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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)

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

FOLDER TITLE:
POTUS Notes [Folder 6]

2012-0463-S
rc816

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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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]
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THE PRESIDENT HAS SEEN
5-24-99

THE WHITE HOUSE

WASHINGTON

cc'd
Sperling
Reed
Jennings
Lambrew
Podesta

May 24, 1999

INFORMATIONAL MEMORANDUM TO THE PRESIDENT

FROM: Gene Sperling, Bruce Reed, Chris Jennings, and Jeanne Lambrew

SUBJECT: Medicare Policy Development Update

NEC and DPC continue to develop Medicare reform policy options for your consideration. We will soon be meeting with you to discuss these options and to receive your guidance. In the meantime, we thought that you might be interested in reviewing some of the attached background information that has been prepared for internal and, in some cases, external briefings for Members of Congress and their staffs. It addresses most, but not all, of the topics under review. As we continue to address policy issues and options, we will forward you additional information.

Policy Development Status. Following the conclusion the Medicare Commission and the recently-released Medicare Trustees' report, we have been working intensively to evaluate the strengths and weaknesses of the Breaux-Thomas reform proposal and the advantages and disadvantages of various alternatives to it. Your White House, OMB, HHS, and Treasury Medicare advisors are reviewing numerous reimbursement and structural reform concepts, drug benefit designs, and offset options to strengthen the financial status of the program and to help pay for benefit improvements. Cost estimates are being run and re-run to reflect the Trust Fund's new baseline (which is now scoring reduced savings for individual policies), new design options of interest to your advisors, and evolving reform positions of key Members of Congress, aging advocates, and health care providers. In preparation for our upcoming policy discussions, you will find:

- Tab 1 contains our Medicare "walk-through" document that is being used for Members of Congress and their staff to detail the strengths and weaknesses of both the Medicare program and the recommendations made by Senator Breaux and Congressman Thomas.

- Tab 2 includes the memo that we gave you in advance of the Senate Democratic retreat that highlights the major issues.

- Tab 3 provides an update of Congressional interest in and action on Medicare, which was produced in collaboration with Larry Stein.

- Tab 4 encloses a background briefing document on premium support and options to inject more competition in the Medicare program. We are closely examining alternatives that meet our objectives of making Medicare more efficient and reducing costs while not undermining the traditional fee-for-service program. (Also attached is the original premium support concept article by Robert Reischauer and Henry Aaron.)

- Tab 5 provides a summary of our talking points on the use of the surplus for Medicare – in particular the common myths and our responses to them.

- Tab 6 includes detailed background information on the status of prescription drug coverage for older and disabled Americans as well as a discussion of the major moving pieces of any drug benefit design.

- Tab 7 includes some background facts on options involving beneficiary contributions to Medicare. These include the income-related Part B premium as well as fact sheets on various services for which cost sharing changes are being considered.

- Tab 8 provides specific back-up facts and trends that strongly support your contention that an increase in the eligibility age without an explicit policy that assures there is not an increase in the uninsured ill advised and flawed policy.

- Tab 9 explains the issues confronting rural beneficiaries under the Breaux-Thomas proposal -- a critically important issue in the Senate and amongst the conservative Democrats most willing to be open to broader Medicare reforms.

- Tab 10 includes your response to the March 30th, 1999 Trustees report on the status of Medicare, and our general talking points supplementing your comments. It also contains your comments responding to the Breaux-Thomas proposal and the general talking points on the topic, your State of the Union comments on Medicare, your AARP speech outlining your principles for reform, and the back-up paper that was released around the speech.

We hope that you will find this information to be useful in preparation for our upcoming meeting with you on Medicare reform options.

SAVARD
SYSTEMS

P.O. Box 515, Wynnewood, PA 19096

THE PRESIDENT HAS SEEN
1 12-99

President William Jefferson Clinton
The White House

THE PRESIDENT HAS SEEN
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 respnsibility 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 it's 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 responsiblity 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 -

P.O. Box 515 • Wynnewood, Pennsylvania 19096 • Tel: (6 ardsys@aol.com

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!

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

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)

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.

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.***

The reality of the situation is that the medical profession is shifting from an expert to and 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)

SAVARD SYSTEMS

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

Significant Family Medical Conditions

Date of Last Immunization and Blood Type

Tetanus _____ Pneumovax _____

Flu _____ Blood Type _____

Primary Care Provider/Family Doctor

Name _____

Telephone _____

Address _____

Emergency Contact

Name _____

Telephone _____

Relationship _____

Living Will [ ] Yes [ ] No

Durable Power of Attorney _____

Medical Conditions (Problems)

Current Medications/Vitamins

(Include dose and directions)

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

FAX COVER SHEET

OFFICE OF LEGISLATION

Number of Pages: 1 Date: 3/5

To: Deborah W. H.

Fax: 456-5557

Phone:

From: Peter Heilman

Fax: 202-690-8168 or 205-5157

Phone: 690-5950

REMARKS: Per your request for estimates on immunosuppressive drugs.

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

The methodology and assumptions for the extension of Immunosuppressive drugs are as follows:

1. For the year 2000, the impact was the sum of the cost of immunosuppressive drugs for the transplanted individuals who are still functioning from more than 3 years.

2. The number of transplants in year 1996 is 10,500
The number of transplants in year 1997 is 11,000
The number of transplants in year 1998 is 11,500

3. The transplants in year 1996 will have a 60% chance of still functioning in year 2000, and a 50% chance of still functioning in year 2001.....

4. So in year 2000 we have the impact of the transplants still functioning from years 1996, 1995, 1994, 1993.....

5. Some of the transplants were not considered for impact For those beneficiaries who are entitled to the Medicare Program under the End Stage Renal Disease only(by law they have to be non entitled after 3 years of successful transplants).

6. The cost per year per user of Immunosuppressive drugs is about $4650 for year 2000 and $4890 for year 2001.

As a background information, we are actually spending about 60.3 million in a year for I,,immunosuppressive drugs.

The estimated Medicare cost for exteding the coverage of Immunosuppressive drugs beyond 3 years after transplants are as follows:

FY	Cost(mil)
1999	25
2000	45
2001	50
2002	55
2003	65
2004	70
2005	80
2006	90

The effective date was 1/1/1999. Should you need any assistance with anything else, please let me know.....Thank you..

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Devorah Adler
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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?
Pls do reply for me—
Thx

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 consi for the administration to support legislation that would eliminate the 3 Medicare coverage of immunosuppressive (anti-rejection) medicatior recipients.

After you have seen, we would send original to Burkhardt

In 1986 Congress directed Medicare to cover anti-rejection medicatic transplant. The benefit was extended to a three-year period by the C Reconciliation Act of 1993. The Balanced Budget Act of 1997 calls f 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 b immunosuppressive drugs, paying for the medications can be very d benefits for these drugs terminate. The average annual cost of thes $11,000. Many transplant recipients are forced to ration their immun increasing the risk of organ rejection. Many dialysis patients do not kidney transplant because of their inability to pay for their immunosu 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 burde dialyzing three times a week and have less morbidity than dialysis patients. Furthermore, whi the transplant operation itself is expensive, in the long run a successful transplant is less costl than recurring dialysis treatments. Moreover, transplant recipients are more likely to be emplc 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 b more likely to if they know their gift will be preserved.

copied Jennings Podesta Burkhardt (original for reply)

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

Sincerely,

[Lola]

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

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Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
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Domestic Policy Council
Devorah Adler
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THE PRESIDENT HAS SEEN
3-3-99

C Jennings
What about this?
He did reply for me—
TC

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 [P6/(b)(6)] if you have any questions.

Sincerely,

[0016]

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

THE PRESIDENT HAS SEEN
3-7-99

copied
Jennings
Podesta

(G) **Letter from Dr. Arthur Ullian forwarded by Sen. Kennedy, via Janet Murguia –** Sen. Kennedy forwarded Ullian letter (and hand wrote, "Great news Friday") as a follow-up to your conversation with Ullian at Steve Grossman's lunch in Boston: the long-term strategy to keep Medicare solvent should focus on making seniors healthier, rather than on benefit cuts or payroll tax increases; for example, a 1.5% annual decline in the number of chronically disabled seniors, who consume 5-7 times more health care dollars, would leave Medicare solvent through 2070; investment in medical innovation will contribute to better health and therefore Medicare solvency; you should consider a White House initiative on this issue. *We'll have a reply prepared in coordination with Chris Jennings.*

3-2-99

THE WHITE HOUSE

WASHINGTON

February 18, 1999

THE PRESIDENT HAS SEE
3-7-99

MEMORANDUM FOR THE PRESIDENT

FROM: JANET MURGUIA JM

SUBJECT: CONGRESSIONAL CORRESPONDENCE

Attached for your review is a letter from Sen. Edward M. Kennedy (D-MA), that I thought you would like to see.

copied
Fenning
Podesta

EDWARD M. KENNEDY
MASSACHUSETTS

United States Senate

WASHINGTON, DC 20510-2101

February 11, 1999

The President
The White House
Washington, DC 20500

Dear Mr. President:

At Steve Grossman's lunch in Boston on February 2, you spent some time talking to Arthur Ullian, a respected leader on health care and disability issues, about a new approach to Medicare solvency by improving the health of senior citizens, rather than through benefit cuts or tax increases.

This approach is increasingly entering the academic debate on Medicare, and I believe it should be an important part of the solution. I understand that OMB and the Medicare actuaries are reluctant to estimate savings based on this idea, but it seems very likely to me that the savings will be substantial.

At the lunch, you asked me to get you some more information about the idea. I'm enclosing a letter from Arthur laying out his thoughts in more detail.

With respect and appreciation,

As ever,

Edward M. Kennedy

Arthur is a very special remarkable thinker and doer - as you probably know. I hope you will take 10 minutes to read Great news Friday -

Task Force on Science, Health Care and the Economy
101 Federal Street - 19th floor, Suite 46, Boston, MA 02110

Voice: 617-342-367
Fax: 617-342-708

February 11, 1999

The President
The White House
Washington, DC 20500

Dear Mr. President:

I'm writing to follow up on our discussion at Steve Grossman's luncheon in Boston on Tuesday, February 2. I am grateful for the opportunity to raise these issues with you.

As we discussed, our long-term strategy to keep Medicare solvent through the 21st century should focus on making senior citizens healthier, rather than on benefit cuts or payroll tax increases. Your proposal to allocate 15% of the surplus to Medicare is a bold plan that will be effective in dealing with the program's current financial problems, and will buy time to implement a future-oriented approach that can produce real savings for the program over the long-term.

Our Task Force has been thinking about these issues since 1996, when we came together to look at problems of spiraling health care costs and the impact of an aging population on Medicare and Medicaid. Initially, these problems appeared to be without acceptable solutions. The proposed remedies — capitation, rationing, reduction of services and benefits, etc. — inevitably deny people the quality of care needed to keep them healthy. By making people sicker, they become all the more costly over time.

Facing this range of unacceptable solutions for controlling health care costs, we looked at the state of medical technology, and determined that it contained a better solution of the health care crisis. In nearly every decade of this century, our country has met critical challenges by relying in large part on innovation and technology.

In the area of health care, molecular biology is proving to be the transforming technology. Our ability to observe and understand human biological processes at their molecular level is rapidly enabling us to treat disease much earlier (even before it becomes symptomatic, in many cases), to treat or cure diseases for which palliative care was once the only option, to expressly target computer-engineered drugs, and to identify and develop

new drugs at an unimaginable rate. All these changes promise to streamline care and reduce costs. But even before this approach realizes its full potential, vast savings can be realized just by communicating and utilizing the best available treatments in clinical practice around the country.

The sea changes taking place in medicine are already showing up in changing health trends in the population. Dr. Manton's paper in the *Proceedings of the National Academy of Sciences*, which I left with you, reports that since 1982, there has been an increasing annual decline in chronic disability among people over 65. Since 1989, that annual rate of decline has been at least 1.5%, and may now be as high as 2.2% at the present time, according to unpublished data.

Chronic disability is a good marker for chronic disease and for health care costs, because Medicare enrollees defined as chronically disabled consume 5-7 times more health care dollars than other beneficiaries. Using a mathematical model, Dr. Manton indicates that, if a 1.5% or higher annual decline can be achieved, Medicare can be sustained in financial balance through 2070. He sees the critical ratio not as that of workers to elderly, but of workers to disabled elderly (those who consume the lion's share of funds). If this rate of decline in disability and chronic disease can be achieved, the ratio of disabled elderly to active workers (currently, one disabled senior for every 22 workers) will actually decline and there will be enough savings to Medicare to keep the program solvent throughout the century.

Other studies point toward this conclusion as well, showing that savings to Medicare will far outweigh the costs associated with increased life expectancy, even without taking into account the additional revenues from longer working lives. Achieving a population of people over 65 who are healthy and active has at least two positive social consequences: (1) healthy people require less frequent and less costly health services; (2) healthy seniors may choose to continue in the workforce, thus contributing to Medicare through payroll taxes, benefitting both sides of the support equation.

Dr. Manton concludes in his paper that sustaining the disability decline rate and securing the resulting cost reductions for Medicare depend on accelerating the pace at which federally-funded biomedical research moves forward. Because there has traditionally been a 10-20 year lag-time between discovery and clinical application (although there is evidence that the lag-times are getting shorter), it is critical to increase funding to maximum levels now, if we expect to be prepared for the population crunch on Medicare eligibility beginning in 2011.

As we do this, however, we must also take steps to maximize what we already know, i.e., to close the gap between optimal care and care that is routinely given. For example,

- Misuse of prescription drugs results in avoidable illnesses that cost Medicare up to $16 billion annually.

- Up to 72% of elderly are not vaccinated against pneumonia, and 40% do not receive flu shots, while these illnesses cost Medicare $3 billion a year.

- Strokes attack three million Americans (most of Medicare age) each year at a cost of $30 billion. People receiving new clot-busting drugs in the first hours after a stroke recover more quickly and more fully than others, but use of this new drug is far from universal.

- Beta Blockers taken after a heart attack should be standard treatment to reduce the likelihood of future attacks, but only a fraction of the elderly now receive them.

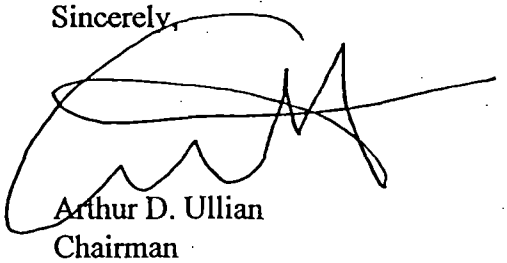
It is hard for me not to view this crisis from a businessman's point of view. Often, we don't have the luxury of looking at a problem academically. We have to consider the most important variables, throw out what doesn't work, and make a decision that moves us toward the best solution. Looking at this problem, it seems clear that investment in innovation — a guiding principle in the private sector — is a quadruple-win solution. It will enable us to control disease and eliminate human suffering sooner. It will increase active life expectancy for the disabled. It will contribute to the financial solvency of Medicare. And it will contribute to a stronger economy.

I urge you to consider a White House initiative that recasts the Medicare debate in terms of making Medicare healthy by making senior citizens healthy. This initiative would recognize the critical link between NIH-supported research, lower Medicare costs and a strong economy. Such an initiative might also include events that would bring together government, the medical community, senior citizens organizations, and others to improve the standard of care for the elderly. And it would encourage the elderly to become proactive participants in improving their own health.

A White House focus on this initiative and on your own strong commitment to expanding biomedical research and improving the health of seniors would be a lasting legacy for your Administration. I would welcome the opportunity to elaborate further on these issues and ideas with you or members of your staff.

With respect and great appreciation for your leadership in this most important endeavor,

Sincerely,



Arthur D. Ullian
Chairman

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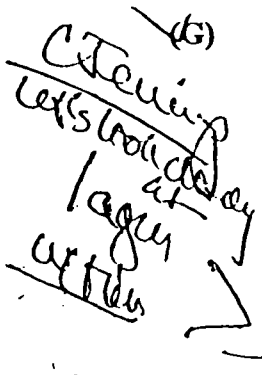

Letter from Dr. Arthur Ullian forwarded by Sen. Kennedy, via Janet Murguia -- Sen. Kennedy forwarded Ullian letter (and hand wrote, "Great news Friday") as a follo up to your conversation with Ullian at Steve Grossman's lunch in Boston: the long-ter strategy to keep Medicare solvent should focus on making seniors healthier, rather than on benefit cuts or payroll tax increases; for example, a 1.5% annual decline in the numb of chronically disabled seniors, who consume 5-7 times more health care dollars, woul leave Medicare solvent through 2070; investment in medical innovation will contribute better health and therefore Medicare solvency; you should consider a White House initiative on this issue. *We'll have a reply prepared in coordination with Chris Jenning*

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C Jennings

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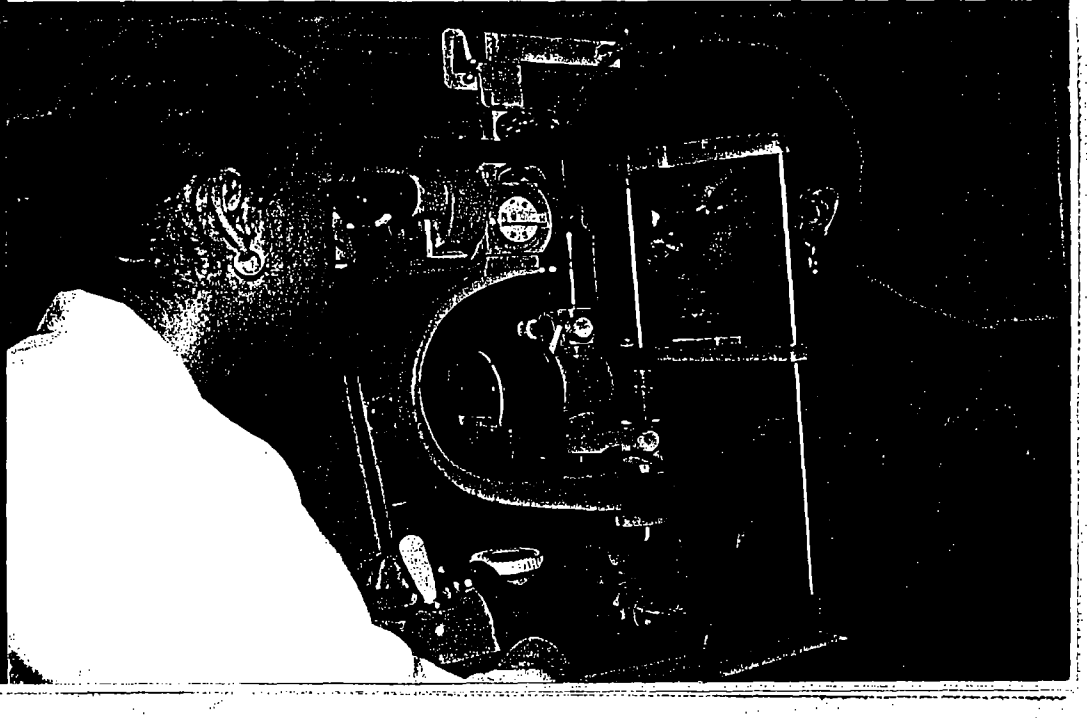
A university-centered eye institute dedicated to excellence in research, education, and culturally appropriate clinical services to preserve and restore vision for underserved, minority, and socio-economically disadvantaged populations, and for the whole of society.

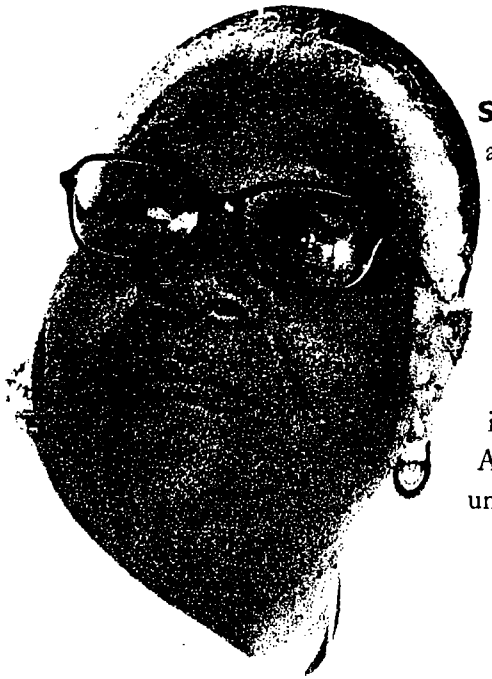
THE LOS ANGELES EYE INSTITUTE



South Central Los Angeles: A Community in Need

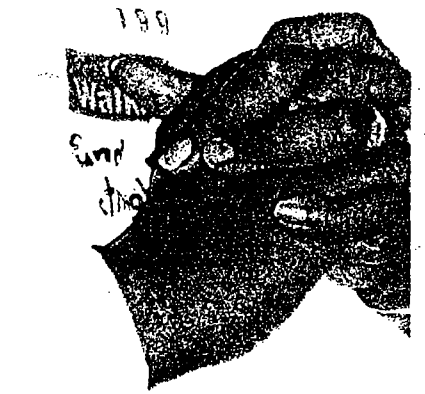
Current treatments of eye diseases are capable of reducing new blindness and visual impairment in this country by at least one-third. Such treatments could prevent or cure two-thirds of the blindness observed in African Americans.

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) nonprofit, 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.

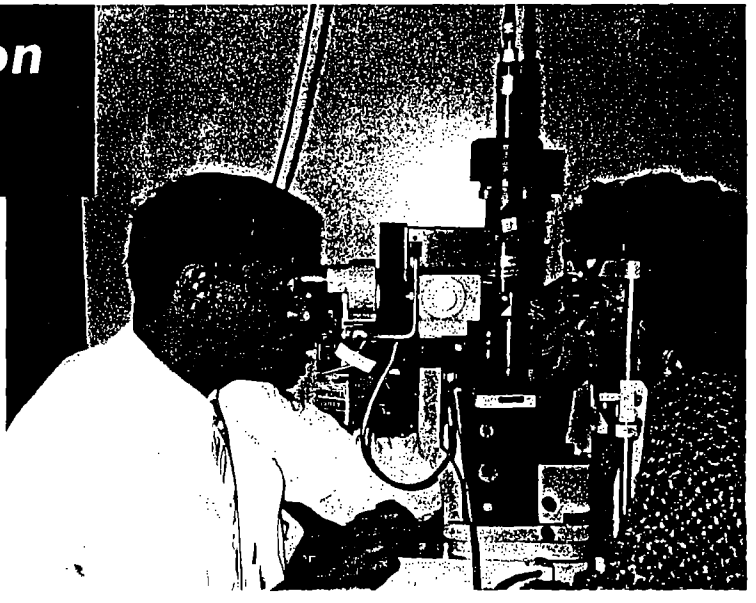
COMPREHENSIVE DIABETIC EYE CENTER AND A GLAUCOMA EYE CENTER
to provide state-of-the-art ophthalmic treatment for these diseases and offer outreach education and screening programs that focus on prevention and early detection. Research and clinical trials will support these programs and create the ongoing 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 pos-

sible to the population of South Central Los Angeles and will

include the following . . .

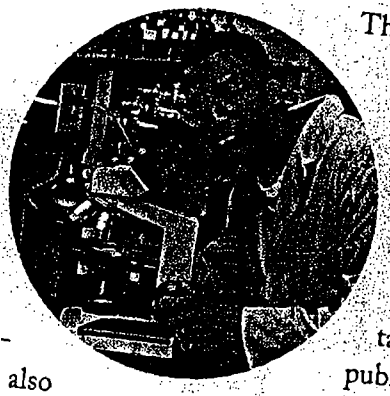
Clinical Research

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 Diabtes 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

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

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 Miedical 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

The Bond Between Cops and Kids

KATHY SALAZAR
Board Member

1425 W. Victoria
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pager: 213-506-7128

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Chief of Panel Seeks Increase For Medicare

Move Would Restore Some of 1997 Cuts

By ROBERT PEAR

WASHINGTON, June 2 — The head of a Federal advisory commission, an influential Republican, said today that Congress should increase Medicare payments for certain nursing home and hospital services because budget cuts appeared to be harming the quality of care for some patients.

The statement, by Gail R. Wilensky, chairwoman of the Medicare Payment Advisory Commission, was a breakthrough for health care providers, who have been pleading with Congress to restore some of the money cut by the 1997 budget law.

Just three months ago, Dr. Wilensky, who ran the Medicare program under President George Bush and is respected by lawmakers of both parties for her technical knowledge of the program, said she had not seen enough evidence to justify increases in Medicare payments. She said then that it was too early to know whether the 1997 cuts were adversely affecting patients.

But today Dr. Wilensky said she agreed with some health care providers that certain patients were vulnerable, particularly those with complex medical problems who are in nursing homes and those needing outpatient hospital services or physical therapy. She spoke with reporters as the commission issued one of two annual reports to Congress.

Medicare accounted for a huge share of the law's savings, $116 billion of the $127 billion that was to be saved over five years. The law, in turn, was a major factor that helped balance the Federal budget in 1998, for the first time in three decades.

Congressional aides said today that Congress seemed likely to take Dr. Wilensky's advice. Medicare issues have traditionally been Democratic issues, but Republicans are aware that increasing numbers of the elderly now vote Republican, and in the last three years, Republican lawmakers have given hundreds of speeches insisting that they want to protect Medicare.

Dr. Wilensky said she was recommending "targeted and limited changes" in the Balanced Budget Act of 1997, not a wholesale revision or repeal of its Medicare provisions.

Paul Hosefros/The New York Times

Gail R. Wilensky, who heads the Medicare Payment Advisory Commission, says cuts may have affected the quality of care for some patients.

Specifically, Dr. Wilensky said, Congress should provide more money for physical therapy, eliminating what she described as an arbitrary limit of $1,500 a year in Medicare payments for physical therapy for any beneficiary.

In addition, Dr. Wilensky said, Congress and Medicare officials should devise some way of increasing payments to nursing homes for patients who need the most costly and extensive care. These patients include nursing home residents who are on ventilators, require infusion therapy, need prosthetic devices or have several medically complex conditions.

Some hospitals say they have had difficulty discharging these patients. Some nursing homes have refused to take such costly patients because the homes consider Medicare payments inadequate.

Finally, Dr. Wilensky said she tended to agree with hospitals that say Medicare is paying too little for outpatient services, which include a wide range of diagnostic tests, treatments and procedures.

As significant as what Dr. Wilensky said is what she did not say. She did not, at this time, endorse pleas by teaching hospitals for more money. And she did not endorse the pleas of home health agencies that say beneficiaries' access to home care has been impaired by the Medicare cuts.

Dr. Wilensky said she knew that some teaching hospitals had reported major reductions in revenue. "We have reports of a lot of hospitals suffering a lot of pain," she said, "but it's hard to know how much of that is due to Medicare." Many private insurers have also cut back payments to hospitals.

Likewise, in a report issued today, the Medicare commission said, "Preliminary data suggest that fewer Medicare beneficiaries are receiving home health care than in the recent past, and the number of visits per user has decreased."

But, the panel said, it is "impossible to assess the degree to which these changes are appropriate," because Medicare does not systematically evaluate the medical condition of patients who receive home care.

Moreover, Dr. Wilensky said, it is important to remember that the cutbacks made in 1997 followed "10 years of explosive growth" in Medicare spending for home health care. Spending soared to $18.1 billion in 1996, from $1.9 billion in 1986.

The General Accounting Office, an investigative arm of Congress, said that 14 percent of Medicare's 10,524 home health agencies had closed since October 1997, but that beneficiaries still appeared to have "appropriate access" to home health services.

The accounting office said that high-cost patients, including those with Alzheimer's disease or multiple sclerosis, might have more difficulty obtaining home health care in the future.

So far, Dr. Wilensky said, savings from the Balanced Budget Act appear to be "much greater than expected" in 1997.

Health care providers want a wholesale revision of the law, Dr. Wilensky said, but "I don't get any sense from Congress" that lawmakers will agree.

Indeed, she said, "The Balanced Budget Act is something we should not undo in haste."

The New York Times

THURSDAY, JUNE 3, 1999