THE WHITE HOUSE

July 18, 1994

Nancy O'Brien, RSM
1580 Mt. Hope Avenue
Rochester, NY 14620

Dear Ms. O'Brien:

Congresswoman Slaughter forwarded your letter about the uninsured and under-insured people you have met through your work. Stories like these constantly remind me of the desperate need for real health care reform.

For too long, those people who need health insurance the most, like the women you wrote about in your letter, have been unable to buy it. Today, many Americans are prevented from purchasing insurance because they have -- or someone in their family has -- a so-called "preexisting condition." Those able to obtain insurance at all are often forced to pay the highest rates.

The President's proposal will guarantee every American private health insurance that can never be taken away. It will be illegal for an insurance company to drop coverage or cut benefits, charge higher premiums based on health condition, or apply lifetime limits on coverage.

The President's plan will also make health care affordable for American families. As you pointed out, people are often forced to "spend down" in order to qualify for Medicaid. Under the President's plan, individuals with incomes below a certain level -- whether they are working or not -- will be eligible for subsidies to help pay for coverage.

Thank you again for your letter. The President and I will continue to work for health care legislation that provides health security for all American families.

Sincerely yours,

Hillary Rodham Clinton

Hillary Rodham Clinton

cc: The Honorable Louise M. Slaughter

THE WHITE HOUSE
WASHINGTON

Nancy O'Brien, RSM
1580 Mt. Hope Avenue
Rochester, NY 14620

WHITE HOUSE
'ASHINGTON

The Honorable Louise M. Slaughter
U.S. House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

June 1, 1994

The Honorable Louise Slaughter
U.S. House of Representatives
Washington, D.C. 20515

Dear Louise:

Thank you for writing to share with me your concerns about the ability of Rochester's community management system to continue to operate after national health care reform. This issue is of real importance to me, and I am pleased that we are having ongoing discussions to ensure the continuing viability of the Rochester model for health care delivery. I had a wonderful visit to Rochester and very much enjoyed seeing firsthand the success of your health care system.

As you know, the Administration is committed to health care reform legislation that meets certain principles -- most fundamentally that all Americans be guaranteed private, comprehensive and affordable health insurance coverage that can never be taken away. The system currently in place in Rochester fulfills many of the President's goals for health reform.

I know that you are continuing to discuss the specific issues that you raised in your letter with Ira Magaziner and Judy Feder. Please feel free to contact me with any additional concerns.

We look forward to working with you to define further the role of the community management system under reform and to make health care security a reality for all Americans.

Sincerely yours,

Hillary

Hillary Rodham Clinton

COMMITTEE ON RULES
COMMITTEE ON THE BUDGET
NE AGRICULTURE CAUCUS
CO-CHAIR
NE-MW COALITION
VICE-CHAIR
CAUCUS FOR WOMEN'S ISSUES:
WOMEN'S HEALTH TASK FORCE
CHAIR
WHIP-AT-LARGE

VIP

CONGRESS OF THE UNITED STATES
LOUISE M. SLAUGHTER
28TH DISTRICT, NEW YORK

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WASHINGTON, D.C. 20515-3228
202/225-3615

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ROCHESTER, NY 14614
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April 29, 1994

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

PAM MAY 4 1994

Dear Mrs. Clinton:

I am sending, to keep you informed, a copy of a letter I recently sent to House Committee chairs dealing with Health Care Reform Legislation. The letter deals with my concerns that some of the provisions in the Health Security Act would preclude the Rochester, New York's community health management system currently in place from continuing to operate successfully. This letter, the result of months of deliberation by my 140-member community advisory group on national health care reform, details specific exemptions that Rochester would need, in federal legislation, in order to continue to operate as it has in the past.

This question will also be pursued at the state level; however, I believe it is important that we build in necessary protections into federal law. As the letter makes clear, Rochester would only be allowed to operate independently as long as we are able to meet or exceed all the goals and standards of whatever national health care reform package is enacted into law. These goals include universal coverage, affordable and accessible care, portability of coverage, no pre-existing condition exclusions and preventive and primary health services for all.

I would appreciate your support for our efforts to preserve the Rochester system, while at the same time improving it. I shall be pursuing these amendments in the three committees of jurisdiction as well as in the House Rules Committee. If you have any questions or comments about this proposal, please do not hesitate to get in touch with me.

Thank you.

Sincerely,

Louise

Louise Slaughter
Member of Congress

April 27, 1994

Dear Colleague;

I have completed a thorough review of the Health Security Act, HR 3600, assisted by an advisory committee of more than 140 residents of my district, with broad representation from all of the Rochester community. Based on this review, we have developed several amendments to the Act which are critical to the continued success of Rochester's system of providing high quality, affordable and accessible health care. In particular, I want to share with you the concerns I have, and recommend some specific amendments concerning the role and structure of health alliances.

Rochester's cooperative system of health care management relies on the involvement of all parties: insurers, providers, consumers, hospitals and businesses large and small. In Rochester, we have already made great progress towards meeting some of the important goals of national health care reform. For example, insurers in Rochester already use a community-rating system to establish premiums for 90% of their policy holders; and this includes the 30,000 employees of Eastman Kodak Company in the Rochester region. Our health insurance premiums are approximately one-third lower than the national average, and hospital costs are several hundred dollars per day lower than national levels (our occupancy rate for area hospitals is 88%). Only 7.1% of Rochester-area residents are without health insurance, compared to a statewide rate of 11.5% and a national average of 13.7% uninsured. One important reason we have made this progress is that metropolitan Rochester has essentially just two insurers offering competing HMO plans and an indemnity plan, thus assuring consumer choice. These plans cover 85% of the insured population under age 65. They are already community-rated with guaranteed issue and no medical underwriting.

Rochester has been working cooperatively to manage health care regionally for several decades, and the statistics show that our efforts have met with success. Although we are concerned that we have not yet achieved universal coverage, and concerned about rising annual premium costs, we believe that our existing system is the best way for us to continue managing our health care, as well as achieving the goal of universal coverage. However, if health care reform legislation is enacted with a requirement for mandatory alliances, Rochester will need several key exemptions if we are continue to operate our existing system.

Even if the final plan includes a requirement that voluntary alliances be established in each region, Rochester would still need to be exempt. No more than 10 to 15% of our market (those individuals not covered by our existing two plans) would be

interested in joining such an alliance, and this would not provide enough incentive for other health plans to enter our market. We would like to have language included in the final legislation that would require states to exempt successful regional health management systems, such as Rochester's, from forming an alliance, if they are able to meet the goals of national reform without doing so.

Alternatively, if the final plan gives authority to states to perform those functions previously assigned to alliances, states must be required to allow communities which meet the standards described below to operate without an alliance or mandatory consumer purchasing cooperative, if they so choose.

Where a community has a very few health plans, with a sizeable majority of the insured population enrolled in these plans, the evidence shows that many of the functions of a health alliance are not necessary. Our experience shows that it is more efficient, as well as providing greater customer satisfaction, to have the enrollment and claims processing functions continue to be handled centrally, as is currently the case for our plans. Those roles are very much linked and difficult to manage even within a single organization; separating them between alliances and health plans will decrease the level of efficiency our community plans are currently able to provide.

Amendments to Mandatory Alliance Requirements of HR 3600

The following amendments which I am proposing would apply if final legislation were to include a requirement that a health alliance must be established in each region, no matter whether the individual decision to join is mandatory or voluntary.

In any community which wished to operate without a health alliance, there must be a protocol established to accomplish these functions, the most important of which is meeting the required universal coverage standard. We would also require our plans to adopt centralized, open enrollment, giving individuals information about and access to enrollment in any health plan offered.

I also recognize the community oversight functions for which the health alliances would bear responsibility. My proposed amendments would therefore require that there be certain standards agreed to by health plans, and establishment of a community Oversight Board, before any community could operate without a health alliance.

Such an Oversight Board would be a non-profit organization, as required for Regional Alliance Boards in section 1301. Among the primary responsibilities of the Oversight Board would be to

ensure that the exempted community achieves universal health coverage under the same time-frame as required for communities with regional alliances. Our Board, however, would not function as an agency of the state. The non-profit private model has served the health care system in Rochester well, providing appropriate flexibility and community oversight.

Section 1302(c) of the current version of the Act would prohibit alliance board members from maintaining a financial interest in health care, either directly or through a family member. While I believe such boards must have consumer majorities, I also feel it is important for providers to have formal representation rather than just an advisory role, as section 1303 of the Act provides. Empowerment of all parties has been an important part of Rochester's health management system; it has allowed us to make sound decisions and to have those decisions recognized as legitimate by all sectors. In the context of my proposed substitution of a limited number of health plans for the alliance, with an Oversight Board handling certain alliance functions, I would likewise require that the health plan boards as well as the Oversight Board have a consumer majority, with significant provider representation also.

In particular, I would amend the Act by adding the following:

* Notwithstanding the provisions of other sections of this Act, the Secretary shall authorize health plans in any Metropolitan Statistical Area to be certified by the State and operate without there being a regional health alliance, whether mandatory or voluntary, for as long as the following conditions are met:

a) On April 1, 1994 those health plans (at least one of which is a fee-for-service plan as defined in section 1322(b)) each enroll at least ten percent (10%) of the population under age sixty-five in the MSA, and those health plans combined enroll at least seventy percent (70%) of the population under age sixty-five in the MSA;

b) The Metropolitan Statistical area must keep health care costs/premiums to no more than 90% of average national cost;

c) Those health plans operating within the MSA agree to a protocol for the health plans to perform functions otherwise required to be performed by a regional alliance, including ensuring universal coverage within the specified timeframe, along with those functions as set forth in sections 1323 (Enrollment Rules and Procedures); 1324 (Issuance of Health Security Cards); 1327 (Data Collection; Quality) in conjunction with Oversight Board; 1343 - 46

(Determination of Family Share; Notice of Family Payments Due; Collections; Coordination Among Regional Alliances); 1353 (Payments to Federal Government for Academic Health Centers and Graduate Medical Education); 1361 (Management of Finances and Records), and 1371-75 (dealing with Reduction in Cost-Sharing for Low-Income Families).

d) An Oversight Board shall be established as a not-for-profit organization with a consumer majority on its governing board. The Oversight Board will assume the duties and functions of regional alliances, as set forth in sections 1325(a) (Consumer Information and Marketing); 1326 (Ombudsman); 1327 (Data Collection; Quality) in conjunction with health plans; 1329(b) (helping to organize providers in areas with inadequate service).

e) State Responsibilities Relating to Health Plans:

- Those health plans hall be exempt from the provisions of section 1203(b) of this Act;
- Those health plans shall meet the criteria of sections 1203(a) and 1203(h);
- Those health plans shall contract with centers of excellence as otherwise provided for in section 1203(e)(2) of this Act;
- In such a MSA, where sections 1202(d), (e) or (g), or 1322 of this Act refer to an Alliance or a Regional Alliance, the provisions of this act shall apply instead to health plans;
- In such a MSA, sections 1301-1303, 1321, 1341 through 1342, 1351(a) through (c) and (e), and 1352 shall <u>not</u> apply.

I am also concerned that the provisions concerning corporate alliances could undercut regional efforts to meet the needs of the entire community. If corporate alliances are included in the final bill, section 1311(c) should be amended to delete the sentence in the Act as proposed which provides "Persons eligible to enroll in corporate alliances are ineligible to enroll in regional alliances unless they meet the multiple-employment family requirements of section 1013." Language should also be included to allow corporations to either enter a regional alliance (or other regional structure as outlined above) or to self-insure as a corporate alliance. In cases where corporations have divisions in more than one region, these individual divisions should be allowed to select on a region-by-region basis whether they wish to participate in the regional alliance, or to self-insure as a corporate alliance. All employers in a region should have the option of participating in regional alliances in any region, if that option represents good value for them and their employees. In addition, a corporation should not be

permanently locked into its choice of joining the regional alliance or self-insuring, but rather have the option to change it's mind at least once every 4-5 years.

In Rochester, several large employers have been a part of the community rate for decades; we would not wish to lose their participation under national health reform. However, corporations that have divisions in other states, as well as in Rochester, may be better off self-insuring as a corporate alliance in those other locations, and they should have the option to do so.

My last proposed amendment concerns section 1329(b) of the Act which permits, but does not require, health alliances to help organize health providers and provide technical assistance only in order to help establish a new health plan in an area with inadequate service. If an area has inadequate services, such assistance would be necessary even if establishment of a new health plan were not required. There should also be a requirement for plans and the Oversight Board to assist in promoting an appropriate mix of providers. The Oversight Board should require insurance plans to provide patients with access to all willing health professionals, who are qualified by virtue of state licensure or certification, to provide those services as outlined in the basic benefits package. This would promote more cost-effective utilization of health professionals.

Having had the occasion to draw on the expertise of many of those responsible for Rochester's maintaining its effective health care system, I appreciate the monumental task you and the members of your committee face in trying both to create a rational health care policy and address the myriad technical issues involved in this undertaking. As the debate moves forward, I will continue to work with you to fashion an appropriate national policy. But I firmly believe that the critical elements of Rochester's health care system that have moved us very close to the goals of national reform must be allowed to continue under reform. The above approaches are designed to bring this about, while ensuring that the Rochester system is held to the same high national standards as every other region of the country.

Thank you for your consideration. I would be happy to meet with you to discuss this situation further, and I look forward to working with you on this and other matters relating to enacting national health care reform.

Sincerely,

Louise M. Slaughter, M.C.

Letter sent on April 27, 1994 to:

Energy & Commerce Committee
Rep. John Dingell
Rep. Tom Manton
Rep. Henry Waxman
Rep. Ed Towns

Education & Labor Committee
Rep. Bill Ford
Rep. Major Owens
Rep. Pat Williams
Rep. Eliot Engel

Ways & Means Committee
Rep. Dan Rostenkowski
Rep. Charlie Rangel
Rep. Pete Stark
Rep. Michael McNulty

Rules Committee
Rep. Joe Moakley
Rep. Tony Hall
Rep. Bart Gordon
Rep. Butler Derrick
Rep. Alan Wheat

House Democratic Leadership
Speaker Thomas Foley
Majority Leader Dick Gephardt
Majority Whip David Bonior

Senator Daniel Patrick Moynihan