditions (Problems)

Current Medications/Vitamins

(Include dose and directions)

This card is part of the *Savard System Health Record*.
For more information or to order call: 1-877-SAVARDS.

the tenure track should they take maternity leave.

The complaint is that is ten. Though the of talented men to work the way to example, university majors. Yet there we uate student male professionals blames the women from at MIT. "We call it microdiscrimination, the feeling of not having your work valued as much as other colleagues," she says. "Those things kind of mount up. . . . Many women along the line have said, 'Why bother?'"

Slippery footing. Such discriminatory practices take place unconsciously, the MIT report found. Virginia Valian, a professor of psychology and linguistics at Hunter College in New York and author of *Why So Slow? The Advancement of Women*, says people in academia tend to favor males for advancement. Though men and women may start their careers on equal footing, men are more likely to be promoted faster and to receive plum assignments. When asked to pick leaders or rising stars, she says, senior faculty will most often select a male over a female because "they see a man as somebody who looks right for the job, who's in charge of things." It's a kind of discrimination found even in liberal arts departments, where the male-female ratio is less skewed, says Martha West, a member of the AAUP committee and a law professor at the University of California-Davis.

But the situation is not hopeless, Valian adds, pointing to the Johns Hopkins University department of medicine as a success story. Between 1990 and 1995, the number of female associate professors grew from four to 26, mainly because senior faculty were encouraged to advise women on the school's promotion criteria—a service previously performed almost exclusively for men. At MIT, modest change is underway, and the School of Science will increase the number of tenured female faculty by 40 percent this year—although even at this rate it will take 40 years before 40 percent of the school's faculty is female. Administrators and committee members alike say they also hope the publicity surrounding the report will make pleading ignorance impossible. Says Lotte Bailyn, MIT's faculty chair: "By making it explicit, by making people aware, people can't still deny it exists."

Copied
Jennings
Podesta

to
1.
ds
of
ig
or
s-
3.
d-
e-
m
ig
rs

No time for the poor

Physicians dependent on managed care provide less assistance to the uninsured

to leverage their - Be



Free clinics struggle to provide care to the uninsured.

BY JOSEPH P. SHAPIRO

The more doctors depend upon managed care for their income, the less likely they are to fill their traditional role of providing free care to the poor. That conclusion comes as no surprise to critics of managed care. Evidence of the trend, documented in a new survey of nearly 10,000 doctors, is striking, even though the fraying of the health care safety net cannot be blamed on managed care alone.

Doctors who get at least 85 percent of their income from managed care provide 40 percent less charity care than those who get no more than one fifth of their income from managed care, according to a study published last week in the *Journal of the American Medical Association*. The majority of doctors—77 percent—still provide some free or reduced-fee care, averaging 10 hours a month. But the report's author, Peter Cunningham of the Center for Studying Health System Change, says that "the holes in the safety net may be getting bigger."

Indeed, there are 45 million Americans without health insurance, and their ranks are growing by 1 million a year. At the same time, doctors are struggling to

dize the care of others.

More affordable. For its part, the managed-care industry says that it has lifted many people from the ranks of the uninsured by making health care more affordable. One 1997 study concluded that up to 5 million more Americans would be uninsured today if not for managed care's success in keeping prices down. Still, managed care can do only so much, says

HEALTH CARE

Karen Ignagni, president of the American Association of Health Plans, the industry's

Washington lobby. The traditional sources of indigent care—free clinics, and public and teaching hospitals—also have limits. They could not serve everyone before, and are even more burdened now. The uninsured, Cunningham has found in a second study, are less likely to get free care if they live in communities where the number of people without insurance is relatively high.

Cunningham and Ignagni agree that it will take renewed political will to reduce the number of the uninsured. A *JAMA* editorial accompanying Cunningham's article suggests one solution: a tax on managed-care companies and other insurers to create a government-managed pool of money to cover the cost of ministering to the uninsured.

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	Linda Tyler to the Honorable William J. Clinton re: phone number (partial) (1 page)	02/11/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20147

FOLDER TITLE:

POTUS Notes [Folder 3]

2012-0463-S

rc815

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 advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

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

RR. Document will be reviewed upon request.

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

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

THE PRESIDENT HAS SEEN

3-3-99

February 11, 1999

The Honorable William J. Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear President Clinton:

As a volunteer with the National Kidney Foundation of Arkansas I would like to inform you of a critical public policy initiative that I hope your administration will consider for the administration to support legislation that would eliminate the 3 Medicare coverage of immunosuppressive (anti-rejection) medication recipients.

In 1986 Congress directed Medicare to cover anti-rejection medication transplant. The benefit was extended to a three-year period by the C Reconciliation Act of 1993. The Balanced Budget Act of 1997 calls for Academy of Sciences of the cost/benefit of eliminating any time limit immunosuppressive drugs for transplant patients.

For transplant recipients who do not have private health insurance but immunosuppressive drugs, paying for the medications can be very difficult. The average annual cost of these benefits for these drugs terminate. The average annual cost of these \$11,000. Many transplant recipients are forced to ration their immunosuppressive drugs, increasing the risk of organ rejection. Many dialysis patients do not receive a kidney transplant because of their inability to pay for their immunosuppressive drugs for three years.

Medicare covers the cost of a transplant and it does not make sense to risk that healthcare investment. First year expenses associated with a kidney transplant average more than \$100,000 including follow-up care. Eliminating the time limitation for immunosuppressive coverage is a protection of Medicare's investment.

For many patients with irreversible kidney failure (End Stage Renal Disease or ESRD), transplantation is the treatment option of choice. Transplant recipients do not have the burden of dialyzing three times a week and have less morbidity than dialysis patients. Furthermore, while the transplant operation itself is expensive, in the long run a successful transplant is less costly than recurring dialysis treatments. Moreover, transplant recipients are more likely to be employed taxpayers than their dialysis counterparts. (Almost 50% of kidney transplant recipients are working full time, three years after they receive a kidney transplant.) Finally, since extending coverage could reduce the number of patients who need a second transplant, the supply of organs available for a first transplant will be increased and potential living organ donors may be more likely to if they know their gift will be preserved.

Thank you for your support and please contact me at [P6(b)(6)] if you have any questions.

Sincerely,



Linda S. Tyler
President, National Kidney Foundation of Arkansas

cc: John Cattelan
National Kidney Foundation
Office of Science & Public Policy
1911 North Ft. Meyer Drive, Suite 801
Arlington, VA 22209

C. Jennings

What about this?
As a reply from -

Get final letter
PO TWO MORE FILE
5-7-99

Don Burkhardt

After you have seen,
we will send
original to Burkhardt

copied
Jennings
Podesta
Burkhardt
(original -
for reply)

[001a]

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. letter	Linda Tyler to the Honorable William J. Clinton re: phone number (partial) (1 page)	02/11/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20147

FOLDER TITLE:

POTUS Notes [Folder 3]

2012-0463-S

rc815

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 advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

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

RR. Document will be reviewed upon request.

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

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

THE PRESIDENT HAS SEEN
3-3-99

C. Jennings
What about this?
He is saying for me -
[initials]

February 11, 1999

The Honorable William J. Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear President Clinton:

As a volunteer with the National Kidney Foundation of Arkansas I would like to inform you of a critical public policy initiative that I hope your administration will consider supporting. I'm asking for the administration to support legislation that would eliminate the 36-month time limitation for Medicare coverage of immunosuppressive (anti-rejection) medications for certain transplant recipients.

In 1986 Congress directed Medicare to cover anti-rejection medications for the first year post-transplant. The benefit was extended to a three-year period by the Omnibus Budget Reconciliation Act of 1993. The Balanced Budget Act of 1997 calls for a study by the National Academy of Sciences of the cost/benefit of eliminating any time limitation for coverage of immunosuppressive drugs for transplant patients.

For transplant recipients who do not have private health insurance benefits that cover immunosuppressive drugs, paying for the medications can be very difficult when Medicare benefits for these drugs terminate. The average annual cost of these medications is more than \$11,000. Many transplant recipients are forced to ration their immunosuppressive medications, increasing the risk of organ rejection. Many dialysis patients do not even consider having a kidney transplant because of their inability to pay for their immunosuppressive medications after three years.

Medicare covers the cost of a transplant and it does not make sense to risk that healthcare investment. First year expenses associated with a kidney transplant average more than \$100,000 including follow-up care. Eliminating the time limitation for immunosuppressive coverage is a protection of Medicare's investment.

For many patients with irreversible kidney failure (End Stage Renal Disease or ESRD), transplantation is the treatment option of choice. Transplant recipients do not have the burden of dialyzing three times a week and have less morbidity than dialysis patients. Furthermore, while the transplant operation itself is expensive, in the long run a successful transplant is less costly than recurring dialysis treatments. Moreover, transplant recipients are more likely to be employed taxpayers than their dialysis counterparts. (Almost 50% of kidney transplant recipients are working full time, three years after they receive a kidney transplant.) Finally, since extending coverage could reduce the number of patients who need a second transplant, the supply of organs available for a first transplant will be increased and potential living organ donors may be more likely to if they know their gift will be preserved.

Thank you for your support and please contact me at [redacted] if you have any questions.

Sincerely,



Linda S. Tyler
President, National Kidney Foundation of Arkansas

[0016]

cc: John Cattelan
National Kidney Foundation
Office of Science & Public Policy
1911 North Ft. Meyer Drive, Suite 801
Arlington, VA 22209

Guerrilla Teaming / Reed**TITLE**Intelligence
RX

For the President

from Jay Roshapelle

BY JUDITH FEDER AND MARILYN MOON

It is now an open question whether Medicare will provide adequate health coverage to the baby-boom generation as it begins turning 65 just over a decade from now. The source of uncertainty is not whether America has the resources to sustain the program; we do. The real challenge comes instead from proposals to save Medicare. Far from preserving its benefits, the major restructuring proposals under discussion would radically alter the principles on which Medicare rests and erode the protection it affords.

5-7-99

The enactment of Medicare in 1965 reflected political support for three fundamental principles regarding health care for the elderly. We decided then that insurance is the right way to spread the risk to the elderly of sizable health care costs, that redistributing income through the tax system is necessary to make that insurance affordable and universal, and that the insurance and taxes are best administered by the federal government if the system is to serve all of the elderly regardless of their income or health.

These principles of insurance, redistribution, and government responsibility are now at risk. The challenge comes from both sides of the political aisle in proposals that would convert Medicare from a universal entitlement to public insurance into a government voucher for private insurance. Such a shift has become the major issue in deliberations by the Bipartisan Commission on Medicare's Future. If these proposals prevail, Medicare may become a dwindling basis of security in old age.

MEDICARE'S PROBLEM

Medicare unquestionably faces big financial problems. In the not-too-distant future, the costs of the hospital insurance program (Part A) of Medicare, which is financed through a dedicated payroll tax, will exceed the revenue that the tax brings in. This immediate problem stems not from the aging of the population, but from the fact that health care costs, whether public or private, tend to rise faster than payroll. When Congress passed

copied
Sperling
Jeannings
Reed
Podesta

the Balanced Budget Act of 1997, it slowed the rate of growth in Medicare's payments to providers and health plans and shifted some payment responsibilities for home health services out of Part A. That action delayed the date when revenue will be exhausted to about the time the baby-boom generation begins entering the program.

At that point, there is a problem that is uniquely Medicare's. By 2030, the program is likely to have double the number of beneficiaries it has today—76 million compared to today's 38 million. Social Security's actuaries project that in 2030 one in five Americans (and, counting disabled Medicare beneficiaries, one in four Americans) will be Medicare beneficiaries—compared to about one in eight today. Too few workers will be paying the payroll tax to support the elderly population that depends on it.

Instead of considering alternative ways to address this imbalance, the standard reaction is to say that Medicare is fiscally "unsustainable" and that government responsibilities for the health care of the elderly have to be retracted. But to treat the problem as purely budgetary obscures the real challenge of an aging population and ignores Medicare's fundamental purpose. For the last 30 years, Medicare—with some significant help from Medicaid for low-income elderly and for long-term care—has provided affordable health insurance for the nation's elderly citizens without the problems that plague health insurance for younger Americans. Medicare is nearly universal, and it avoids dividing the healthy from the sick and the poor from the better off.

Limiting the government's liabilities for health care won't make those liabilities go away. Rather, it will shift them back to the elderly and their families. In either case, Medicare's signal advantages—its ability to spread risk and to make insurance affordable—will be lost. That is not solving the problem; it's abdicating responsibility.

This shift of risks back to the elderly would take place under the option that many reformers have been promoting: transforming Medicare from the *defined benefit* it now represents (the guarantee to beneficiaries of a specified set of benefits) into a (the guarantee only of a fixed-dollar amount, or voucher, for purchasing private insurance). The Balanced Budget Act passed by the Republicans in 1995 for the most part adopted this strategy, and that was one of the major reasons

President Clinton vetoed it.

Two years later, however, the President joined Congress in a proposal that would gradually pave the way for a voucher approach. Although the Balanced Budget Act of 1997 slowed the growth in Medicare costs by cutting payments to providers, it also set up an expanded "choice" system for Medicare. This is an arrangement allowing beneficiaries to choose from a number of competing health plans, including the traditional Medicare system. In theory, such a competitive system can achieve greater efficiency in Medicare by making consumers sensitive to price and providers sensitive to costs. In practice, however, a competitive system poses a major challenge to the principles of risk spreading, redistribution, and government responsibility on which Medicare rests.

BREAKING UP THE POOL

For the bulk of its history, Medicare has operated as a single insurance pool, spreading the costs of any individual's illness across the full population. By contrast, a system of competing health plans threatens to fragment the pool, separating the healthy from the sick. The easiest way for insurers to keep premiums low, and thereby win more enrollees, is to attract the healthy and avoid people who are sick and will run up heavy claims. Not only insurance plans, but also healthy beneficiaries have a short-term stake in this separation since they pay less until they need health care. But this fragmentation or risk selection undermines the pooling of risk that insurance is supposed to provide. It leaves sick people in a smaller pool with higher costs.

Any system of choice, even Medicare's previous arrangements allowing beneficiaries to join HMOs, raises the likelihood of risk selection. The Balanced Budget Act took explicit steps to minimize that likelihood, including rules to require health plans to accept all applicants and charge them the same premiums, regardless of their health. It also required Medicare to adjust its method of paying health plans to pay less for healthier patients and more for sicker ones.

Other provisions, however, actually aggravated the problem. The Medical Savings Accounts (MSAs) established under the act are attractive to people with both minimal health needs and the resources to take risks and profit from tax shelters. New "provider-sponsored" organizations, run by

doctors and hospitals, are exceptionally well-positioned to separate the healthy from the sick, since they will know which beneficiaries are which and will benefit financially from sorting them appropriately. Although these arrangements have been slow to take off, advocates of "choice" see the limited availability of private plans as the problem needing to be fixed—not the likely appetite of the plans for skimming off the cream.

Even the architects of choice recognized that if plans are paid based on average risk and they enroll beneficiaries who are healthier than average, Medicare will overpay and the taxpayers will lose. To correct that problem, the Balanced Budget Act required the secretary of Health and Human Services (HHS) to develop a new way of paying Medicare's health plans that recognizes or "adjusts" for risk selection. When the act was passed, everyone agreed that was a good idea, although a difficult one to implement. But once HHS announced a method that, not surprisingly, would reduce payments to health plans, the insurance industry cried "foul." In part, the dispute reflects the technical difficulty of tying payment to risk. But it also reflects the political difficulty of countering the rational behavior of private insurers. As a result, it seems unlikely that Medicare will be able to overcome the tendency of insurers to attract the healthy and avoid the sick, and the fiscal problems that sorting creates.

THE RISK TO EQUAL TREATMENT

Federal policy has promoted equal treatment of Medicare beneficiaries regardless of income in two ways. First, it has limited what health plans and providers can charge above what Medicare pays. Second, through Medicaid, it has extended assistance to low-income families to cover the payments that Medicare requires. The 1997 legislation began to unravel these protections.

For the first time, the act authorized so-called "unrestricted fee-for-service" or traditional indemnity insurance plans in Medicare. Unlike other plans offered to beneficiaries, these plans and their providers are allowed to charge more than Medicare's limit. Another provision allows physicians and beneficiaries to contract directly for services outside the Medicare program, with no restrictions on charges—a provision known as the Kyl Amendment, which some would like to expand.

Advocates of these provisions argue that they are "liberating" Medicare beneficiaries from unreasonable restrictions, enabling them to pay more to get more. In practice, however, such provisions are far more likely to liberate physicians to increase their charges and avoid beneficiaries who are unable to pay. Although there has been little market response to these new provisions so far, their introduction into the program lays a foundation for pulling the higher-income elderly away from the rest.

New policies affecting the elderly poor have had a more significant impact. Historically, Medicaid has helped low-income beneficiaries pay the premiums and co-payments required of Medicare beneficiaries. The Balanced Budget Act, however, limited Medicaid's obligation to cover the co-payments; now it must do so only to the extent that Medicare pays a provider less than a state Medicaid program would have. Where Medicaid fees are low, as they are in many states, this policy change cuts off help that the elderly poor have counted on. In the future, the low-income elderly will be treated more as Medicaid than as Medicare beneficiaries, and they will thus face the very barriers to treatment that Medicare was supposed to eliminate.

The Balanced Budget Act also increased the premiums that beneficiaries are required to pay, while explicitly limiting assistance to seniors with low and modest incomes. Although the act established state block grants to make up for these cuts, the grants are adequate to serve only about a third of the beneficiaries who could qualify for help. Many beneficiaries with modest incomes will find the price they must pay for Medicare's protection beyond their means.

A SET-UP FOR FAILURE?

Choice and competition do not eliminate a role for government. "Managed competition" implies that government establishes and enforces rules for health plans and provides information and support to consumers—all to promote efficient service delivery rather than avoiding risk and denying care. But whether policy will actually take this direction is open to question.

In recent years, proponents of health care competition have been more committed to competition than to its management. Even carrying out the Balanced Budget Act itself—approving plans, setting better rates, educating beneficiaries—is an enor-

mous task that requires more resources than Congress has apparently been willing to provide. Inadequate preparation for further expansion of private options may actually prove a setup for government failure.

Although the Balanced Budget Act of 1997 did not eliminate the entitlement to Medicare's traditional fee-for-service program, its structural arrangements set the stage for moving Medicare the rest of the way toward a voucher approach. If that happens, Medicare beneficiaries would receive a fixed amount to shop with and their access to the traditional program would depend upon the ability to pay extra.

Already there is considerable agreement across party lines on vouchers. The chief difference of opinion is about how the vouchers should be set. One way is to establish a dollar value for the vouchers and then allow it to grow at a predetermined rate. That approach explicitly ignores the cost of health care or pretends that the magic of managed care and the marketplace will keep it low. The alternative is to peg the voucher to a share of the average premium, which would mean that the value of the voucher would rise as costs increase. That approach, called a "premium support," still favors a competitive system but does not assume savings in advance. For that reason, it is more benign than the fixed-growth approach.

Even the "good" voucher, however, threatens to abandon the three premises on which Medicare is based. A system that sends individual seniors out to shop among competing health plans is not the same as a system that brings all seniors together into a single health plan. The competitive market would be likely to separate the sick from the healthy. Instead of the redistributive arrangements that assure the affordability of Medicare, the elderly would face a market in which the better-off would pay more and the less well-off would take what they can get. And in the long run, budgetary politics may transform the "good" voucher into a "bad" one, downgrading the "premium support" from average costs to "average minus 5 percent," minus 10 percent, and so on.

This restructuring of Medicare is also a fraud as a solution to the fiscal problems that the program really faces. Managed competition or managed care will do little more to reduce Medicare's per-capita costs than Medicare can already achieve using traditional cost controls. Medicare's enormous market

power has long enabled it to obtain the discounts in purchasing that private managed care plans have lately discovered. In fact, Medicare has already taken advantage of the discounting strategy that has probably contributed most to the recent slowdown in private health care costs. And Congress used this market power in the Balanced Budget Act of 1997 to bring Medicare's per-capita spending growth into line with or even below growth projected for the private sector. The only way to gain any further savings is to push Medicare well below the private-sector growth rates.

Moreover, Medicare's benefits are not that comprehensive to begin with. They do not include prescription drugs and do not limit out-of-pocket expenses like most policies provided through employers do. As a result, the typical Medicare beneficiary already pays about 20 percent of income on Medicare premiums, cost-sharing, and health services that Medicare doesn't cover, without even counting spending for long-term care.

The restructuring now being proposed only solves Medicare's financing problem if it dismantles Medicare's protections. That's no solution. Slowing growth in health care costs is a national problem, which Medicare cannot solve on its own. Medicare's particular problem is not per-capita costs; it's the number of "capitas." And to address that problem, the right focus for public policy is on revenues.

The most ardent proponents of restructuring claim that the nation cannot afford new revenue for Medicare. But the economy is growing, and the population as a whole, including the elderly with significant incomes, provides a sufficient tax base. As the elderly increase from the current 12 percent to 20 percent of the nation's population, they will necessarily, and appropriately, absorb a larger share of national income. The current payroll tax does not provide for the increased funds Medicare will need to support the larger numbers of people who will need Medicare. Whether by increasing that tax or relying on other revenue sources, the financing must change. A modest increase in the payroll tax (or other comparable revenue sources), combined with efforts to control Medicare spending over time and perhaps modest increases in beneficiary contributions, can keep the program on a strong footing for many years to come. For example, the Medicare actuaries have estimated that a 0.5 percent increase in the payroll tax both on employers

and employees would by itself extend the date of exhaustion of the Part A trust fund to 2032. (WHAT IS THE DATE IF YOU ALSO COUNT THE REVENUE THAT THE PRESIDENT WOULD TAKE FROM THE SURPLUS?-P.S.)

President Bush used to justify limits on social expenditures on the grounds that Americans had "more will than wallet." The truth is that we have more wallet than will. The United States is no less able today than it was 30 years ago to use the dividends of economic growth to provide health care for the elderly. The question is whether we have the political resolve to do it.

POSSIBLE CALLOUTS

Convert Medicare into a voucher and it may become a dwindling basis of security in old age.

Limiting the government's liabilities for health care won't make those liabilities go away.

Under the new provisions, the elderly poor increasingly face the very barriers to treatment that Medicare was supposed to eliminate.

The chief difference of opinion among advocates of restructuring is about how the vouchers should be set.

Restructuring Medicare with vouchers is a fraud as a solution to the fiscal problems that the program really faces.

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002a. memo	Mildred Alston to the President (2 pages)	05/07/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20147

FOLDER TITLE:

POTUS Notes [Folder 3]

2012-0463-S

rc815

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 advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

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

RR. Document will be reviewed upon request.

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

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

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002b. letter	Abbey Meyers to Kathy McClanahan (1 page)	04/29/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20147

FOLDER TITLE:

POTUS Notes [Folder 3]

2012-0463-S

rc815

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 advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

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

RR. Document will be reviewed upon request.

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

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

OFFICE OF THE PRESIDENT
THE WHITE HOUSE

(202)456-6610
(202)456-6703 Fax



Date: 5/11/99

Please Deliver to: Devorah Adler

Number of Pages (including cover sheet): 2

Fax Number: 65557

Sender: Mary Morrison

Message: _____

NOTE: The information contained in this facsimile is CONFIDENTIAL and intended for the recipient ONLY. If there are any problems with the transmission, please call (202)456-2825.