Blanche Clair

1019 Longshore Avenue

Philadelphia, Pennsylvania 19111

September 22, 1994

Dear Jennifer:

It was a pleasure speaking with on Wednesday, and to be able to share my views on In-Home Care with you and Mrs. Clinton. In-Home Care is a valuable service at a lesser cost

I hope you find my brief valuable, and if there should be any concerns or questions please feel free to call me at my home (215) 342-2623. I strongly believe that Congress should work as a **team** to settle and to pass the Health Reform Bill. This would benefit not only the lawmakers but the constituents as well.

Again, I am open for suggestions as to how to go forward with this important service.

Warm regards,

Blanche

CARE YOU CAN COUNT ON

BLANCHE CLAIR
Director

WOMENS MEDICAL GROUP
IN HOME CARE • MEDICAL EQUIPMENT

215-332-9500
1-800-323-4564

4569 Cottman Ave Philadelphia PA 19135

BLANCHE CLAIR
1019 LONGSHORE AVENUE
PHILADELPHIA, PA 19111
(215)342-2623

August, 1994

Health Reform Bill-I suggest a package should have a plan of the needs of Health Care. Figure the costs then present the package for consideration. How can one determine costs before the content is established. When the final plan is presented to Congress lawmakers and constituents will be able to communicate.

•IN HOME CARE-THE WAVE OF THE FUTURE
Home care is an alternative to nursing homes and convalescent homes
Patients would rather be at home to recuperate as it is more comfortable, peace of mind and lesser costs.

Home Care should be available to everyone of all ages
In Home Care to be included in all insurance policies i.e Blue Cross and Blue Shield, Keystone, U.S. Health Care, Medicare and Medicaid

Hospitals stays and out-patient visits are cut due to costs. Monies can be saved by having Home Care aides take care of the needs of all patients when skilled care is not needed.

•CUTTING COSTS
RN'S and LPN'S are being sent to the homes of patients at higher costs when not needed. Home Health Aides can provide services such as

- •Bathing
- •Grooming
- •Simple exercises
- •Shopping
- •Light housekeeping
- •Preparing meals
- •Care of new mothers and babies

Costs vary from $8.50 per hour to $25.00 per hour. Compared to skilled care this is a tremendous savings. Womens Medical Group rate $8.50 per hour with a four hour minimum $85.00 for 24 hour service.

•T. V. APPEARANCES-
November, 1992-CH 10 NEWS
August, 1993-CH 6, PERSPECTIVES
August, 1994-TAPING-WPEN, MILESTONE-IN HOME CARE-WAVE OF THE FUTURE

The Philadelphia Tribune
Tuesday, May 31, 1994
Page 8-B

Home health care is alternative to nursing homes

By Stephanie Grant
Tribune Correspondent

America's population is growing older. By the year 2000, approximately 15 percent of the United States' people will be older. Because of this trend, and the health problems that often accompany aging, more and more families are facing the difficult decision of the best way to care for their elderly.

For many the decision to place a family member in a nursing or convalescent home is a heart-wrenching option. But there are alternatives, such as the one offered by the Women's Medical Group — home health care.

The Women's Medical group is a division of Women's Medical Equipment Company. The Women's Medical Equipment Company was founded in 1990 by Mavis Roth, and provides durable medical equipment, such as wheelchairs, walkers and such, to private homes. The Women's Medical Group was developed in 1992, and Blanche Clair was brought in to serve as its director. That same year the Women's Medical Equipment Company was brought by Jane Steinman.

Clair's challenge is to attempt to meet the growing demand and need for alternative home health care service. Clair is up to the challenge, having served for over 10 years as the Director of Constituent Services for Philadelphia City Councilwoman Joan Specter.

Clair's responsibility was to serve as liaison between the Councilwoman and her constituents, and in the course of her tenure Clair helped solve all kinds of constituent problems from potholes to legal issues to health care problems. She has brought those experiences, including the sense of well-being and satisfaction she gains from helping people, with her to Women's Medical Group.

"It was very rewarding helping the people at large — people grew to trust me," states the Northeast resident. "It is a rewarding feeling to help families in crisis."

Clair is intricately concerned with the issues of the elderly, which comprise the majority of Women's Medical Group's personal clients. She has been appointed by Mayor Rendell on the board of directors for the Riverview Nursing Home and the Mayor's Commission on the Aging.

The Women's Medical Group provides all levels of home health care, from short-term to long-term. The primary goal of Women's Medial Group is to provide a sense of ease to families caring for a loved one who can't take of his or her self.

Having a home health care aide allows the family to maintain their lifestyles, an especially important issue for families who work. Furthermore, the patients themselves benefit greatly from Women's Medical Group services; it frees them from the nursing/convalescent home system, placing them in a much more comfortable environment at home.

In addition, the costs for caring for a patient are much more reasonable when care is provided by a home health care professional, as opposed to nursing/convalescent care. All the way around, the answer that institutions like Women's Medical Group provide can be a God-send.

The home health care aides will perform all kinds of tasks, including dress, feed, groom, bath, perform simple exercises, shop, do light housekeeping and prepare meals for patients, as well as more strenuous and medical assignments depending on the levels of care needed.

If need be, home health aides will live within the home for a period of time. Any type of situation can lead to the need for home health care service, anything from the fact that hospitals are not keeping patients after surgery or hospitalization as long as they used to, due to cost, or perhaps a family plans to take a vacation — in both cases knowing that a loved one is being properly cared for will help provide a sense of peace.

All home health care aides working for Women's Medical Group are certified nursing assistants and home health care aids. Applicants are gathered through advertising and networking, carefully screened, and placed in a registry where they can be accessed when an assignment comes up. Aides are placed according to their expertise in different areas.

In some cases services provided by Women's Medical Group has acquired a wonderful reputation, with major clients including St. Agnes Hospital, the Alzheimer's Association, Philadelphia Corporation for the Aging, and the 509 South Broad/Senior Center. Under the guidance of Clair, the division has grown and prospered, and she is anxious to share her skills and experiences with other organizations on a consultant basis. If you are looking for a "better answer," call the Women's Medical Group at (215) 332-9500, or 1-800-323-4564.

Prev-Med Clinics, Inc.
Suite 206
10713 Highway 620
Austin, TX 78726
Phone: (512) 331-9906/7 • Fax: (512) 331-6100

September 23, 1994

Ms. Jennifer Klein
Special Assistant to the President
Domestic Issues
West Wing, Second Floor
The White House
Washington, DC 20500

Dear Ms. Klein,

Thank you for meeting with us on Tuesday 20, 1994. It was encouraging to hear that my concept of prescriptive preventative medicine is consistent with this Administrations Health Policy Reform.

My view is that as an adjunct to basic health care providers, we at Prev-Med Clinics will be able to assist in keeping the patient well, after the medical incident, for longer periods at a time.

The goals are :
- Reduced drain on medical costs,
- Reduced drain on insurance costs,
- Improved patient care,
- Education of the patient.

Our approach is aggressive and innovative in that the clinics can be set up quickly either as a turnkey, franchise or physician incubator.

In the model that I drew on the flipchart, a physician may choose to deposit or invest a sum of money to cover the costs of his referred patient group i.e. a cost of $35 per visit would require a deposit of an amount sufficient to pay for the estimated number of patients to be seen that year.

We have a number of options available for the physicians and the communities who desire our model.

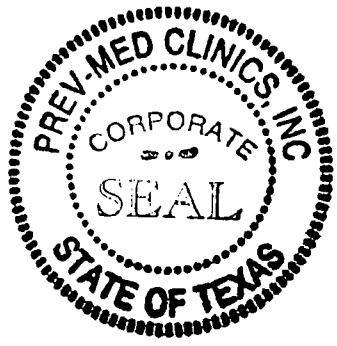
Please advise me of those areas of our clinic model which are consistent with the Administrations philosophy and policy.

If we can be of service to the President in any manner whatsoever, please advise.

Again, thank you for meeting with me. Now that you have seen our video I look forward to hearing your comments on our clinic design and philosophy.

Yours Sincerely,

W. FOURIE
Chairman of the Board



The Washington Campus

1625 Massachusetts Avenue, N.W.
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202/234-4446 FAX 202/234-4505

September 15, 1994

Ms. Jennifer L. Klein
Special Assistant to the President for
Domestic Policy
The White House
Washington, D.C.

Dear Ms. Klein:

Thank you very much for speaking to the executives who attended the program, "The Shaping of Public Policy in Washington," sponsored by The Duke Endowment for the North and South Carolina Hospital Association. Your remarks were well received, and all of the participants enjoyed the opportunity to meet with you.

Your presentation was a highlight of this program and added a necessary dimension to the participants' understanding of the public policy process. We appreciate your being a part of this program in light of your demanding schedule. Again, thank you for your time and interest in the Campus.

Sincerely,

Roz

Rosalyn Davidson Fitch
Associate Director

Thanks for a great session - The group gave you high marks on their evaluation. I'll call you again to speak.

RDF/cs

JEN

The one you love is closer to you
than you think.
Lucky Numbers 36, 32, 43, 51, 5, 11

DANIEL E. HARRISON
40 KATHLEEN LANE
MOUNT KISCO, NEW YORK 10549

2nd Fl
W. W

Ms. Jennifer Klein
Office of the First Lady
The White House
Washington, D.C.

DANIEL E. HARRISON
40 KATHLEEN LANE
MOUNT KISCO, NEW YORK 10549

9-2-94

Dear Jenny,

There are two girls I know who think you are very – no, make that "totally" cool. They haven't stopped talking about their White House tour, and frankly, neither have we. It was the most memorable part of an exciting week. You and your boss are both on the 'serious role models' list around here along with Mozart and Mme Curie.

Thanks again, and did I forget to mention that we're delighted you went to Brown?

Best regards,
Barbara, Dan,
Emily & Debbie

WILLEM VAN MIERIS (1662–1747)

A Woman and a Fish-pedlar (detail)

Born and active in Leiden, Willem van Mieris painted in the style of his father, the genre painter Frans van Mieris. His meticulous technique can be seen in even the smallest detail.

THE NATIONAL GALLERY

3:20 pm

Dear Jen,

Thanks for my book. My computer went down again and I got divorced, so I went home.

I want you to know how much I appreciate your support and encouragement through this difficult year. It has helped in many ways.

See you domani

Love e

faci

Pam

Jen

XO

memo from **DR. JEFF LINDENBAUM**

3/6/94

Jennifer:

Sorry this took so long. Tried to keep it fresh, new and very personal.

Thanks for your ear.

Jeff

Jeffry A. Lindenbaum, D.O., FACOFP
BOARD CERTIFIED - FAMILY PRACTICE
Fellow of American College of Osteopathic Family Physicians

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March 6, 1994

Jennifer Klein
Special Asst. to the President
for Domestic Policy
Second Floor West Wing
Office of the First Lady
The White House
Washington, D.C. 20500

Dear Ms. Klein, Mr. and Mrs. Clinton:

I would first like to thank you, Jennifer, for extending to me the opportunity to communicate directly with the White House on matters that concern me greatly.

For Mrs. Clinton, I thank you for so warmly receiving my initial package of information in Hilton Head at New Years, spending the time to review the information, making yourself as accessible to your temporary "neighbors" in Hilton Head, and allowing me through Dan Emmett and Julie, the opportunity to make my feelings heard all the way to the White House. The fact that private citizens can have that kind of access to you and the President goes a long way in instilling confidence that the present administration is dedicated to trying to do things the best way possible with the maximum amount of input. We are facing a cancer eating away at society today and if we do not stop it here, our children will not be able to cope with the future.

I have spent the better part of the last two weeks since I spoke to you on the phone saying to myself, what do you say to the President and First Lady that they haven't already heard one thousand times before? After all I am not a professional writer, a legislator, a lawyer, politician or even a political activist. I am a doctor who through almost 23 years now in healthcare has seen it all- from medical school in the early 1970's where I faced 23 finals in 11 days sophomore year while my father lay dying in a VA hospital in Philadelphia, to working 36 hours on and 12 hours off for two years as a senior student then as Chief Intern at our community hospital. This hospital was rebuilt and moved in 1983 and since has faced bankruptcy, layoffs and has almost been forced to close its doors due to the changes that

have occurred in the past 10 years. Through hard times, the hospital still stands amid the rumors, the layoffs and the uncertainty that pervades all of medicine today.

As one of few primary care physicians who have participated with both Welfare and Medicare since graduating my internship, I have first hand seen the inequities of the system and to this day, still wonder how these decisions that affect so many can be made without regard for consequences- and once made, create an entirely new bureaucracy to undo the mistakes once they are made. I used to make housecalls until a doctor near us was shot going to a patient's house and when my plumber and visiting nurse are both making more for house calls than I do from Medicare, you say to yourself, "why bother!"

I have faced the terrible epidemics of Pertussis, hepatitis, TB and now HIV, and honestly do not know how much progress we have made when thousands of people are dying every year of these diseases despite all of the advances in diagnosis and treatment. I have seen children that are underimmunized with preventable diseases die because of neglect and the ignorance of their parents.

I have seen the effects of violence and the terrible suffering and psychologic scarring that it has on innocent people and their families and the lack of psychiatric and mental health support out there but unreachable for the majority of Americans today. Sadly it is the criminals that our system seems to protect and not the victims. Your attempts at Crime are noble but fall short and until these repeat offenders are eliminated from society completely, crime will continue and erode at our society like cancer itself.

What are the effects of these changes on the physicians, themselves? The stress is spectacular. I can only predict that it has not even begun to manifest itself as yet but as Reform proceeds, effects will be widespread and catastrophic. Four years ago, I almost died from Sleep Apnea. I was working 20 hours per day trying to keep my practice together, knew I had a Sleep disorder since I was only sleeping one hour a night due to mortal fear of dying in my sleep, and not finding the time to be properly diagnosed and treated, myself. Luckily for me, I was hospitalized with a severe case of phlebitis and while in the hospital, I asked to have a Sleep Study performed. I arrested 5 times that night while on monitor. These incidences are becoming commonplace. Look at the recent incident in Hebron by an ER physician. Look at the abortionist in Florida who was shot in cold blood. Where once we were the center of healing, we no longer "heal thyself". Doctors today are being abused by the patients, the system, abusing themselves, the media and it will only get worse.

Page Three: Healthcare in America in the Eyes of a Primary Physician:

Many of my colleagues are selling out or retiring. In their place are coming 9 to 5 physicians, who for the most part, are being trained to "plug into the system" but are not committed to making the sacrifices their predecessors have made. It is the personal one-on-one relationship with your own physician that made our system great, and now with the advent of managed care, it is take whatever you can get.

In the past, we have seen Jonas Salk, Everett Koop, Denton Cooley and Christian Barnard made the heroes of America. Now they have been replaced with athletes, Rap artists, criminals, big trial lawyers and CEO's of big Corporations as the ICONS of society and every chance the media gets, the medical profession is being bashed. The disaster cases are sensationalized on Phil Donohue or Oprah and the true human interest stories for which there are many more, are at best relegated to the back page of the local newspaper. Where do our priorities lie?

What is even more incredible, the medical profession is being blamed for much of what has happened to Healthcare in this country today. No one wants to shoulder the responsibility and put the blame where it belongs- that is,on each and every American who has taken advantage of the present system and has allowed the insurance industry to dictate policy in the face of obscene profits without consideration to premium reductions with the profits they are making. Each individual in this country must become responsible for their own actions- whether it be smoking, alcohol abuse, illegal drugs, illicit sex, sexually transmitted disease, violence or abuse of the Healthcare system itself through overutilization of available services or working with unethical lawyers creating bogus cases where none actually exist. It is the reponsibility of each Amercian to realize that they are only hurting themselves by allowing this to continue. I feel that education is the ultimate solution to this problem, not legislation.

The Key to Healthcare Reform is that each American must be responsible for their own actions. Only they can eliminate drug and alcohol abuse and tobacco abuse, only they can practice Wellness and physical fitness, only they can utilize services that are available only when necessary and follow the rules of the system, only they can respect the tort system and be fair in its implementation, only they can refrain from the abuses of the immigration system system that allows a hundred Haitians with HIV into this country and then bears the cost of treating them, only they can refrain from abuse of the entitlement system, only they can control the insurance industry and make them accountable for their abuses and only they can elect officials who are dedicated to the good of all and not to special interest groups who rule 'the lobbies in Washington. All must ultimately share the blame and must then share financially, morally and ethically in the Final Solution to the Healthcare problem as it exists in America today.

Page Four: Healthcare in America in the Eyes of a Primary Physician:

As I alluded to in my letter to Mrs. Clinton at Christmas, I created a phrase called "Managed Cooperation" which I believe represents the integration of all of these entities above working together to effect a cure for this cancer that threatens all of us in this country today. It is a financial, moral and ethical issue. It embodies not only who is going to pay for what but how we have to start saying no to care that is not in the best interests of the majority of the people in this country today. As with raising children, often the hardest word in our language is the word "NO". I think we have lost sight of this.

How this is to be implemented in detail is beyond the scope of this letter and in my conversation with Jennifer, she asked me to identify the points of greatest concern to me and what I feel should be done about it. I will do my very best to verbalize concerns to anyone who will listen. I am neither a professional writer nor a university professor type although I do hold faculty appointments as a clinical preceptor to 5 medical schools at the present time and have trained students, interns and residents for all of about the past 20 years. To characterize better I am a primary care physician who has fought disease, patients, insurance companies attornies, bureaucrats and anyone else who stood in the way of my patients getting the best care possible that I could provide. For the past 15 years I have given out at least$2,000 to $5,000. per week in free samples just to be sure my patients would take their medication. I have given money to patient to bury her son of 7 months because she couldn't afford to do so. I was given the "Man of the Year" award by the Bucks County Chamber of Commerce in 1991 for my work with patients with Alcohol and Drug Abuse. Unfortunately, I am not seeing the doctors come out of medical school today with the same work ethic and moral and professional resposibility that was ingrained in me 20 years ago and it scares me to think that this is our future.

MANAGED COOPERATION: A System that integrates an efficient, cost effective delivery of quality healthcare which involves the cooperation and integration of the insurance company, the employer, the consumer, the hospital, the patient, and the inpatient and outpatient network of providers who will provide direct distribution of wellness and treatment of illness to each individual in this country who qualifies for it. It also involves the ethical and prudent decision making process which allows us to realize that we all must die and the ultimate goal is to die in peace and with dignity and without placing unwarranted burden on the healthcare system to effect an outcome that is unrealistic and unattainable.

MY CONCERNS: Enclosed is a list of my greatest concerns and without solutions to these problems, healthcare reform can not be efficiently managed. Some items are causes and some are already effects which serve as a threat to all of us.

Page Five: Healthcare in America in the Eyes of a Primary Physician:

1. Overuse of the Emergency Room and lack of assigned primary care physicians to be called prior to being seen in the ER and treated as an outpatient in a cost effective manner. I will expand on this in the next section "Draining the System".

2. The Stark legislation has backfired!!! This has forced many of the quality concerned physicians to close cooperative ventures which provided immediate access for our patients, provided us a means of helping the more needy individuals to get studies done that they could not have afforded at the hospital and we now have had to fire or lay off thousands of tax paying workers because we have closed our doors to avoid prosecution for self referrals. Instead, businessmen such as accountants, lawyers and the like are opening up their own centers now with no clue what quality in medicine is all about but with bottom line mentality pushing them along. The doctors? The ones that could afford to do it, brought their entities under their own corporate roof and now face the pressure of being the sole support for these entities instead 10 or 20 physicians are bearing that responsbility- who is going to self refer now??? This is a perfect example of how legislative intervention is creating chaos in healthcare today. The winners from Stark? Not the doctors for sure nor the patients- the Hospitals because we have to refer the patients there for many of these studies and the waits are now 6 weeks for the test that I could have done tomorrow at my own facility. Who else- the attorneys who have profited from the formation of these ventures and now are profiting from dissolving them and in many cases, buying them for themselves!!!

3. Physician burnout and overwork: Increase in the number of hours worked to maintain the lifestyle they have worked to attain and often support the debt service they have already committed to, the abuse of drugs, alcohol and themselves and their families- the rising amount of non-reimbursable time for phone calls, night calls and administration of paperwork and running the office. The average physician today taking into consideration for overtime makes about $45 to $75. per hour which puts him closer to my plumber than to my accountant or lawyer and they paid to talk on the phone and have no night call!!!

4. The Incorporation of Private Practice- the wholesale selling of private practice to large insurance companies, hospitals & businessmen who have virtually no clue as to managing these practices efficiently, have no desire to maintain the physician-patient relationship and no sensitivity as to treating their employees to make them feel as though they are an integral part of the practice as in the past. If any group should be banned by Stark, it should be this one!

5. Calling Doctors Primary Physicians when they have not been trained as such! Due to the pressures of Reform, many specialists are opting to call themselves primary physicians when in fact, sadly they are not. Many OBGyn's are treating women for hypertension, many surgeons are now treating patients with colds and Internists who are trained to deliver primary care are sadly not trained in orthopedics, sports medicine, office ENT, psychiatry, pediatrics and Gynecology and yet, the insurance companies allow them to call themselves Primary care physicians because they need to offer more sites to their enrollees to keep them as members. This will only get worse as more and more patients are lumped into the managed care pool. Patients who choose a physician are often in the dark about who they are choosing, and often it is the geopgraphical decision that supercedes the decision of which Primary is most compatible with what patient. This leads to further stress in the relationship when the doctor and patient are confronted with strong philosophical differences.

6. Very Unfocused Medical School and Postgraduate Training- this is our future and in most cases, education still revolves around the unpractical knowledge and less about the real world. Most primary care programs are not training doctors in private offices but in clinics on guinea pigs for patients. These are poorly supervised at best with physicians who are paid much less than in the private sector so the good ones stay in their offices. Most primary care residents will practice in a private office setting and yet, they receive often less than 20% of their training in these primary settings.

7. Lack of Educating Doctors and their Staffs to "Manage the Office let alone Manage the Patient's Care". The key to being successful in Managed Cost Effective Care is to know how and when to utilize the services most efficintly- there is incredible waste both within and without the office as it exists today. The doctors have not been trained themselves, and those that have, do not have the time to train their staffs. Often, it is these staffs that are the most important in controlling costs and yet they are often made of relative, friends and neighbors who have little or no training themselves other than watching a special on TV or overhearing something someone else said at a cocktail party! It is incumbent upon the system to provide this educational process to both the doctor and his staff immediately or no change in the system will work.

8. Sacrificing of Quality in the Face of Economy: the challenge delivering quality preventative care without the fear or the feeling of being economically penalized for ordering a test that a doctor feels is indicated. In addition, being provided access to testing in a timely fashion without being burdened with spending hours trying to obtain approvals

from the insurance company before the test can be done.

9. Universal Anxiety and Depression Among Many Physicians: loss of self esteem, lack of family time, loss of income, loss of free time replaced by non-reimbursed time for call demanded by the insurance companies and at the same time overwhelmingvolumes of paperwork. Patients have become more demanding with often unrealistic expectations. We often are treated without respect and our staffs are verbally cursed and abused trying to enforce the dictum of the insurance industry.

10. Tort Reform: the risk of a malpractice litigation is forcing many physicians to order defensive and expensive tests in order to avoid exposure to malpractice claims. Although over 85% of malpractice cases in this area are found in favor of the physician, the physician often has to undergo a degrading 5 year ordeal before resolution of even the most spurious claim against him. In addition, while these cases are still pending, we must report these cases to every insurance company we participate with and every active Hospital Staff we have privileges at. In other words we are treated as guilty until found innocent.

11. Paperwork Deluge: often also these services are non-reimbursable but yet expected. Ask a patient for $25.00 to copy a 100 pages of medical chart and then put in the ear plugs! The overhead expense has tripled in the past 5 years but the services they perform are for the most part non-compensable.

12. Escalating Office Overhead: not only from processing of Paperwork, but the increase in dues to belong to all of the local, state and national organizations in order to maintain board certification, but to belong to multiple hospital staffs to qualify to enroll in many of the existing insurances (it's blackmail) and now to drive a stake into our heart, the DEA has just sent us an arbitrary increase in their fee from $60. to $210. overnight- in fact so sudden the $60 fee is crossed out and the $210. is written over it!!! I'd be in jail if I did that to a Medicare patient!!! In addition, the cost of employee benefits is breaking our backs and many offices have resorted to hiring parttime help again decreasing the quality of the delivery of care in the office. All of this in the face of Insurance company scams (I mean legislation such as Act 6 and Act 44 in Pa.) whereby insurance premiums have increased and payment to providers has been cut by more than 40% in many cases. In addition, the Medicare fee schedule was used as a templete in determining reimbursement in Workman's Compensation even though Medicare patients generally do not work or are disabled and can not work- is this fair and equitable??? This is making a living running an office almost impossible- in fact, the reason why

hospitals are buying practices is to obtain the referral base for ancillary procedures and Pete Stark does nothing about this!

13. Introducing a Universal program all over America before it is tested in maybe 10 or 20 markets around the country. These should be Urban, Suburban and Rural in nature and should be instituted for at least two years before final decisions should be made- if not, the cost of correcting mistakes could far exceed the proposed cost savings. Medicare should have taught us this lesson.

14. Erosion of the Doctor-Patient Relationship- confidence in physicians is at an all time low. The media doen't help. Many patients have switched primary physicians or have had to enroll in a new office with multiple doctors because of insurance company dictum, and often, it is nearly impossible to see the same doctor twice for the same problem. The private sector is often put into a clinic type setting and they resent it. As access becomes more and more difficult, these problems will become worse, not better. It is alarming but when I see a new patient, I always ask them who was seeing them previously, almost 50% of these patients can't even remember his name or the location of the office they went to? When I ask how they were referred to my office, 10 years ago it was by word of mouth, reputation or how nice my staff was on the phone with them, now the most common response is "I got you out of the insurance book and your office was close to me"- surely not a foundation for developing a good doctor-patient relationship.

15. Push for increasing the rights and practice scope for non-physicians to perform the roles that physicians previously held solely. Thus P.A.'s, optometrists, chiropractors, certified nurse practioners, midwives are being pushed for further privileges by the insurance industry because they offer a cheaper alternative. Not only this, but often, they are reimbursed as much if not more than the physician is due to coding quirks or being able to circumvent the system with creative CPT-4 coding antics which are legal but create further inequities in the system. I know many chiropractors that are making two and three times what doctors are making solely because they are manipulating more than their patient's backs and yet are working less than their physician counterparts.

16. Excess profits of Insurance companies should be capitated just like we are and should be put back into the system in form of mandatory premium reductions. The screws keep tightening on the healthcare vendors but the resulting increase in profits are not being passed on to the consumer.

17. Mental Health Support is in most cases POOR. Access is POOR. In many situations, psychologists are seeing patients as an economic alternative to psychiatrists and then they are calling us on the phone to suggest we medicate these same patients without hardly any training in administration psychopharmacologic drugs to patients who are in crisis. I have been trained to some degree and am still uncomfortable doing this 4 to 5 times perweek. In many cases I refuse and have to spend more non-reimbursed time trying to beg an insurance company to send this patient to a qualified psychiatrist for medication.

    People are becoming more violent, promiscuous, permissive, abuse is rampant and if there was ever a need for more not less, it is now. This lack of access is also adding the escalating ER costs since many of these patients end up in ER in crisis seeing an ER physician who is too busy to talk to these people and this is what they need the most!

WHAT IS DRAINING THE SYSTEM???

1. Enough is Enough Care- the 91 year old nursing home patient who is subjected to cataract surgery, the tertiary care patient who has no hope of surviving and who is kept alive on support because a family can not or will not make that decision, spending a million dollars on separating siamese twins who have no hope of surviving, treating the terminally ill with more than just palliative custodial care in their own homes or in extended care facilities instead of acute care hospitals. In order for this to be done ethically, each hospital that already has an ethics committee would have a group of physicians, attorneys, clergy and other reponsible local leaders including healthcare administrators, that could rule along with the families to make immediate rulings on cases that are now a catastrophic burden on the system. If we do not responsibly embrace the healthcare cost of futile healthcare in this country, it will be the death of the system, not the patient that will affect all of us who survive.

2. Unnecessary Entitlement Care- caring for those who should not qualify either because they can work and contribute to society or because they are illegally in this country- this may not be politically correct but must be addressed. Medical care to Mexicans and Canadiens who flood over the border as well as boat people and refugees from Europe and Asia are affecting all of us and must come to an end. Human rights are important but allowing these people to fall through the cracks is hurting all of us. I recently met a woman in my office sent to me by Social Security Disability who was from a Third World Country and who had just arrived

in America two months earlier, could not speak any English, who had never worked a day in her life, and the government was paying to have her evaluated for Social Security benefits? Figure that one out and probably multiply the cost by ten thousand or more. Who screens these people?

3. Crimes and Violence and Medical Treatment Expense that Results- this is the single most rapidly growing drain on the resources in this country today and is closely related to number 4 and 5 below. Until we can control this, we can not hope to get a grip on healthcare costs. I firmly believe that the main reason for the 5% discrepancy in GNP between the USA and the rest of the World in relating to healthcare costs, is due to domestic violence, the more ready access to the ER that Americans have over the rest of the World and the epidemic increase in domestic violence, drugs and alcohol abuse and accidents due to these problems in this country today. The discrepancy is also caused by number One which mandates over-utilization of medical services until the last breath no matter how futile for fear of litigation which does not exist in many other societies around the World.

4. Abuse of Drugs, Alchol and Nicotine: this is escalating despite the pouring of millions of dollars into programs of law enforcement and treatment. The money should be invested in stopping the act before it happens in the pre-teens in schools and around the country- once they are hooked it is too late. It is the morals and ethics that are degraded and the media is as much to blame as anyone. Taxes on these items are a start but unfortunately cannot deter a person who is physically addicted to one of the items above- they will only go out and steal more to afford their habit often resulting in more violence in society. If the tobacco lobby was not so large in Washington, I am sure that a Federally mandated smoking cessation program would have already been instituted in the country today.

5. Poor Mental Health Access: I will not belabor the point but managed care has even worsened an already pathetic delivery of care today. Triaging of crisis care in mental health today over the phone is the rule, not the exception. Many of my patients are given appointments weeks after the initial call, only to be hung up on when they call back asking to be seen sooner. In most cases, the mental health provider makes more money by not seeing the patients. The more stressed and abused people are becoming, the more necessary these services are, and the less they are getting. Most good psychiatrists remain in the private cash paying sector, having tasted reimbursements of less than 50% of their fee as a rule and a record keeping requirement that has them as more secretary than physician.

In addition, the requirement from the insurance company making it imperative to furnish often confidential information to the company to qualify for reimbursement of sensitive, ethical issues, makes it a form of medical blackmail that the insurance industry is holding over the physicians. This forces patients often to quit care and self medicate with alcohol, street drugs or to seek a bandaid drug from an already beleaguered primary physician who just wants to get these troubled people who need talk and not often drugs, to get out of their office because they are taking up too much time.

6. Overuse of the ER: I keep landing back in this court but it is vital to realize that ER physicians are not trained in primary care, and often 30-50% of what they see is primary care oriented. Because the patient never comes back to see them again, I see these patients days later and find the care they received was not worth it for the most part. Primary physicians can often handle immediate care for earaches, strains and sprains, simple fractures, bronchitis, etc. as an emergency call over the phone, as well if not better after a person has waited in an overcrowded ER for 3 hours and then run up unecessary expense receiving expensive ala carte treatment which would have been covered the next day for free in the primary physician's office or by referral elsewhere. ER should not have to live in fear of Hill Burton, and must be required to call the primary office before patients are seen in the ER. This seems oversimplified but with the advent of the 24 hour pharmacy in our area, I can treat most "emergencies" over the phone at no additional cost and see these people hours later in my office anyway. However, there should be an incentive to the physician for being on 24 hour call- not in existence at this time.

7. Overutilization of Services: This is eating away at everyone's wallet- the duplication of tests because old records are not readily available and sick people need immediate care. Some tests are not necessary because it is easier for the physician to order a test than it is to spend 15 minutes of time listening to that patient and finding out what is really wrong with them. Tort reform and malpractice is also causing the ordering of tests which are more for window dressing and are not vital to the diagnosis and treatment of most patients. Often physicians attempt to CYA in order to avoid further exposure.

8. Unrealistic Expectations of Patients demanding the "Best" just as long as their insurance company foots the bill but the same people will refuse a test if they know there is a co-insurance or deductible involved.that they must pay for themselves. If patients were required to pay to come to any office, a great number of unnecessary visits would be eliminated. This would allow greater access for "sick" patients to be seen sooner.

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In 1941, Ted Williams hit .406- for this he has received honors for the past 50 years. If we as physicians batted .406, we would have so many malpractice cases we would be in court more than in the office!!! Doctors consistantly bat over 95% but this is often not good enough if the one bad case happens- it is both a tragedy for the patient and their family and devastating for the physician, himself. The physician oftens feels badly enough without being put through 5 years of litigation and disruption, humiliation and often discrimination by insurance companies for that one bad case. This must be put to rest immediately. There are enough stressors out there already without adding this to the fire. Physicians are so afraid of making a mistake, the decisions theydo make are often without logic and are often much more costly. Malpractice phobia is so pervasive in the teaching of the doctors in training, good judgement and the investment of time in listening to patients is often forgotten. The fear of referral to more qualified individuals is often a cause for malpractice and this should not be. Instead of being penalized as a primary physician for having a sick patient, he should be rewarded if the early diagnosis and treatment affords a cure or a more cost effective approach to treating the disease.

9. Spiralling Costs of Running a Practice: With regulatory disasters such as OSHA, CLIA and OBRA and American Disability Act (in which I installed $15,000. in repairs to my office to accomodate the new law and was then told by my accountant that the practice grossed $16,000 too much to qualify for the tax credit on this handicap construction), these laws are creating another$5-10,000 per year overhead expense in each office. In addition, as stated earlier, the dues, licensing fees and fees to join IPA, PHO etc. are doubling and tripling expenses in the office and when more than one physician is involved, each physician is charged ala carte creating incredible burdens on practices financially. The increased costs of Payroll and Benefits, the new Pension laws and the expense of administrating them, the accounting costs of tracking all of these new Federal mandates with ERISA and discrimination practices, etc. has made the doctor's office a House of Horrors instead of a House of Healing. Most physician's can not cope with handling cost effective administration of their own practice, how naive can those in Washington to believe that they can handle referrals and cost-effective medical care outside of their office???

   Through tax credits and the consolidation of much of this overhead expense with malpractice insurance, dues and licensing requirements, maybe then there maybe some light at the end of the tunnel.

SUMMARY: As I have described the patient is on one side of the fence and the insurance company is on the other side with the healthcare providers stuck somewhere in between- often, it is right on the fence. Often this system is so large that the patients can not see past this & try to bypass the system by calling the insurance company directly. They are then told insurance company rhetoric which puts the healthcare provider in a bad light, causing the relationship with the patient to deteriorate. Often, if the patient does not like what they hear, they go to the ER or worse, go to a specialist without a referral. Basic coverage should be provided as you have already stated however, each person should pay something they can afford in order to prevent a flood of patients at our door looking for a free ride. By instituting mandatory up front co-pays, it would act as a deterent for patients spending hours in our office on a weekly basis. More definitive treatment should also be provided but the payment for these more complex services should be accompanied by larger co-pays which is based on annual reported income on a sliding scale. These larger co-pays should be guaranteed by MSA's or other funds that are not in control of the patient since often these patients would try to avoid payment and thus create further billing headaches for our office.

If you amortize the amount of time a physician spends on non- reimbursed time including emergency calls, phone calls, hospital meetings, midnight ER calls and the deluge of paperwork which can often amount to 20 additional hours per week that a physician works for free, most doctors calculating for overtime, are making between $40 and 75 per hour!!! On the surface for 70-80 hours perweek, this appears to be a good living and to the general public it is. Is it quality living at 80 hours per week? Are their families seeing them? Are the physicians abusing themselves and ultimately going to abuse their patients for they are functioning impaired? Are we creating a new class of berserk individual that can go into a mosque in Hebron and shoot up a Holy place? Is it the irony of physician's being trained to heal that these same individuals are now the messengers of death?

Before we proceed much further with Healthcare Reform, I suggest that we look closely at the engine and transmission of of the machine, and make sure that the system can bear the stress that these changes are going to place on it. If the physicians are not functional and can not deliver the quality of care the system demands, we are going no where!!!

It should also be said that the oil in the engine must also be changed frequently or the motor will burn out. This real danger is from the effects that the insurance industry is already dictating to the "system". Via legislative changes which their lobbies have pushed such as Act 6 and 44 in Pa., independent peer reviews are creating windfall profits for the companies in the spirit of Healthcare Reform but in actuality, these are not independent since they are being funded by the insurance companies, themselves. This results in unnecessary litigation further adding

to the expense of medical care today. If truly independent reviews for utilization were to honestly be monitored, a true and fair system for charges in question would occur. It is important to work on this aspect and to take the power out of the insurance company whose motivation is obvious. After Act 6 and 44 were enacted, although physicians suffered cuts in reimbursement of up to 50%, insurance premiums hardly decreased at all if any. Instead, windfall profits went to the insurance companies and stocks like US Healthcare, Equitable, John Alden and Humana more than doubled in one year. There are many others that doubled in the same year of the floods in the middle of our country, Hurricane Andrew, the fires, earthquakes in California and the worst Winter in the East in history. Our healthcare system is subsidizing the liability industry.

If the insurance company can capitate the provider and hospital, we should be able to capitate them. A cap should be built into the system to cap their profits as well and these excess profits should automatically be fed back into the system to fund premium reductions for the following year before the shareholders are able to profit on our misfortune.

Finally, I must also say that although we have 2 attorneys in the White House, tort reform is overdue and adds further stress to a system that can not bear it. I also included an article sent to me about capitating legal services just as medical services are being capitated. I would like to hear what the two most famous lawyers feel about this proposal from Mike Royko from Tribune Media Service- I would like to see the legal profession trade their $150 to $250 per hour fees and the ability to charge for phone calls and to generate reports without taking night call or having fees regulated by a profit driven insurance company.

There is a lot right about Healthcare in America but there is also alot wrong. Before we take a leap, we better look and see where we are heading and who we are going to trample in the process of getting there. I do not know if the providers in this country are capable of getting smashed any further.

In conclusion, I care very much about what is going to happen in Congress and in Washington about Healthcare Reform in the next 5 years. I wish the President and Mrs. Clinton and Congress the courage, wisdom and strength- and oh yes, patience to make all of right choices.

Sincerely,

Jeffry C. Lindenbaum D.O., FACOFP

Jeffry A. Lindenbaum D.O., FACOFP
Board Certified-Family Practice
Fellow of American College of Osteopathic
Family Physicians

A lawyer in every pot

Why not comprehensive legal care for every American?

Mike Royko

TRIBUNE MEDIA SERVICES

The elderly woman said her neighbors are driving her crazy. They have noisy parties; their kids throw junk in her yard; and their dog barks at all hours of the night. When she complains, the neighbors are rude.

She calls the police, but they are busy with more serious crime.

"So I went to a lawyer in my neighborhood and asked him if he could do something," she said. "But he told me that mostly he does real-estate closings and wills and things like that. And that it was just a neighbor thing and it wouldn't be worth his bother, and besides, I couldn't afford it."

This woman is an example of one of the most serious social injustices in this country. She does not have a lawyer of her own. When she needs one, she has to go scrounge around.

Even if she found a lawyer to take her case, he probably wouldn't be top-drawer, because she is a person of modest means and can't afford the best legal care.

It's clear that what this country needs is a massive overhaul of the legal system, leading to comprehensive legal care for every American.

I'm surprised President Clinton, his wife and Congress haven't placed comprehensive legal care as an entitlement high on their agenda to make us all happier.

I'm surprised President Clinton, his wife and Congress haven't placed that as an entitlement high on their agenda to make us all happier.

Many millions of Americans have no legal care. Others have to depend on some neighborhood storefront lawyer, who is no match for some slickster from a big firm.

Every day, hundreds of thousands of Americans go into traffic courts and plead guilty, even when they are innocent. Why? Because they can't pay a lawyer to get them off the hook.

Others go to divorce courts and feel they got shafted because their lawyer was not zealous or clever enough.

It isn't that there aren't enough lawyers. We have more than 800,000 in this country. That's 150,000 more lawyers than physicians.

The problem is in the way the law industry operates.

Most of the brightest lawyers try to join big, established law firms, where they can represent corporations and individuals who have lots of money, so they can become wealthy themselves.

Let some bag lady walk into one of these plush firms and say she wants to sue someone for shoving her off a heated sidewalk grate. Why, she won't get past the reception desk.

Others specialize in real estate, zoning, taxation, estate planning, work for corporations, or concentrate on other specialties. That means they have no time to bother with someone who doesn't have real estate, a corporation, a big tax problem or an estate to plan.

Ask one of them to go to police court and represent you for punching out someone in a bar and they will turn up their noses.

The result is that the average mope gets no legal care or only that which might be second-rate.

Consider someone like Hillary Rodham Clinton. She is said to have been one of the finest lawyers in the country when she was in Arkansas with Governor Bill, and I don't doubt it.

But did she represent some snaggle-toothed Ozarks Rufus in a dispute with neighbors over possession of stray pigs?

No, despite her social conscience and compassion for common folk, she was in an executive boardroom, showing corporate suits how to structure multimillion-dollar deals.

The same can be said for her husband, also a lawyer, and the many other lawyers in the Clinton inner circle, as well as the Congress. Few, if any, ever went to court to battle over child custody or possession of the car and stereo and dog.

The system demands change. We should have a system of National Legal Care that would assure all Americans a lifetime of the finest legal care. The lowliest purse snatcher should be assured of legal care equal to that of the wealthiest Wall Street swindler. And at reasonable prices. Or no price, for those who don't have money, or prefer spending their money on fun things.

This could be done by breaking up the big law firms and assigning lawyers to Legal Maintenance Organizations. Then, all Americans could have their choice of which LMO they want to belong to.

To cut down on waste, the government could establish a bureaucracy — or require states to do it — that would decide how much a lawyer could charge for any service and to reject needless meetings, phone calls, briefs, motions and other bill-padding practices.

They also could set limits on how much lawyers could earn a year and how much they could spend on ties and tasseled loafers.

The bureaucracy also could set other professional quotas, such as how many lawyers can specialize. That could force many lawyers who chase ambulances instead to settle family disputes over who inherits grandpa's three-flat.

How could this be funded? Through a variety of special taxes on yellow legal pads, expensive cigars, cuff links, health-club memberships and other legal necessities. There also could be law school tuition taxes, graduation taxes, bar test taxes, and a special tax on the income of any lawyer who works for a governmental agency, a higher tax on lawyers who run for public office, an even higher tax on those lawyers who win election and a 100 percent re-election tax. Let them live on their campaign boodle.

And who would administer this new, fair, comprehensive legal-care system?

The answer is obvious. A panel of impartial doctors.

I'm sure the Clintons would consider that only fair.

THANK YOU MR. ROYKO...

maybe this will allow us to share a little pain together.

Jeffry A. Lindenbaum, D.O. FACOFP

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March 14, 1994

Dear Jennifer:

Enclosed please find a copy of a letter that I wrote to my local legislator Foy Reinard who is the Republican Vice-Chairman of the Pennsylvania House Insurance Committee. This letter outlines just one aspect of what "Healthcare Reform" is already doing in the State of Pennsylvania. It does illustrate the early effects of the Cancer that is now spreading through our legislatures around the country and must be addressed before further mistakes are made. I hope that by writing to you, I can make you aware that from my perspective, not all that is legislated is done with the full understanding of the far reaching effects and these effects are not only not anticipated, but are often overlooked in our zeal for cost containment.

I encourage your response to the points raised. Thank you for your interest.

Sincerely,

Jeffry A. Lindenbaum DO, FACOFP

COPY

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March 13, 1994

Dear Mr. Reinard:

I recently received your March 1994 report and would like to offer my observations as a Primary Care Provider in Bucks County and one of your constituents for the past several years in Bristol and Bensalem (I live in Ivyland).

On page two you mention that you have supported Act 44 which from my perspective has been nothing short of the insurance industry's license to steal. Similar to the windfall profits of the 1973 oil embargo for the oil companies, the legislature railroaded this bill through without the State government being prepared to administrate the provisions of peer review, cost containment and facilitation of the backlog in our legal system. In stead it has produced the following:

1. Incredible confusion in the legal system whereby even the attorneys can not figure out what the law states and has created greater likelihood that litigation will occur.
2. Has propagated the myth of the " Independent medical Exam" which is funded by the Insurance industry and is composed of a stable of Medical "hacks" who will say anything for the insurance company in order to keep a steady income coming in.
3. You have bragged that the Law has resulted in a 6.7% rate reduction- wake up and realize that the physician fees and ancillary rates have been cut over 30%- where is the difference in rates going? I trust it is landing up in the treasuries of the insurance companies and being made to disappear in order to fund the horrible casualty losses they have suffered with all of the natural disasters this past two years- at the health care provider's expense.
4. The premise itself for coming up with a fee schedule is in itself absurd- how can you base a fee schedule for Workman's Compensation based on a patient population that is either too old to work or is disabled and can not work??? Somehow, a very shrewd insurance company whiz has once again come up with an actuarial scam which has hoodwinked the Government of the State of Pennsylvania. Congratulations!

5. Legislation that follows along the line of the Pete Stark mentality that says that physician self referral to centers in which a physician has a financial interest, is now a CRIME to refer a patient. Our entities which have functioned for the quality care that are patient's received and not the financial rewards are now closing. People who were paying taxes and Centers who were owned by us and paying taxes are now closing with a significant loss of tax basis, loss of jobs and patient inconvenience because these patients are now having to "wait their turn" at hospitals and other free-standing facilities due to over-crowding- does this make sense? I for one received less than a 14 % return based on the number of referrals I made to the center in 1993. What this means is if I had performed the "physical therapy" in my own office with not not nearly the quality of staff and equipment that our center has with the pooled resources of 15 physicians, I would have realized almost a 700% greater return by keeping these patients under my roof as Stark is recommending. In addition, by bringing everything under my roof with only my practice to support it, don't you think this is a greater incentive to overutilize rather than having a 5 or 6% ownership in a quality venture? I also can not afford the $200,000 in equipment and the 8 physical therapist salaries that were on staff when we were going strong. All this for cost containment? Instead guess who is buying up these centers? You guessed it- the very people that are legislating against us- the accountants, lawyers and insurance industry mavens who know a good deal when they see one! Did you ever go to a real estate settlement and watch your attorney get a legal kickback from the title insurance company??? Were you ever sold a tax shelter from your attorney and see him get a 10% finder's fee or more? Why is this legal and having a physician refer to a center in which he is a 6% owner not? I think this is absurd.

6. Are you aware that the average physician performs about 15 hours of non-reimbursed work per week on paperwork, night and emergency call, bad debts, insurance markdowns which are arbitrary fee cuts and if you amortize the true overtime they work over 40 hours per week, they are making in the neighborhood of $45- 81. per hour. My attorney charges $175.00 per hour, charges for phone calls, takes no night or weekend call and is able to enter into any joint venture, side venture, insider venture and can get away with a license to practically steal. It is no wonder the medical profession is becoming more and more inflamed. I enclose an article referring to capitating legal services and encourage you to draw parallels to medicine and see what would happen to the legal profession if this were to become the gospel. WOW!!!

Page Three:

All of this rhetoric is of no use if I do not make valid suggestions. Here they are:

1. Charge the insurance industry with the task of honestly assessing their windfall profits since Act 6 and Act 44 were enacted and pass these excess profits along to the consumer as REAL premium reductions (retroactively).

2. Reinstate the ability of physicians to own ventures as long as they are monitored for cost containment principles, quality assurance and that no one physician owns more than 10% of the entity and that all owners share equally no matter what their referral volume is.

3. Make "Independent Medical Exams" just that- independent. Let a fund be established by the State funded by the Employers and Insurance Companies as part of the premium the employer already pays for Workman's Compensation, so that there is no further burden on the employer, but this would allow physicians to review cases without fear they will be cut off from the Insurance Company referral list if they side with the plaintiff. This would result in much fairer decisions, thus eliminating the horrific backlog of cases in the Work Comp courts that are plaguing our patients often jeopardizing their medical condition since they are delayed in getting proper treatment due to funding being held up and the hospitals refusing to admit patients without proper insurance clearance. It is a disaster!

4. Establish true Quality Assurance and Utilization Boards who are also independent and can rule immediately in cases of overutilization and unreasonable and unnecessary care to avoid further litigation where possible. I have been involved with Quality Assurance and Peer Review for the past 17 years and can tell you when a case I review goes back to the treating physician, it is often met with much less resistance and less resultant litigation because I am fair. I do both plaintiff and defense work and thus, I try to be as independent as possible. This is truly the most cost effective way to be.

5. Establish a mechanism whereby a physician can contact the State to immediately rule in a case where a patient needs medical treatment immediately and can not obtain a ruling for months and often years because the case is tied up in the legal system. It can be a disgrace at times.

I can go on for hours and have. I am also enclosing several other letters I have recently sent for your further information. I look to your leadership to get the word out and really inform the legislature what is happening in healthcare today. I thank you for your interest.

Sincerely,

Jeffry A. Schneiderman, DO, FACOFP

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

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DRUG UTILIZATION IN PRACTICE

For Physicians Serving Patients Enrolled in the Blue Cross and Blue Shield Federal Employee Program

Volume 1, No. 4 July 1994

To Comply Or Not to Comply?

A Physician's Perspective

By Bruce Kehr, M.D. and John Hawks

Noncompliance has become an all too common problem in the physician/patient relationship. Although it is difficult to determine the actual scope of the problem, as many as 60% of patients may be noncompliant with their medication regimens. [1]

In order to examine this issue thoroughly, one must first ask, what is noncompliance?

After receiving a prescription from the physician during an office visit, the noncompliant patient falls into one of three categories:

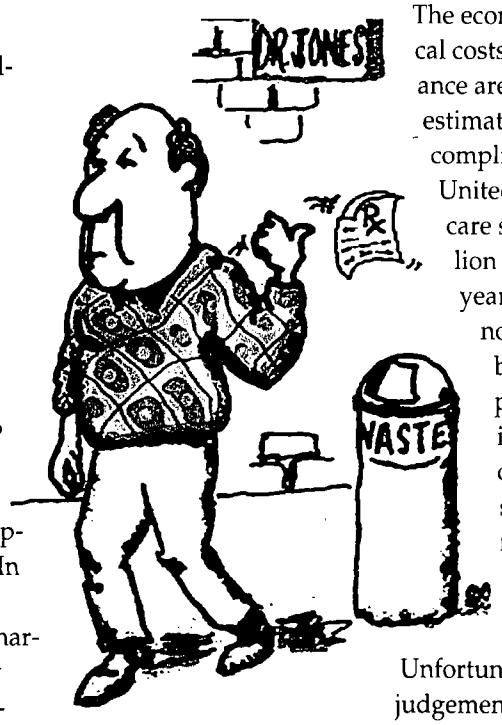
1 The patient gets a prescription from the doctor, but does not have it filled.

2 The patient does not take the medication as prescribed.

3 The patient does not have the prescription refilled, although he or she has been instructed to do so.

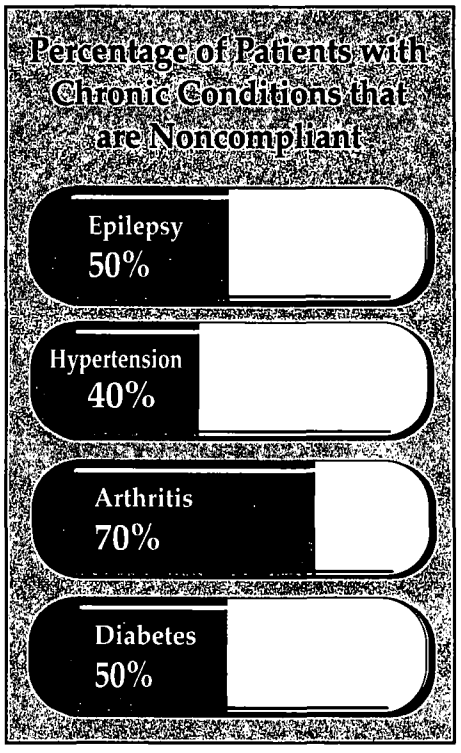
A 1991 Elixhauser study found that 75% of patients with chronic illnesses do not refill their prescriptions after one year. In a 1988 Upjohn Company study of pharmacy services, nearly one in five (19%) consumers interviewed reported that they had failed to fill a prescription at least once in the past year. The main reasons were that they felt they did not need the medication or did not want to take it. Cost was a factor in less than 10% of cases. The American Association for Retired Persons (AARP) found similar reasons for noncompliance in its 1992 study.

Noncompliant patients fall into two groups: intentional and unintentional noncompliers. The first group knowingly omits medications for the reasons cited above. The second group really wants to self-medicate properly, but can't because of forgetfulness or confusion, particularly when taking more than one medication.



The economic and clinical costs of noncompliance are staggering. It is estimated that noncompliance costs the United States health care system 150 billion dollars each year. In addition, noncompliant behavior exposes patients, to the increased risk of disease progression, relapse, failure to improve, and even death.

Unfortunately, clinical judgement is not enough to recognize a noncompliant patient. Studies show that physicians accurately predict only 10% of noncompliant patients. Rates of noncompliance are unrelated to age, race, gender, education, or socioeconomic status. It appears to be highest in people with chronic conditions.[2]



Numerous studies demonstrate that patient knowledge and understanding of prescribed medication and its purpose help ensure compliance. Yet research shows that 60% of patients do not know why a particular medication has been prescribed. Physicians can increase the likelihood of patient compliance by counseling them about their condition, the role of treatment, and the importance of compliance. A Johns Hopkins University researcher who studies the role of communication in the

Continued on page 2

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July 27, 1994

Ms. Jennifer Klein
Special Assistant to the
President for Domestic Policy
The White House
Washington, DC 20500

Dear Jennifer:

We are pleased to enclose a recent newsletter published by PCS Health Systems Inc., which features current issues in medication noncompliance, and Medication Management Technologies Inc. Recall that PCS was recently acquired by Eli Lilly for over $4 billion. PCS is one of the largest prescription drug benefits managers in the United States, and we are pleased with their interest in medication compliance related matters.

Our private placement memorandum is complete. All consultants and management are under contract. We are especially pleased that Mark Maciejewski has joined us as Vice President of Operations and Business Development. Mark has 15 years experience in medical product development, marketing and sales.

We hope that you find the enclosed article interesting. Best regards.

Sincerely yours,

Bruce A. Kehr, M.D.
President

Enclosure:
As Stated

BAK/dlb

Kehr\PCS-News.Ltr

tele: (301) 984-1566
fax: (301) 816-0907

MEDICATION MANAGEMENT TECHNOLOGIES, INC.
Georgetowne Park
5920 Hubbard Drive
Rockville, MD 20852

June 21, 1994

Ms. Jennifer Klein
Special Assistant to the President
for Domestic Policy
The White House
Washington, DC 20500

Dear Jennifer:

We thought you might be interested in the enclosed article from American Medical News, which references our company. A product development company is at work transforming our prototype design into fully production-engineered products, incorporating focus group data into the design effort.

Private placement capitalization is planned for September. Thank you for your continued interest. Best regards.

Sincerely yours,

Bruce A. Kehr, M.D.
President

Enclosure:
As Stated

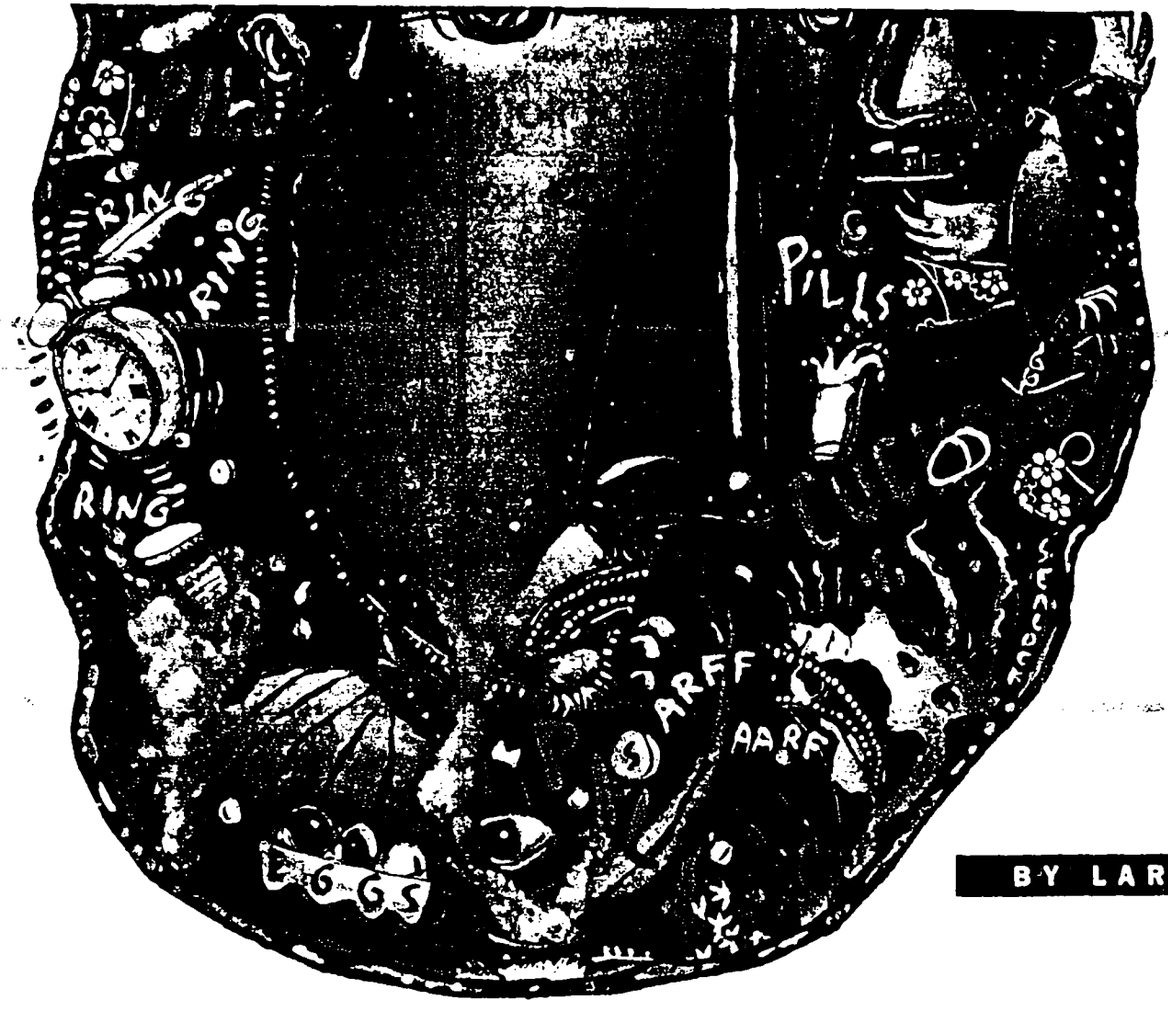
tele: (301) 984-1566/fax: (301) 816-0907

American Medical
News - June 13, 1994

HEALTH

Oh, that reminds me!

With compliance devices, you can help patients follow treatment plans



One of the biggest frustrations of doctoring, says Bruce A. Kehr, MD, a Rockville, Md., psychiatrist, is that your success or failure depends on the cooperation of patients. And their motivation to comply with treatment instructions is uneven and largely unpredictable.

"No matter how accurate your diagnosis and effective your treatment plan, you'll fail if the plan isn't implemented," he said, arguing that helping patients comply should be a part of the plan itself.

Dr. Kehr became interested in patient compliance after having to hire a full-time caregiver for his grandmother solely to monitor her medication regimen. "She was basically very competent," he recalled. "But the regimen was complicated, and it was hard for her to keep up with it."

Also advocating more attention to compliance is surgeon John Urquhart, MD, now professor of pharmacoepidemiology at the University Of Limburg in Maastricht, the Netherlands.

As a medication's dosage increases it may approach toxicity, making compliance monitoring essential, Dr. Urquhart said. A physician who increases the dosage to improve response without realizing that the patient wasn't previously taking the

See ***REMINDS****, page 20*

BY LARRY STEVENS

ILLUSTRATION BY RICK SEALOCK

Reminds

Continued from page 17

full prescribed dose "could be making a dangerous, even fatal, mistake."

Both Dr. Urquhart and Dr. Kehr have proprietary interests in their advice. Each has designed a high-tech product to aid compliance.

Dr. Urquhart's "Medical Event Monitoring Systems," or MEMS, monitors adherence. It provides a computer-generated report that lists the dates and times a pill container is opened. He is chief scientist for its manufacturer, Aprex Corp. of Fremont, Calif.

Dr. Kehr's "Multi-Monitor" is due on the market later this year from Medication Management Technologies, which he heads. It automatically dispenses drugs on schedule, while also providing more limited patient compliance data.

Array of devices

MEMS and Multi-Monitor are two of a group of devices aimed at helping patients comply with their drug regimens. The products range from microprocessor-based machines to mechanical bottle caps or stick-on labels. They can be as simple as homemade calendars or charts.

Their cost and ease of use also vary widely. For example, at several dollars per week to track one medication, MEMS is intended for short-term use, mainly by noncompliant patients who are unable or unwilling to own up to the problem. The Multi-Monitor dispenser is expected to sell for $100 or more, so it is advised for severely impaired patients who can't keep track of dosages or schedules, and who have caregivers to load and program the device. A variety of low-cost, lower-tech dispensers, some with timers, can help competent patients who simply need reminders.

Medicare does not cover the devices. Nor generally do indemnity insurers and managed-care programs, which are awaiting more evidence of cost-effectiveness, spokesmen said. One distributor said he had persuaded the his state's Medicaid and workers' compensation programs to cover his company's device; but such examples are rare.

As a result, physicians must consider carefully before recommending a device. In addition to cost, important factors include patient temperament and lifestyle, said Peter Rudd, MD, a California internist who has researched the impact of compliance on hypertension.

Dr. Rudd, associate professor of medicine at Stanford University Medical Center, asked patients who admitted to having trouble with medication instructions if they would be willing to use a device.

"There was a wide range of answers," he said. "Some people would only use one type of device, but not any other. For some, no device was well-suited. For example, many patients who had to be in public for most of the day were uncomfortable with devices that include an audible alarm. And only the most organized of patients, or those who had help from a family member, were successful using pill containers with different compartments for each med or time of day."

Continued from facing page
taken only one pill daily.

If the physicians had relied on the pill count, they might have assumed the boy was missing one dose a day, and therefore switched him to a once-daily dose. That, of course, would not have solved the problem of his lengthy "medication holidays."

As a result of the MEMS data, the patient's pediatrician was advised to counsel the family and monitor the boy's pill-taking behavior more closely through telephone calls and more frequent office visits.

Another study involved 32 diabetic patients who were taking one, two or three pills a day (*Annals of Pharmacotherapy*, July/August 1993). Fifteen patients were monitored using MEMS; the rest were checked using the pill-count method. After two months, investigators were asked to make follow-up recommendations. They advised counseling over pharmacological intervention for 47% of the MEMS patients, but for only 12% of the others.

"The MEMS data showed doctors that problems which were assumed to be pharmacological were sometimes actually adherence-related," explained co-author Barbara J. Mason, PharmD, clinical pharmacist at the Veterans Administration Hospital in Boise, Idaho. "That's an extremely important distinction to make."

Dispensers offer benefits

Like monitoring devices, drug-dispensing tools appear to be effective under some circumstances.

In 1992 and 1993, 39 patients receiving visiting nurse services from the New York state Dept. of Social Services were outfitted with "CompuMed Automated Medication Dispensing," manufactured by CompuMed Inc., of Meeteetse, Wyo. The device holds a week's pills in locked plastic compartments. At drug-taking time, an alarm sounds and the appropriate medication drops into a plastic drawer. At the same time, the screen displays instructions, such as "Take with food."

Use of the device improved compliance in 31% of the patients, and for nine the frequency of RN visits was reduced with no adverse effects, researchers reported. The experiment was sponsored by the company and the state social services agency.

Nancy Ryan, associate director of Mclean Home in Simsbury, Conn., said the nursing home is using CompuMed in its outpatient assisted living program. Each week, Mclean nurses travel to patient homes to fill the CompuMed compartments. "It allows a lot more patients to remain independent." But, for CompuMed to work, she noted, "You have to have someone who is trained to use the device and who is diligent about filling it each week."

Of course, the first step in assessing and increasing adherence is to interview and counsel both patient and caregivers.

For patients who just can't remember to take medication, physicians may suggest one of the simpler devices.

For those who need more help, and who have a caregiver to assist, an automatic dispensing device can make the difference between remaining at home and being moved to a nursing home.

Finally, for patients who cannot or will not admit to nonadherence, a monitoring device can help the doctor gain an accurate view of the problem.

g - ec e pe 's

Examples of compliance devices, by category. (Electronic products generally are for severely impaired patients and require caregiver assistance to operate.)

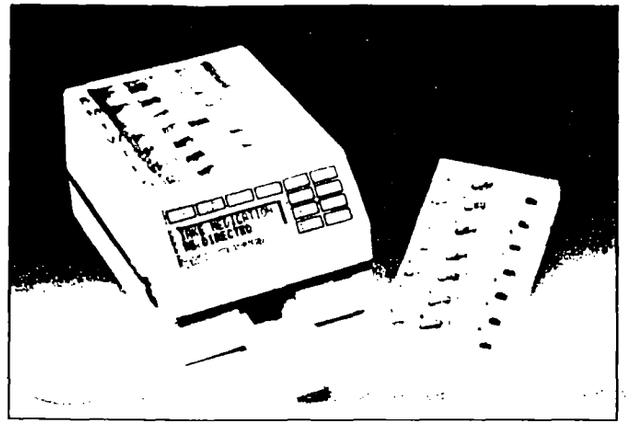
MONITORS

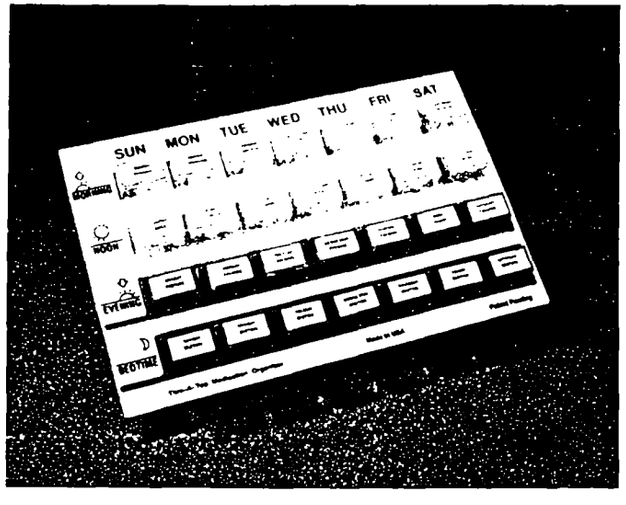
Medication Event Monitoring Systems (MEMS), Aprex Corp., (510) 656-5900. Leases for $3 to $4 per week per medication container. (Upper left photo)
Microprocessor in pill container's lid records date and hour each time vial is opened. Data is fed to a computer, which generates a compliance report to help physician manage treatment.

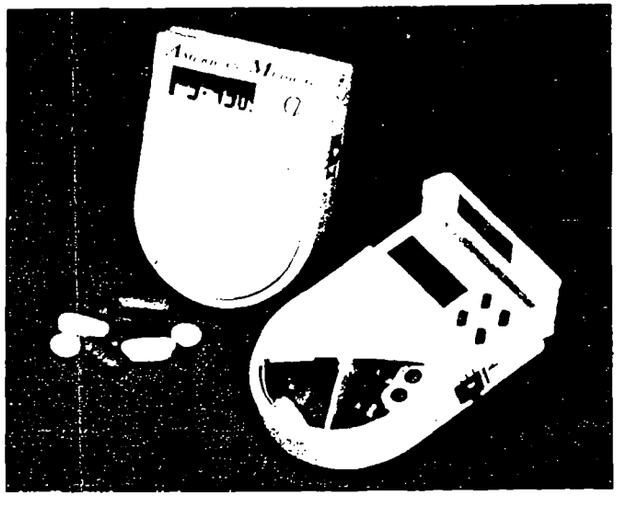
AUTOMATIC DISPENSERS

CompuMed Automated Medication Dispensing, CompuMed Inc., (307) 868-2555; $595. (Upper right photo)
Organizes one week's supply of pills in plastic compartments. A buzzer signals pill-taking time, programmed instructions are displayed on screen, and medicine drops into a removable plastic drawer. Locked drawer prevents pills from being taken at unscheduled times.

Multi-Monitor. Due later this year from Medication Management Technologies, (301) 984-1566; $100 to $400, for one to five pill compartments.
An alarm signals programmed time for administering medication; pills drop from separate compartments into a removable drawer. Locked drawer prevents pills from being taken at unscheduled times. One hour after a missed dose, on-screen display flashes warning. Device also tracks compliance and displays results.







TIMERS

Electronic Pill Box Timer-Clock, American Medical Industries Inc., (605) 428-5502; $12.95 to $15.95. (Lower right photo)
Two-compartment pill box contains two separately programmable timers. Patient responds to alarm, then resets it for next scheduled dose. Compartments do not lock or automatically deliver correct dosage.

TRACKING DEVICES

Flex-A-Top Medication Organizer, Shaw-Clayton Plastics Inc., (800) 537-6712; $19.95. (Lower left photo)
Tray organizer holds one week of pills. Containers are color-coded by time of day. Planning chart included for special instructions and refill dates.

VOLUNTEERS IN MEDICINE CLINIC

July 15, 1994

Ms. Jennifer Klein
The White House
Second Floor West Wing
Office of the First Lady
Washington, DC 20500

Dear Jennifer:

Thanks for your help. Here is a copy of a letter to Mr. Arrindell following my conversation with him today. If I may, I would like to keep you up to date as it progresses.

Sincerely,

Jack McConnell, M.D. /dmk

Jack McConnell, M.D.

JM/dmk

Volunteers In Medicine Clinic • 15 Northridge Road • P.O. Box 23287, Hilton Head Island, SC 29925-3287
Phone: 803-681-6612 Fax: 803-681-6614

VIM CLINIC | VOLUNTEERS IN MEDICINE

July 14, 1994

Mr. Evan R. Arrindell, D.S.W.
Acting Director
Division of Shortage Designation
Department of Health and Human Services
Bureau of Primary Care
4350 East-West Highway
Rockville, Maryland 20857

Dear Mr. Arrindell:

Mr. Demarest, of the South Carolina Health and Human Services Finance Corporation, kindly forwarded me a copy of your recent letter (undated) to him regarding our request for designation as a Health Provider Shortage Area (HPSA). I regret very much your rejection of our request.

The basis on which the decision was made seems to us at the Volunteers in Medicine (VIM) Clinic to be flawed. While I understand the need to use, as one parameter, the 1990 census data, in actual fact, they are incomplete, out of date, and unfortunately do not reflect the reality of the area and target population we are serving.

There are several reasons why the 1990 data are incomplete. Many of the patients we treat may have no postal address, thus preventing them from obtaining a census form. Even if they received it many cannot read or write. Many have a long standing distrust of inquiries and resist what they feel is outside interference.

We have data that are more current then the 1990 census and, as such, we feel reflect more accurately the reality of the target population of patients. Our in-depth study included a survey of all the 2,961 employers on Hilton Head Island. Analysis of those data revealed 4,439 residents who were at or well below the poverty level and received little or no health care. Additional residents of Daufuskie Island will add to this figure.

Following the completion of our survey, we discovered a community of approximately 3,000 Hispanics which existed up until then as a "ghost" community and had not been picked up in any census -- ours or the 1990 census. Many cannot read or write English and, as such, would have been unable to respond to a census form, even if they received one. They now use and trust the VIM Clinic. Without us, they would go without medical care. It is important not only for them but also for the larger community that we understand and serve their health and wellness needs.

Post Office Box 23287
Hilton Head Island, S.C. 29925-3287
Phone (803) 681-6612
Fax (803) 681-6614

In addition, we actually rode the Low Country Rural Transportation (LCRT) buses to interview those workers who commute to the Island daily for work. They leave home before their local clinic opens and return well after it closes. I recognize this as a problem of scheduling but even more so as a problem of patients not obtaining care when they need it.

Our data showed that at least 1,500 (there are probably many more) of the 10-12,000 who commute to the Island daily would use the Clinic. Obtaining this information was more of a success than one might recognize unless you knew, in depth, the culture of privacy of the low country African-Americans.

They have a high distrust of all institutions, especially medical institutions, as we know from their hesitation in using our local hospital . This does not keep them from getting ill, but it may prevent their obtaining early and appropriate care. That is why the VIM Clinic was established. Without the VIM Clinic they would go without -- regardless of what the 1990 census data show.

Because of the needs and demands of the Island retirees and tourists, we have a minimum of 1,500 migrants who service the hospitality, landscape and construction businesses. This number tends to swell in the spring, summer and autumn months at the height of the tourist season.

As you can see we have a community of indigent and medically underserved citizens with little or no access to health care which totals approximately 10,500 who live or work on Hilton Head Island and are in desperate need of the VIM Clinic and the services it provides.

Providing care to the medically underserved benefits not only those who need our services, but also the regional community. As you know, disease is no respector of person, town or region. An infectious disease in one of the patients in our target population will spread more quickly to the rest of the region without an appropriate place, such as the VIM Clinic, to which he can turn for help.

The Volunteers in Medicine (VIM) Clinic is the only place this group can receive care. Without us they will receive no care -- except possibly the Emergency Room (ER) of the local hospital. That is an unwelcome environment and expensive method of providing primary care.

There are no primary care physicians on Hilton Head Island who accept Medicaid patients, with the exception of the obstetricians who deliver them and then refer them to us for post-natal and well-baby care.

The Emergency Room in the local hospital has agreed to refer their primary care patients to the VIM Clinic. In addition we will triage our patients and send only the most ill to the ER so that the hospital are used more efficiently. We will see the patients earlier, preventing an early problem from progressing into a major problem which requires expensive therapy when an inexpensive approach would have been adequate.

Mr. Arrindell, the nearest clinic which has evening hours is available only if the patient calls and makes an appointment -- and it is 18-35 miles away, depending on where you are on the Island. The only clinic in Beaufort County which is open evenings is on St. Helena, 54 miles from Hilton Head and even that is limited in what it can offer the patients, in term of hours available and extent of care. There are no clinics with evening hours in Jasper County.

In summary, Mr. Arrindell, there are approximately 10-11,000 patients in our region who now receive little or no medical care. We have, at VIM, several dozen retired medical personnel who are ready and able to donate their services free-of-charge. They practice under a "Special Volunteer License" granted by the General Assembly of South Carolina. As the VIM Clinic is a prototype, at this time there is no other clinic to which these patients can go to seek care. If we are not allowed to treat them, they go untreated.

I strongly urge you to reconsider your earlier decision. It would seem to me that the Volunteers in Medicine Clinic is the very sort of place you would welcome to deliver low-cost/high-quality medical and dental care to thousands of medically underserved.

I look forward to hearing from you.

Jack McConnell, MD

Jack B. McConnell, M.D.
Founder and Chairman
Volunteers in Medicine Clinic

cc: David Brand
Richard Demarest

Group Health Cooperative
of Puget Sound

ADMINISTRATION AND CONFERENCE CENTER

521 Wall Street
Seattle, WA 98121

March 4, 1994

Ms. Jennifer Klein
The White House
1600 Pennsylvania Avenue NW
Washington, D.C. 20500

Dear Jennifer,

I am enclosing a letter written to Mrs. Clinton by Phil Nudelman, the President and CEO at Group Health Cooperative of Puget Sound. Dr. Nudelman recently attended a presentation of a study sponsored by the Advanced Technology Laboratories to assess the effectiveness of a new procedure for diagnosing breast cancer. The results of the study show that approximately 40 percent of the biopsies performed may have been avoided using this digital ultrasound technology.

Group Health has no proprietary interest in this technology. Dr. Nudelman was extremely impressed by this study and technology and felt it his duty to apprise the First Lady of this new information and to share in her commitment to improve the quality of American healthcare.

We would really appreciate it if you could pass this letter on to Mrs. Clinton. Thanks, and I look forward to seeing you in Washington the end of this month.

Sincerely,

Michele Manowitz

Michele Manowitz

See HRC files.

Group Health Cooperative of Puget Sound

Phil Nudelman, PhD
President and
Chief Executive Officer

Administration and
Conference Center
521 Wall Street
Seattle, Washington 98121
Phone (206) 448-6460
Fax (206) 448-5844

March 3, 1994

Ms. Hillary Rodham Clinton
The White House
1600 Pennsylvania Ave. NW
Washington, D.C. 20500

Dear Ms. Clinton,

It is an honor and a privilege to continue working with you and Ira and a most dedicated staff in support of the President's healthcare efforts. We at Group Health Cooperative of Puget Sound continue our efforts to reduce the burden and impact of illness on the people of our communities.

I know of your interest in women's healthcare and your support for early detection of breast cancer. Last week, both Governor Lowry and I were apprised of the two year, multi-center breast study that was sponsored by a local company, Advanced Technology Laboratories (ATL). The purpose of the study was to determine whether ATL's digital ultrasound technology could increase the ability of physicians to diagnose benign breast disease following abnormal mammography findings, thereby reducing the need for biopsies.

Dr. Kenneth Taylor, professor of diagnostic radiology at Yale University School of Medicine presented the findings that included a total of 1,021 masses found in 964 women following a mammogram or physical examination. The study's findings showed that approximately 40 percent of the biopsies might have been avoided using a clinical protocol of digital ultrasound technology. This is an amazing finding in a procedure that causes needless pain, suffering and disfigurement.

I understand that the technology will not be available until it winds through the FDA process. ATL submitted, in mid February, a Premarket Approval application to the FDA for the use of the system in differentiation of solid breast masses. They have also applied for the FDA's expedited review process. All involved believe that the data and the potential to spare women the trauma, pain and cost of unnecessary breast biopsies qualify the application for this prioritized FDA process.

Mammography is currently recognized as the best modality available to screen for breast cancer. Although it has a relatively high sensitivity, its specificity in most medical practices is around 30 percent. Typically, out of 100 breast biopsies, 70 are found to be benign and 30 are malignant. Approximately 500,000 surgical breast biopsies are conducted in the United States annually at a cost ranging from $2,500 to over $5,000 per biopsy. An additional number of needle biopsies are also conducted at costs ranging from $750 to $1,000 per biopsy. Cost is only one aspect. Biopsies are a traumatic procedure for most women. Surgical biopsies are highly invasive, typically removing 2.4 cubic inches of tissue, often deforming the breast.

I am writing to inform you of this technology advance and asking you to let the FDA know of the importance of expediting applications that have such immediate and positive effect on the health status of women. Please note that I have no proprietary interest in ATL, it's products, or the technology. As the President & CEO of the largest consumer owned managed care organization in the country my one goal is to help reduce the impact and burden of illness on all Americans and to improve their health status.

Please continue your great efforts. You have our continuing support.

Sincerely yours,

Phil Nudelman, Ph.D.

Phil Nudelman, Ph.D.
President and Chief Executive Officer
Group Health Cooperative of Puget Sound

SPRINGFIELD MEDICAL ASSOCIATES, INC.

2150 MAIN ST.
SPRINGFIELD, MASSACHUSETTS 01104

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MICHAEL P. COPPOLA, M.D.
CHEST DISEASES AND INTERNAL MEDICINE

PAUL C. HETZEL, M.D.
ONCOLOGY, HEMATOLOGY AND INTERNAL MEDICINE

ROBERT P. HOFFMAN, M.D.
INFECTIOUS DISEASES AND INTERNAL MEDICINE

THOMAS J. KEENAN, M.D.
CARDIOLOGY AND INTERNAL MEDICINE

BRUCE M. METH, M.D.
CHEST DISEASES AND INTERNAL MEDICINE

DAVID H. MILLER, M.D.
RHEUMATOLOGY AND INTERNAL MEDICINE

JEFFREY J. OCHS, M.D.
ONCOLOGY, HEMATOLOGY, AND INTERNAL MEDICINE

DAVID J. PIERANGELO, M.D.
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DAVID L. PLEET, M.D.
GASTROENTEROLOGY AND INTERNAL MEDICINE

THOMAS F. RACE, M.D.
GASTROENTEROLOGY AND INTERNAL MEDICINE

MICHAEL H. ROSEN, M.D.
HEMATOLOGY, ONCOLOGY, AND INTERNAL MEDICINE

ROY STILLERMAN, M.D.
CHEST DISEASES AND INTERNAL MEDICINE

July 8, 1994

Ms. Jennifer Klein,
Assistant to the First Lady
The White House
Washington, D.C. 20500

Dear Ms. Klein:

Thank you for contacting me on May 27, 1994 on behalf of the First Lady. I am sorry that your call had not been put through immediately. I have since learned that the telephone operators did not understand that the call was from The White House.

Recent developments on Capitol Hill have been quite interesting. I am following the debates closely. It is quite clear as each day passes in my medical practice, there is a need for significant change. I have not been contacted yet by Simone Rushmeyer but remain willing to participate in any manner in which I may be helpful. I am sure that the entire staff is extremely busy with the developments on Capitol Hill.

Please feel free to contact me if I may be of any assistance.

Sincerely yours,

Michael P. Coppola, M.D.

MPC/nbr

THE WHITE HOUSE

WASHINGTON

July 5, 1994

Jack B. McConnell, M.D.
Volunteers in Medicine Clinic
Post Office Box 23287
Hilton Head Island, S.C. 29925-3287

Dear Dr. McConnell:

I was so pleased to turn on my television today to find a report about the Volunteers in Medicine Clinic on CBS This Morning. Congratulations on your outstanding accomplishment.

I am sorry that I was not able to attend the opening of the clinic. I look forward to hearing more about the success of the Volunteers in Medicine Clinic and other clinics that follow in your footsteps.

Sincerely yours,

Jennifer Klein

Jennifer Klein
Special Assistant to
the President for
Domestic Policy

THE WHITE HOUSE

WASHINGTON

June 27, 1994

L. Jean Townsend
Four Breeds Hill Court
Little Rock, Arkansas 72211-2514

Dear Mrs. Townsend:

I very much enjoyed speaking with you this morning. As I mentioned on the phone, the First Lady was honored that you chose to share with her your personal and professional experiences with the health care system. She hopes that you will also share your knowledge and suggestions with others who are working on health care reform.

Please feel free to contact me at (202) 456-2599 with any questions or concerns.

Sincerely yours,

Jennifer Klein

Jennifer Klein
Special Assistant to
the President for
Domestic Policy

June 10, 1994

Hi Sweetie -

I thought I'd send you a non-electronic mail this morning.

I bought this card in Kyoto in February 1991, but never sent it to anyone. I thought you might like it.

mostly I just wanted to tell you (again) that I think you're completely wonderful & I'm thinking of you and I hope you're feeling alright. I miss you constantly and I'll see you soon. Love & Kisses.

I.

MEDICATION MANAGEMENT TECHNOLOGIES, INC.
5929 Hubbard Drive
Rockville, MD 20852

Fax: (301) 816-0907 **Telephone: (301) 984-1566**

FAX

To: **Jennifer Kline**
At: **The White House**
Date: **June 7, 1994**
Re: **Pilot Programs in Medication Compliance**

From: **Bruce A. Kehr, M.D.**
President

THIS FAX IS - 1 - PAGE(S) INCLUDING THIS TRANSMITTAL SHEET

I have interest in participation from five large pharmaceutical manufacturers and The Task Force for Compliance. Are you still interested? Please contact me as to how to proceed, at (301) 984-1566. Best regards.

(202) 225-5768 (202) 225-5494

COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
320 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515

SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS

May 26, 1994

Ms. Jennifer Klein
The White House
1600 Pennsylvania Avenue, Second Floor, West Wing
Washington, D.C. 20500

Dear Jennifer:

I wanted to take this opportunity to thank you for the wonderful cooperation that you gave me and my staff through your arduous efforts and long hours of work. Simply stated, we could never have pulled off the quality product that our subcommittee produced without your help, understanding, and patience. Jon, Phyllis, Suzie and Corinne join me in thanking you for all your help.

Best regards.

Sincerely,

Pat

Pat Williams
Chairman

TELEVISION CORPORATION OF AMERICA
9 SUTTON SQUARE
NEW YORK, N.Y. 10022

NANCY DICKERSON WHITEHEAD
PRESIDENT

(212) 371-1645
FAX (212) 751-3505

May 15, 1994

Dear Hillary Rodham Clinton:

This is a brief letter to tell you of an incident when your office worked wonderfully!

Last Friday night, May 6, I learned at ten to seven that Pat Moynihan could not be at the dedication of the cornerstone at the Hospital for Special Surgery, set for the following Monday. I phoned your office at 7:00 p.m. and found Jennifer Klein and she could not have been more empathetic. Together with Lloyd Bentsen, Roger Altman, and Pan Burnette over the weekend, they found Bruce Vladek, head of Medicaid and Medicare; and at 9:30 p.m. on Mothers Day, Jennifer phoned to say Mr. Vladek could fill in, which he did the next day with charm, describing himself as a "designated hitter," happy to stand in for the administration any time. (This was especially appropriate since we have an outstanding sports medicine center at the hospital.)

As I mentioned to you before, I have worked with nine administrations and no White House Office has ever been more helpful. This was especially impressive since it was over a weekend when your staff was busy helping you get ready to go to South Africa.

I hope you get to see this letter -- it's good to hear when things go well.

Keep up the good work.

Nancy Dickerson Whitehead

Hillary Rodham Clinton
The White House
Washingotn, D.C., 20500

cc: Bentsen, Altman, Vladek, Barnett, Klein

michael s. grossman, d.d.s.
a professional corporation
diplomate of the american
board of periodontology

May 1994

mercy medical building
4060 fourth avenue
san diego, ca 92103
suite 303 • **(619) 543-0905**
fax (619) 543-0422

Basically there would be two levels of health insurance: each separately paid for an administered. One level would be at the so called catastrophic level, the other at the basic and intermediate level.

LEVEL 1

Mandatory employer based universal coverage.

I suggest a $15,000 deductible policy for a calendar year, $25,000 deductible over 2 years and $35,000 deductible over a three year period. Employers would be responsible for 80% of the premium which would be totally tax deductible. Employees would be responsible for 20% of the premium which would be tax deductible on a sliding scale according to income. The savings accomplished by the sliding scale of deductibility would fund insurance premiums at the poverty level and higher, if enough savings is achieved. Guns, ammunition, tobacco and alcohol taxes are of course an option for additional revenue sources if need be.

The self employed would be able to deduct 80% of the insurance premium and the remaining 20% would be deductible on the same sliding scale mentioned above.

Private insurance companies would administer this plan after creation of a uniform benefit design. Both an HMO and a PPO would be offered and the government would pay premiums at the HMO level to the insurance company that it chooses (after evaluating cost and quality).

Once an employer or an individual chooses a plan, they would have to remain with that plan for a minimum of one year. If the employer changes to a different plan, the employee could still remain with the old plan by paying the premium by him or herself, thus insuring portability.

Community rating would be permitted according to age but not based on "pre-existing conditions". Purchasing cooperatives or alliances would be encouraged for individuals and small employers, but would not be mandatory.

LEVEL II

Universal access for basic and intermediate care at the below $15,000/year level.

This level of insurance would be strictly optional and would be subject to negotation between employer and employees. The percentage of premium paid by each could vary from employer to employer. There would be universal access to everyone including the self employed. Purchasing cooperatives or alliances would be optional but encouraged. Tax deductibility would be capped at a dollar amount equal to a national average of the two lowest HMO premiums, the two lowest PPO premiums and the lowest fee for service premium based on a standard package. However, policies could be designed that deviate from the standard package regardless of the criteria for tax deductibility. Community rating would be acceptable in regard to age but not in regard to "pre-existing conditions".

Preventative services for the less fortunate population such as immunization would be paid for by the government with the savings achieved from the limits on tax deductibility and from other sources if necessary. The preventative services that are decided upon by healthcare professionals would be mandatory and no government financial assistance would be given to anyone without proof of receipt of these preventative healthcare services.

All dental insurance would exist at the universal access level. Individuals without dental insurance could access dental providers who would agree by contract to accept lower contracted fees.

In this integrated system, level one would have to be national in scope. Level two would also work more efficiently being national in scope but I can visualize room for some deviation from state to state.

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May 18, 1994

Ms. Jennifer Klein
White House
West Wing Second Floor
Washington, D.C. 20500

Dear Jennifer,

Enclosed are summarized thoughts as to a practical way that the sometimes conflicting concepts of universality, accessibility, affordability, quality and individual freedom can be reconciled in healthcare reform.

A compromise such as this among the various plans would be a monumental achievement that the White House could be proud of. I am interested in your critique.

Best Regards,

Michael S. Grossman, D.D.S.

MSG/jh