[redacted]

Mineta, Norman

THE WHITE HOUSE

WASHINGTON

March 7, 1994

The Honorable Norman Y. Mineta
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Mineta:

Thank you for sending the information and video from Dr. Edmund Tai about the Treatment Center of the Sunnyvale Medical Clinic.

The Treatment Center has shown true leadership in adopting innovative reforms in health care delivery. By increasing competition among health plans and giving consumers the information and ability to make meaningful choices among plans, the Health Security Act provides incentives for the development of innovative, high quality and cost-effective health care.

I look forward to working with you in the coming weeks and months as Congress considers the Health Security Act.

Sincerely yours,

Hillary

Hillary Rodham Clinton

cc: Edmund Tai, M.D.

NORMAN Y. MINETA
MEMBER OF CONGRESS
15TH DISTRICT, CALIFORNIA

DEPUTY WHIP

CHAIRMAN
PUBLIC WORKS AND TRANSPORTATION COMMITTEE

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AVIATION
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November 3, 1993

Mrs. Hillary Rodham Clinton
Chair
President's Task Force On Health Care Reform
The White House
Washington, D.C. 20500

Dear Mrs. Clinton:

I would like to take this opportunity to introduce to you the Treatment Center of the Sunnyvale Medical Clinic in Sunnyvale, California. This revolutionary health care delivery system offers patients a cost-effective alternative to hospitalization for intravenous therapies.

I would greatly appreciate it if you or someone on the Task Force could view the enclosed video tape and press releases. The tape demonstrates the benefits of this cost-effective system through the words of both the patients and doctors.

If you are interested in personally touring the Treatment Center, I would be happy to arrange this for you. Thank you for taking the time to view the tape.

Sincerely yours,

NORMAN Y. MINETA
Member of Congress

NYM:ldc

Treatment Center
Sunnyvale Medical Clinic

The Sunnyvale Clinic Treatment Center was created for the purpose of providing sophisticated care to patients with complex medical problems such as cancer, AIDS, infectious diseases, and hematological disorders. The need was perceived several years earlier when we realized that many therapies that had been previously provided in the hospital setting can now be done as an outpatient due to technological innovations. People want to be treated as individuals by caring and competent people whom they know and trust. They want to be able to retain control of their lives by scheduling treatment at their convenience which is no small feat when they have to work or care for children and receive treatment at the same time.

The Sunnyvale Medical Clinic is a large multispecialty group that has been in the forefront of managed care for decades. We realized that importance of proper management of limited resources. It was felt that an intermediate level of care was needed between the hospital setting and the office. The medical therapeutics are getting ever more complex and intensive and a specialized staff is necessary to carry this out. Transferring care to the Treatment Center results in significant savings in cost and improves the quality of the patient experience. It is an effort to get the "biggest bang for the buck".

Health care is different from other businesses in that there is a moral commitment by its members to provide service in a caring and personal manner. It is a cooperative rather than a competitive venture. In the era of managed care what we strive to achieve is to bring together the scientific innovations and the traditional caring process in a "high tech-high care" environment.

Edmund Tai, MD

582 South Sunnyvale Avenue • Sunnyvale, California 94086 • (408) 524-5075

Treatment Center
Sunnyvale Medical Clinic

FOR	Treatment Center Sunnyvale Medical Clinic 582 S. Sunnyvale Avenue Sunnyvale, CA 94086 (408) 524-5075	DATE	9/23/93
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FOR IMMEDIATE RELEASE

New Care Delivery System Offers Cost Effective Treatment Alternative

One step ahead of the cry for health care reform, the Sunnyvale Medical Clinic and CPS/Advanced Infusion Systems, Inc. have designed a whole new care delivery system to offer patients a cost-effective alternative to hospitalization for intravenous therapies. Their new infusion Treatment Center, located at 582 South Sunnyvale, Avenue opened its doors in June-three months before President Clinton unveiled his Health Care Plan calling for a more cost-effective approach to medical care.

Guided by a forward vision, Sunnyvale Medical Clinic CEO Pete Templeton said the plan to build an innovative infusion Treatment Center was the product of a two year project developed in conjunction with the Mountain View-based CPS/Advanced Infusion Systems.

"We definitely see this Treatment Center as the wave of the future," said Templeton. "Our goal was to create a new type of delivery system that meets the needs of patients in a more cost-effective way."

As the first and largest non-hospital-based facility of its kind in Santa Clara County, the state-of-the-art Treatment Center offers comprehensive, physician-supervised therapies to ambulatory patients who require blood transfusions, chemotherapy, antibiotic therapy and pain control-treatments previously only available in a hospital setting or skilled nursing facility. Sunnyvale Medical Clinic oncologist, Dr. Edmund Tai, and immunologist and allergist, Dr. Robert Frascino, serve as Co-Medical Directors for the facility. The Treatment Center is open to individuals through physician referral.

Although home care can also be an option for patients who need infusion services, Karen Flores, President of CPS/Advanced Infusion Systems, said the availability of a physician on site in case of complications is a key consideration for many patients. Cost is also a factor. Since the Treatment Center is an outpatient facility, like a doctor's office, it often results in significant cost savings for the patient over home care or a hospital setting costs.

For Treatment Center patient, Sharon, a recent newly-wed, the Treatment Center means she doesn't have to incur costly hospital expenses. After trying several different types of therapies during a two year process, Sharon, who comes in three times a week for three hours of Chemotherapy infusion, has been unable to work at her job as a buyer for an electronic computer company.

"It's hard because I'm not able to work. Thankfully, my insurance company covers the cost for the infusion. I like the Treatment Center because there is more privacy and I can sleep if I want to. I like to read while I'm here, too," Sharon said.

With both private and semi-private rooms, the Treatment Center is decorated more like a home than a doctor's office. A kitchen, usually stocked with cookies and fruit, is available for patients and staff. Televisions equipped with VCR's give patients the option to watch a movie during their treatment in comfortable chairs or recliners.

For patients like Ruth Riley who has lung cancer, the Treatment Center's "homey" feeling is very different than the hospital settings she became very familiar with as a now retired Licensed Vocational Nurse and peace officer. Ruth spends three to four hours each visit at the Treatment Center for her infusion therapy.

"My first treatment was in the hospital, but it is much more comfortable here," said Riley. "I'm used to dealing with hospitals and it can be a dehumanizing experience. The Treatment Center is more like the old style care I remember, where the patient comes first."

So far, the youngest patient at the Treatment Center is eighteen month old, Laura. Prone to infections and diagnosed with a fungal infection in her lungs, Laura comes every other day from San Jose with her mother, Ruth, and five-year old sister, Jennifer, for a two hour infusion therapy. Laura's mother holds her daughter, who usually sleeps, while sister Jennifer talks to the nurses and staff, watches TV, or raids the cookie jar in the kitchen.

"I like the idea that there is a doctor close-at-hand in case there are any complications," said Ruth. "The Treatment Center is convenient for us because our pediatrician is right next door at the Sunnyvale Medical Clinic."

In addition to cost effective treatment, Flores said convenience ranks high on the patient's list. In addition to comprehensive IV therapy services, the Treatment Center also provides health benefits assistance, insurance billing, pharmaceutical services, nutritional counseling, social worker and educational services.

"It makes it easier for the patient to have all resources in one central location," said Flores. "We are definitely patient-oriented. Both CPS/Advanced Infusion Systems and the Sunnyvale Medical clinic see the Treatment Center as a way to provide high quality, cost-effective care in a setting that is warm and caring."

CPS/Advanced Infusion Systems, Inc.

In addition to the Treatment Center, CPS/Advanced Infusion Services, Inc. (CPS/AIS) specializes in IV (intravenous) services in the home environment and in health care facilities. Established in 1972, CPS/AIS is locally owned and managed by a team of pharmacists who believe the patient always comes first. With a well-known reputation for integrity, professionalism and the highest quality of pharmacy and patient care, CPS/AIS nurse specialists and clinical pharmacists provide a full range of services to home patients as well as to more than 110 health care facilities throughout Northern California.

Sunnyvale Medical Clinic

The Sunnyvale Medial Clinic offers a comprehensive range of health care services. With more than 100 physicians in primary and specialty medicine, the central clinic facility is located at Sunnyvale Road and Old San Francisco Road in Sunnyvale and houses the Clinic's Surgi-Center, Urgent Care Center, Vision Care Center, and the new Treatment Center. Satellite facilities include the Occupational Medicine Division on Mathilda Avenue in Sunnyvale and primary and urgent care clinics in Los Altos, Santa Clara, and Cupertino. Sunnyvale Medical clinic Participates with most major health plans and has provided medical service to residents of Sunnyvale and the surrounding communities since 1955.

NORMAN Y. MINETA
MEMBER OF CONGRESS
13TH DISTRICT, CALIFORNIA

DEPUTY WHIP

COMMITTEES:
PUBLIC WORKS AND TRANSPORTATION
SUBCOMMITTEE ON SURFACE TRANSPORTATION
CHAIRMAN

SCIENCE, SPACE, AND TECHNOLOGY

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February 11, 1993

Ms. Melanne Verveer
Deputy Assistant to the President and Deputy Chief of Staff
Office of the First Lady
The White House
Washington, D.C. 20500

Dear Ms. Verveer:

I would like to get a list of all the members of Hillary Clinton's Health Care Task Force if such a list is available. I understand that the group has been divided into several "subgroups" each dealing with different pieces of the whole package. Would it be possible to indicate which "subgroup" each member of the task force working in?

Thank you for your assistance in this matter and I look forward to working with you in the future.

Sincerely yours,

Jeffrey J. Janssen
Field Representative to
NORMAN Y. MINETA
Member of Congress

THE WHITE HOUSE

November 23, 1993

Hon. Norman Y. Mineta
U. S. House of Representatives
Washington, D. C. 20515

Dear Congressman Mineta:

Thank you for your recent letter and encouraging comments. We are anxious to address the concerns you outlined in your letter and will respond in a comprehensive manner as soon as possible.

It was good to hear from you.

Sincerely yours,

Hillary

Hillary Rodham Clinton

bcc: Chris J.
Melanne

NORMAN Y. MINETA
MEMBER OF CONGRESS
15TH DISTRICT, CALIFORNIA

DEPUTY WHIP

CHAIRMAN
PUBLIC WORKS AND
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SUBCOMMITTEES:
AVIATION
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cc: Melanne
Chris

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TDD NUMBER (408) 984-5409

Congress of the United States
House of Representatives
Washington, DC 20515-0515

November 10, 1993

PAM NOV 18 1993

Mrs. Hillary Rodham Clinton
Chair
President's Task Force On Health Care Reform
The White House
Washington, D.C. 20500

Dear Mrs. Clinton:

I have reviewed the legislation submitted by the President to implement the Health Security Act. I am very impressed with the structure and the overall scope of the plan, and I am hoping to give it my full support.

However, there are a number of important points on which I need to have clarification. I have outlined them on the attached pages.

In some cases, resolving these issues may require actual changes in the legislation. At a minimum, report language or other legislative history will be needed to clarify the intent of these provisions.

These particular concerns aside, I would like to take this opportunity to congratulate and thank you for the tremendous service you have done this Nation in developing this proposal. I am very much looking forward to working with the President and you to make these vital reforms a reality.

Once again, thank you for your consideration. I look forward to hearing from you.

Sincerely yours,

NORMAN Y. MINETA
Member of Congress

NYM:cws

HEALTH SECURITY ACT
Comments
Norman Y. Mineta, M.C.

MINORITY HEALTH ISSUES

1) Linguistically and culturally appropriate care - The plan frequently uses the term "demographic characteristics" as a factor which must be taken into account in providing patient care, measuring provider performance and tracking health data. Some clarification must be made to specify that language and cultural barriers are included in that term. These will be new issues for many providers and insurers, as well as for those who will design the health data collection system. If language is not specifically mentioned, it will likely be left out.

2) Health professions training - Measurements of provider supply and funding for increasing representation of minorities in the health professions must be based on ethnicity in addition to race.

In aggregate, Asian Pacific Americans are over-represented in the health professions (10.1% of physicians vs. 3% of the population). However, this is largely due to the Japanese American, Chinese American, and increasingly, the Vietnamese American communities. Other groups are substantially under-represented.

If the provider supply data is not broken down by ethnicity, one of two problems will surface. Either Asian Pacific Americans will be ignored because of their aggregate over-representation, or benefits will end up going to the communities which are most readily able to access them - which happen to be the groups that are already over-represented.

3) The data collection provisions need to be tightened to clarify that health alliance enrollment forms must record ethnicity and language requirements, and that this data should be tracked as part of the proposed national health information network. Similarly, the language abilities of physicians need to be recorded as well. A third-generation Japanese American physician isn't necessarily going to be able to speak Vietnamese or Cambodian, or even Japanese. He or she might be unable to provide linguistically appropriate care, while a Caucasian physician might be fully qualified to do so. A fully accurate portrait of patient needs and provider skills is needed.

INSURANCE ISSUES

McCarren-Ferguson anti-trust exemption repeal for health insurers - I have fought successfully for a number of years to preserve the McCarren-Ferguson anti-trust exemption. With the changes to health insurance under the reform package, I agree that this is no longer necessary for health insurance. However, I am concerned that there may be an attempt during consideration to widen this to a total repeal. I hope the Administration will oppose any attempt to expand this beyond the health insurance area.

GAY RIGHTS ISSUES

1) The non-discrimination statements in the legislation cover all categories under existing federal law, but does not cover sexual orientation either in patient care or employment. At a minimum, it must be made clear that these provisions do supersede state and local laws that do prohibit such discrimination.

2) The bill includes language aimed at allowing religious hospitals and physicians to refuse to provide items or services if they have a "religious or moral conviction against doing so". However, as the language is currently drafted, it is the provision of an item or service that triggers the religious conviction issue -- not the item or service itself. That leaves room for a provider to refuse to treat patients the provider finds morally objectionable. This must be clarified.

CORPORATE ALLIANCES

I have been contacted by a number of large, self-insured companies with the following concerns. The companies are Allied Signal, Ameritech, Amoco, ARCO, Bell Atlantic, Boeing, Cox Enterprises, Dow Chemical, DuPont, General Electric, Hershey Foods, Intel, IBM, Pacific Telesis and Southwestern Bell. They may be willing to publicly support the plan if these issues are resolved.

1) How will corporate alliances barely above the 5,000-employee threshold be treated in the event of layoffs or firings? Will they be automatically enrolled in the alliances, and can they get back out again if they climb back above 5,000 employees?

2) If an employer grows to the 5,000-employee level after the plan goes into effect, can that employer leave the regional alliance and establish a corporate alliance?

3) Is it possible to include ERISA-preemption language for multi-state corporate alliances to allow for direct regulatory oversight by the National Health Board rather than by individual states? This would substantially reduce the regulatory burden under which multi-state corporate alliances would be required to operate.

THE WHITE HOUSE

WASHINGTON

December 9, 1993

The Honorable Norman Y. Mineta
United States House of Representatives
2221 Rayburn House Office Building
Independence & South Capitol Street, S.W.
Washington, D.C. 20510

Dear Congressman Mineta:

Thank you very much for your recent letter and for your supportive statements about the Health Security Act. Your words of encouragement mean a great deal to me.

I am grateful also for the opportunity your letter gives me to respond to your specific concerns about the President's proposal. Attached are responses to the points you raised.

I look forward to working with you to bring true health care reform to the country.

Sincerely yours,

Hillary

Hillary Rodham Clinton

Happy Holidays!

A. Minority Health Issues

1) Linguistically and Culturally Appropriate Care

The introduced version of the Health Security Act provides that a health plan may not discriminate against an individual on the basis of language, race or national origin, among other factors. The provision also specifies that a health plan may not engage in discrimination against a provider based on language, race or national origin, among other factors. (See section 1402(c).)

In addition, funding is provided through the Public Health Initiative Fund to improve access to health services for urban and rural medically underserved populations and to expand capacity of community practice networks.

2) Health Professions Training

The Health Security Act requires the National Council on Graduate Medical Education to consider race and ethnicity of training participants in making allocations for medical specialties among programs and to consider the extent to which a racial or ethnic group is underrepresented in the field of medicine generally and in particular specialties. (See section 3031(C).) In addition, funding is provided to support projects to increase the number of underrepresented minority and disadvantaged persons in medicine and other health professions. (See section 3062(b).)

3) Language Skills and Other Patient Needs

The Administration has addressed the need for language skills of physicians and other means for meeting patient needs as part of the national quality system rather than through data collection requirements. The national quality system in the Health Security Act measures patient satisfaction as well as access to care, use of health services and health outcomes. Consumer surveys specifically assess the impact of the Act on vulnerable populations. Health plans measured on their ability to reach and serve patients will consider the language skills of their physicians and other means of meeting patient needs.

II. Insurance Issues

The Administration supports only the repeal of the McCarran-Ferguson anti-trust exemption for health insurance.

III. Gay Rights Issues

1. Anti-discrimination Provisions

Based on the recommendations of lawyers in the field of anti-discrimination law, the Act provides that no health plan may engage in any activity that has the effect of discriminating against an individual on the basis of race, national origin, sex, language, socio-economic status, age, disability, health status, or anticipated need for health services. In addition, in selecting providers for networks or in establishing the terms and conditions of membership in a network, a health plan may not discriminate against a provider on the basis of race, national origin, sex, language, age or disability. (See section 1402(c).) Legally, these provisions augment any state or local laws that prohibit discrimination on the basis of sexual orientation.

2. Conscience Objection

The intent of section 1162 (Provision of Items or Services Contrary to Religious Belief of Moral Conviction) is to permit health professionals or health facilities to refuse to provide an item or service if they have a moral or religious objection to <u>that item of service</u>. We would support an effort to clarify that language.

D. Corporate Alliances

1. Corporate Alliances Falling Below 5,000 Employees

Corporations eligible to form corporate alliances may continue to operate as corporate alliances until the number of employees falls below 4,800 full time employees. If the number of employees falls below 4,800, the corporations's employees would enroll in a health plan in the regional alliance.

2. New Corporate Alliances

An employer that reaches 5,000 employees after the effective date of the Health Security Act may elect to form a corporate alliance.

3. Regulation of Corporate Alliances

The states have no authority to regulate corporate alliances. The requirements under the Act are supervised by the Department of Labor.

HEALTH SECURITY ACT
Comments
Norman Y. Mineta, M.C.

MINORITY HEALTH ISSUES

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