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COLLECTION:
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Domestic Policy Council
Devorah Adler
OA/Box Number: 20462

FOLDER TITLE:
Abortion

2012-0463-S
rc705

RESTRICTION CODES

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

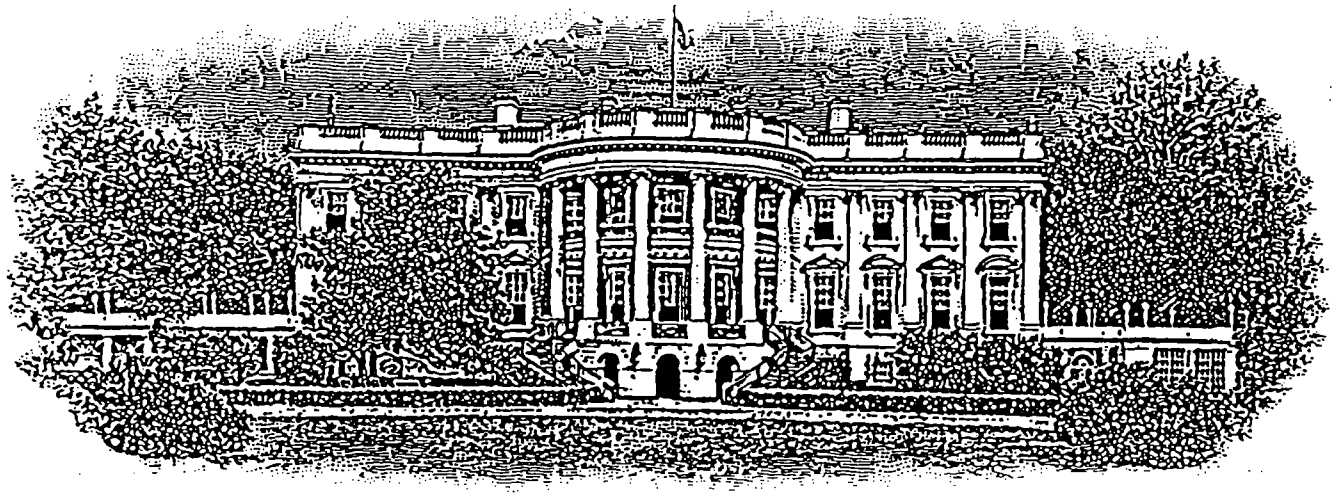
P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

The White House



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: PETER HARBAGE / JENNIFER RYAN

FAX NUMBER: _____

TELEPHONE NUMBER: _____

FROM: DEVORAH

TELEPHONE NUMBER: _____

PAGES (INCLUDING COVER): C+4

COMMENTS: see edits.

Call w questions. thanks!

Draft: Stop Clock

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
Family and Children's Health Programs Group
7500 Security Boulevard
Baltimore, MD 21244-1850

we need to be very specific about what's required - this makes it sound like we need the report when all we need is a letter w/signature.

Dennis G. Smith
Director
Department of Medical Assistance Services
Commonwealth of Virginia
Suite 1300
600 East Broad Street
Richmond, Virginia 23219

Dear Mr. Smith:

Insert # on taxes & don. from approval.

Thank you for your latest response to our questions for Virginia's title XXI State plan. Again, we want to express our appreciation of your staff's effort to diligently work with us in this review process. However, additional clarification is still required to ensure that Virginia's plan is consistent with the statutory requirements of title XXI relative to the actuarial analysis of the benefit package.

With respect to the benefit package, you have now indicated Virginia's desire to propose a benchmark-equivalent benefit package. In order to comply with Section 2103(c)(4) of Title XXI, the State must, therefore, ". . . set forth in an actuarial opinion in an actuarial report . . ." the value of coverage under the benchmark, coverage under the State child health plan, and coverage of any categories of additional services under benchmark benefit packages and under coverage offered by such a plan that meets all the requirements of Section 2103(c)(4). [While your response indicates that this actuarial opinion and report have been done, the State must submit that opinion and report.] In addition, Section 6 of the draft application template should be modified to indicate that the Title XXI plan will now provide benchmark-equivalent coverage and specify the benchmark plan on which the equivalence has been or will be determined.

Under section 2106(c) of the Social Security Act, HCFA must either approve, disapprove, or request additional information on a proposed title XXI State plan within 90 days. This letter is our notification that additional clarification is required on Virginia's formal responses to ensure that your proposal conforms to the statutory requirements of Title XXI. As Debbie requested yesterday, we are awaiting the actuarial materials referenced

in your October 19 response. We feel confident that these materials will resolve this final issue so that we will be in a position to approve Virginia's plan. This issue is critical to plan approval under the statute and, therefore, if we cannot reach agreement we will be forced to disapprove the plan as submitted.

You may send your response electronically or in hard copy to Dan McCarthy, project officer for Virginia's title XXI proposal. A copy also needs to be sent to Claudette Campbell, Associate Regional Administrator for the HCFA Region III Division of Medicaid and State Operations. Mr. McCarthy's Internet address is dmccarthy@hcfa.gov. His mailing address is:

Family and Children's Health Programs Group
Division of Integrated Health Systems
Health Care Financing Administration
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

We appreciate the efforts of your staff and share your goal of providing health care to low income, uninsured children through title XXI. Your staff may contact either Mr. McCarthy at (410) 786-2079 or Ms. Campbell at (215) 861-4263 to provide or arrange for any technical assistance you may require in preparing your responses. Your cooperation is greatly appreciated.

Sincerely,

Richard Fenton
Deputy Director

cc: HCFA Region III

Draft approval

Claude A. Allen, Secretary
Commonwealth of Virginia
Office of the Governor
Department of Health and Human Resources
P.O. Box 1475
Richmond, VA 23218

Dear Mr. Allen:

We are pleased to inform you that your Children's Health Insurance Program (CHIP) plan has been approved as amended by the additional information you submitted on August 7, September 9, and October 19, 1998. We appreciate your efforts and the efforts of your staff, and extend our congratulations to Virginia on the approval of your CHIP plan.

move to sec.

In regard to compliance with 1903(w), the Commonwealth has informed us that no health insurer subject to the tax participates in, or owns an HMO that is currently participating in, Virginia's Medicaid managed care program. Thus, no health insurer that is subject to the tax receives federal Medicaid dollars. Under these circumstances, the tax in question does not burden the federal Medicaid program, and so is not an obstacle to the approval of the Commonwealth's CHIP plan.

The Department of Health and Human Services has held several regional meetings across the country to provide States with guidance on designing and implementing their CHIP plans. Information has been provided related to areas such as enrollment and administrative simplification, models of successful outreach programs, comprehensive systems and measures of quality care, linkages to other children's health programs, and data options. We are also maintaining a Departmental website, which I hope you will find helpful as you implement your program.

Your project officer is Dan McCarthy. Mr. McCarthy is available to answer any questions concerning the implementation of your Title XXI Program and can be reached at (410)786-2079. His address is:

Health Care Financing Administration
Center for Medicaid and State Operations
Mail Stop S2-03-08
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Jeanne —
this is what
we sent
- Deborah.

The Honorable Don Nickles
Assistant Majority Leader
United States Senate
Washington, D.C. 20510

Dear Senator Nickles:

Thank you for your most recent letter and the opportunity to clarify our October 13, 1998 response concerning coverage of abortion services under the Title XXI State Children's Health Insurance Program (S-CHIP).

I would like to clarify my response to you concerning the conditions under which I would approve S-CHIP benefit packages. In general, our policy has been that a state must provide a benefit package that is equal to, or better than, Benchmark ~~or Benchmark-Equivalent~~ Coverage. In order to be approved In my letter to you yesterday, I stated that we have limited the exercise of our discretion under the Secretary-Approved Coverage option to cases in which the benefits offered under a state's ~~S-~~ non CHIP program are the same as under its Medicaid plan. Medicaid ~~Indeed, we decided as a matter of policy in devising our S-CHIP implementation process that this approach provided an important benefit option that states might not otherwise have~~. However, after asking staff to review our ~~administrative~~ records yesterday, it appears that we ~~may have considered for~~ approval at ① Secretary-Approved Coverage some benefit packages other than Medicaid. This occurred in instances ✗ which a state provided benefits ~~that are~~ in excess of the statutorily defined Benchmarks. ~~Apparently, there was discussion in the Department that it might be desirable to use the Secretary-Approved Coverage option~~ for states that wanted to provide more benefits than required by law without requiring them to submit a formal actuarial estimate. In order to provide flexibility

~~While it is clear under the law that benefit packages that are in excess of Benchmark Coverage must be approved, it is not clear whether they should be approved as Benchmark or Secretary-Approved Coverage.~~ As a result of this review of our ~~administrative~~ records and staff deliberations, I have decided that as long as a state proposes to provide benefits in excess of Benchmark Coverage, states will ~~not be required to~~ cover ing permissible abortion services under the Secretary-Approved Coverage option. ~~Thus, provided states comply with other applicable provisions of law, they are not required to cover permissible abortion services under any of the S-CHIP program options~~. We have already informed you that states are free to exclude coverage for permissible abortion services in their Benchmark (provided a state's Benchmark plan does not cover abortions) or Benchmark-Equivalent options. have the option of

I would also like to address the specific questions you raised in your October 13, 1998 letter.

1) On the basis of your letter dated October 13, 1998, is it the Department's view that the Hyde language contained in the S-CHIP program does not require states to provide abortion coverage in the circumstances where the abortion is necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (*See section 2105 (c)(1), 2105 (c)(7), 2110 (a)(16)*)?

As discussed above, states are not required to provide permissible abortion services under any of the ~~three S-CHIP~~ program options. However, to the extent that a state chooses a Benchmark package that covers abortion services, they must provide the services that are allowed under the S-CHIP statute.

non medicaid

2) Is it your contention that a state which covers elective abortions under Medicaid and which opts to offer "Secretary-approved coverage" under S-CHIP must cover elective abortions for teenage girls under its S-CHIP program?

As discussed above, states are not required to cover permissible abortion services in order to receive Secretary-Approved Coverage. States do, however, have to offer at least the scope of benefits provided in their Benchmark plan.

3) In light of your letter, is it your contention that abortion is no longer considered a "medically necessary" service under the Medicaid program (*See section 4707(e)(1)*)?

No. We do not believe that Section 4707(e)(1) affects whether abortion services are medically necessary services under Medicaid. As a general matter, this section of the law describes the intermediate sanction regime a state must put in place in implementing the law. It does not affect the scope of benefits required under a state plan. Specifically, Section (e)(1)(A) permits states to provide for sanctions against any Medicaid managed care organization contracting with a state if that organization fails substantially to provide medically necessary items and services under the law or the organization's contract. Accordingly, if a managed care entity has agreed by contract to provide those services and does not do so, it may be sanctioned by operation of this section of the law. Notwithstanding that provision, Section (e)(1)(B) instructs that there shall not be any sanction imposed on a managed care entity that has contracted with a state and that fails or refuses to provide abortion services, so long as the contract itself reflects no obligation to provide such services. Moreover, the inclusion of these provisions strongly indicates that abortion services are medically necessary services under the Medicaid program, otherwise an exception to the general rule would not have been included.

4) In what manner do you view abortion as "appropriate coverage for the population of targeted low-income <u>children</u> proposed to be provided such coverage" by Virginia or any other state which submits an application for Secretary-approved coverage *(See Section 2103(a)(4))*?

Abortion services may be covered under Section 2103(a)(4) to the extent that a state chooses to include coverage for permissible abortion services in its otherwise qualified plan. Limited abortion services qualify as covered services under Section 2110(a)(16) of the S-CHIP law.

I hope this information addresses your concerns. Please let me know if you would like to discuss this matter further.

Sincerely,

Donna E. Shalala

please insert as 1st sentence:

Because of the many coverage options available, States have the flexibility to determine which services they consider part of to be appropriate coverage.

Barbara V. Scheil and Associates, Ltd.
15426 POUNCEY TRACT ROAD
P. O. BOX 249
ROCKVILLE, VA 23146
(804) 749-4341 FAX (804) 749-4469

BARBARA V. SCHEIL, FSA, MAAA
DIANE B. BOXLEY, FSA, MAAA

October 22, 1998

Michael R. Jay
Cost Estimation Manager
Department of Medical Assistance Services
600 East Broad St.
Suite 1300
Richmond, VA 23219

Re: Determination of Actuarial Values

Dear Michael:

Actuarial values of coverage of benchmark benefit packages, coverage offered under the Virginia child health plan,[1] and coverage offered of any categories of additional services under benchmark benefit packages and under coverage offered by such a plan are set forth in the Table A attached to this letter.

The values for all plans were computed:

- Using generally accepted actuarial principles and methodologies;
- Using utilization and price factors derived from the experience of children under 19 covered under the Commonwealth's Key Advantage self-funded health benefit plan for its employees and former employees and their families during state fiscal year 1996;[2]
- Using the population of children under 19 covered under the Commonwealth's KeyAdvantage self-funded health benefit plan for its employees and former employees and their families during state fiscal year 1996;[3]
- Applying the same principles and factors in comparing the value of different coverage (or categories of services);
- Without taking into account any difference in coverage based on the method of delivery or means of cost control or utilization used; and

[1] You have stated that the proposed Virginia child health plan is the same as Medicaid, except that it provides certain substance abuse services that Medicaid does not. Thus, although a relative value was not computed for the proposed plan, in my opinion the relative value would exceed the Medicaid value.
[2] See Table B, attached
[3] Coverage was provided to an average of 41,013 children during this period

- Taking into account the ability of the Commonwealth to reduce benefits by taking into account the increase in actuarial values of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

Based on the calculations described above, in my professional opinion the proposed benefits exceed the benchmark values.

Sincerely,

Barbara V. Scheil

Barbara V. Scheil
Fellow, Society of Actuaries
Member, American Academy of Actuaries

Consulting Actuary

Attachments:
Table A
Table B

Table A

Virginia Child Health Plan Updated Benchmark Plan Values

(Using Key Advantage Data for Children Under 19)

Scenario 1
Cover Children up to 200% of Nominal FPL

	Estimated Relative Value	Estimated PMPM	
Medicaid/Options	100%	$69.91	**
Key Advantage	85%	$59.42	
Cost Alliance	68%	$47.54	
BCBS FEHBP	78%	$54.53	
Optima	86%	$60.12	
Key Advantage No Copays	93%	$65.02	

Scenario 2
Cover Children up to 200% of Countable Income

	Estimated Relative Value	Estimated PMPM	
Medicaid/Options	100%	$78.71	**
Key Advantage	85%	$66.91	
Cost Alliance	68%	$53.53	
BCBS FEHBP	78%	$61.40	
Optima	86%	$67.69	
Key Advantage No Copays	93%	$73.20	

*** Estimated from Options FY98 rates and anticipated age distribution of the Virginia Child Health Plan*

Table B
Key Advantage Data for Children Under 19
(Claims Incurred FY96 and Paid Through March 1997)

Provider	Service	Adm/1000	Svcs/1000	Chg/Svc	Chg PMPM
HIP	Maternity	2.7	9.0	1,790.38	1.35
	Medical	25.7	115.2	1,627.41	15.63
	Surgical	5.8	34.6	3,053.30	8.80
	Psychiatric	3.5	38.9	952.21	3.08
HIP Total		**37.8**	**197.7**	**1,751.62**	**28.86**
HOP	Diagnostic Testing		27.4	114.49	0.26
	Maternity		3.0	245.49	0.06
	Medicine		41.6	292.81	1.02
	Emergency Room		213.2	93.35	1.66
	Home Health Care		1.0	678.35	0.00
	Hospice		0.0	-	-
	Outpatient Services		26.4	91.35	0.20
	Psychiatric		0.0	-	-
	Rad/Path/Lab		325.8	189.10	5.13
	Surgery		61.9	1,187.45	6.13
	Vision & Hearing		7.1	130.42	0.08
	Other		138.0	68.35	0.79
HOP Total			**845.5**	**218.29**	**15.38**
PIP	Consults		17.3	122.52	0.18
	Critical Care		4.1	457.98	0.15
	Diagnostic Testing		5.1	78.17	0.03
	Hospital Inpatient		115.7	98.73	0.95
	Maternity		3.0	1,217.96	0.31
	Medicine		14.2	95.91	0.11
	Newborn Care		39.6	87.83	0.29
	Nursing Facility		0.0	-	-
	Psychiatric		37.4	72.60	0.23
	Rad/Path/Lab		50.8	44.92	0.19
	Surgery		27.4	610.48	1.39
	Vision & Hearing		1.0	31.33	0.00
	Other		33.5	239.35	0.67
PIP Total			**349.0**	**155.06**	**4.51**
POP	Consults		84.2	107.06	0.75
	Diagnostic Testing		74.1	59.57	0.37
	Emergency Department		169.5	69.51	0.98
	Home		0.0	-	-
	Maternity		2.0	289.16	0.05
	Medicine		762.3	63.82	4.05
	Nursing Care		13.2	313.62	0.34
	Office/Other Optional		2,815.6	40.08	9.40
	Preventive Medicine		372.5	44.68	1.39
	Psychiatric		295.2	73.77	1.81
	Rad/Path/Lab		1,102.3	28.59	2.63
	Surgery		219.2	231.44	4.23
	Vision & Hearing		106.6	37.60	0.33
	Other		82.2	166.08	1.14
POP Total			**6,099.0**	**54.07**	**27.48**
Rx Card			**3,371.0**	**29.45**	**8.27**
Dental			**2,272.6**	**41.30**	**7.82**
Grand Total			**13,134.7**	**84.35**	**92.33**

FAMILY AND CHILDREN'S HEALTH PROGRAM GROUP

Center for Medicaid and State Operations

FAX Transmittal Sheet

Health Care Financing Administration
7500 Security Boulevard
Mailstop S2-01-16
Baltimore, Maryland 21244
FAX Number 410-786-8534

Date: _____ Total Pages (including cover): _____

To: Jennifer Ryan, Jeanne Lambrew, Kate Kirchgraber

Organization: HCFA, WH, OMB

Phone Number: _____ FAX Number: ~~(202) 395-3910~~ (202) 690-6262 (202) 456-7431

From: _____

Phone Number: _____

Comments: FYI

If the transmission is not complete, contact _____

at _____.

OCT 14 1998

The Honorable Don Nickles
Assistant Majority Leader
United States Senate
Washington, D.C. 20510

Dear Senator Nickles:

Thank you for your most recent letter and the opportunity to clarify our October 13, 1998 response concerning coverage of abortion services under the Title XXI State Children's Health Insurance Program (CHIP).

I would like to clarify my response to you concerning the conditions under which I would approve CHIP benefit packages for Title XXI non-Medicaid state programs (S-CHIP). In general, our policy has been that a state must provide a benefit package that is equal to, or better than, Benchmark or Benchmark-Equivalent Coverage. In my letter to you yesterday, I stated that we have limited the exercise of our discretion under the Secretary-Approved Coverage option to cases in which the benefits offered under a state's S-CHIP program are the same as under its Medicaid plan. Indeed, we decided as a matter of policy in devising our S-CHIP implementation process that this approach provided an important benefit option that states might not otherwise have.

However, after asking staff to review our records yesterday, it appears that in addition to Medicaid plans, we may have considered as Secretary-Approved Coverage other benefit packages. This occurred in instances in which a state provided benefits in excess of the statutorily defined Benchmarks. Apparently, there was discussion in the Department that it might be desirable to use the Secretary-Approved Coverage option for states that want to provide more benefits than required by law without requiring them to submit a formal actuarial estimate.

As a result of this review of our records and staff deliberations, I have decided that as long as a state proposes to provide benefits in excess of Benchmark Coverage, states will not be required to cover permissible abortion services under the Secretary-Approved Coverage option. We have already informed you that states are free to exclude coverage for permissible abortion services in their Benchmark (provided a state's Benchmark plan does not cover abortions) or Benchmark-Equivalent options.

I would also like to address the specific questions you raised in your October 13, 1998 letter.

1) On the basis of your letter dated October 13, 1998, is it the Department's view that the Hyde language contained in the S-CHIP program does not require states to provide abortion coverage in the circumstances where the abortion is necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (*See Section 2105 (c)(1), 2105 (c)(7), 2110 (a)(16)*)?

As discussed above, states are not required to provide permissible abortion services under any of the three S-CHIP program options. However, to the extent that a state chooses a package that covers abortion services under the Benchmark option, they must provide these services to the extent they are allowed under the CHIP statute.

2) Is it your contention that a state which covers elective abortions under Medicaid and which opts to offer "Secretary-approved coverage" under S-CHIP must cover elective abortions for teenage girls under its S-CHIP program?

As discussed above, states are not required to cover permissible abortion services in order to receive Secretary-Approved Coverage. States do, however, have to offer at least the scope of benefits provided in their Benchmark plan.

3) In light of your letter, is it your contention that abortion is no longer considered a "medically necessary" service under the Medicaid program (*See section 4707(e)(1)*)?

We do not believe that Section 4707(e)(1) affects whether abortion services are medically necessary services under Medicaid. As a general matter, this section of the law describes the intermediate sanction regime a state must put in place in implementing the law. It does not affect the scope of benefits required under a state plan. Specifically, Section (e)(1)(A) permits states to provide for sanctions against any Medicaid managed care organization contracting with a state if that organization fails substantially to provide medically necessary items and services under the law or the organization's contract. Accordingly, if a managed care entity has agreed by contract to provide those services and does not do so, it may be sanctioned by operation of this section of the law. Notwithstanding that provision, Section (e)(1)(B) instructs that there shall not be any sanction imposed on a managed care entity that has contracted with a state and that fails or refuses to provide abortion services, so long as the contract itself reflects no obligation to provide such services. Moreover, the inclusion of these provisions strongly indicates that abortion services are medically necessary services under the Medicaid program, otherwise an exception to the general rule would not have been included.

4) In what manner do you view abortion as "appropriate coverage for the population of targeted low-income <u>children</u> proposed to be provided such coverage" by Virginia or any other state which submits an application for Secretary-approved coverage *(See Section 2103(a)(4))*?

Abortion services may be covered under Section 2103(a)(4) to the extent that a state chooses to include coverage for permissible abortion services in its otherwise qualified plan. Limited abortion services qualify as covered services under Section 2110(a)(16) of the CHIP law.

I hope this information addresses your concerns. Please let me know if you would like to discuss this matter further.

Sincerely,

Donna E. Shalala

abortion

DATE: October 13, 1998

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
ROOM 406G, HUMPHREY BUILDING
200 INDEPENDENCE AVE, SW
WASHINGTON, D.C. 20201

PHONE: (202)690-6786 *FAX: (202)690-6351*

OFFICE OF THE DEPUTY ASSISTANT SECRETARY
CONGRESSIONAL LIAISON OFFICE

TO: Chris Jennings

OFFICE: Office of Policy Development

ROOM: _____

PHONE: _____

FAX: (202) 456-5557

FROM:

[X] IRENE BUENO

[ ] JULIA HUDSON

[ ] LORENA AHUMADA

[ ] MARION ROBINSON

[ ] CYNTHIA JOYCE

[ ] TIJUANA TRIPPLET

[ ] STACEYE ARRINGTON

[ ] BEATRICE BUTLER

TOTAL PAGES
(INCLUDING COVER): 3

REMARKS:

Please find attached letters from Sec. Shalala and Dr. Jane Henney.

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

OCT 12 1998

The Honorable Don Nickles
Assistant Majority Leader
United States Senate
Washington, D.C. 20510

Dear Senator Nickles:

Thank you for the letter from you and Chairman Hyde concerning the Department's interpretation of the Hyde amendment as it affects federally funded abortions. As you know, I take very seriously the Department's obligation to fully implement the law as enacted by the Congress. Nancy Ann DeParle, the Administrator of the Health Care Financing Administration (HCFA), shares this commitment.

Let me assure you that in order for federal funds to be used to cover abortion, a physician must certify that a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

We have no intention to instruct states on this issue other than to reiterate the statutory obligation that must be met to utilize federal funds for legally permissible abortions.

I trust this addresses your concerns. Please let me know if I can be of further assistance in this matter. An identical letter has been sent to Chairman Hyde.

Sincerely,

Donna E. Shalala

Donna E. Shalala

October 9, 1998

The Honorable Don Nickles
Assistant Majority Leader
United States Senate
Washington, D.C. 20510

Dear Senator Nickles:

As you know, I have been nominated by President Clinton to serve as Commissioner of the Food and Drug Administration (FDA). I appreciate the consideration that you and your colleagues in the Senate have given to my nomination.

I wanted to take this opportunity to clarify what I believe is a misconception about my views concerning FDA's regulatory authority. First, let me say that I respect the role of Congress in defining the parameters of FDA's authority and the goals and mission of the Agency. During my service at both the National Cancer Institute and the FDA, I worked hard to maintain collaborative relationships with our committees of jurisdiction, and to ensure that our activities were in full compliance with the law and congressional intent. Indeed, in the context of my current nomination, I have pledged that my top priority will be timely implementation of the FDA Modernization Act of 1997 based on the letter and spirit of the law.

I also want to clarify any misconceptions about my service at the agency from 1992-1994 with respect to the FDA tobacco rule and the Agency's review of RU-486. As I stated in response to questions submitted by the Committee on Labor and Human Resources, I did not participate in the FDA's consideration of whether the Agency has authority under existing law to assert jurisdiction over tobacco products. If confirmed as Commissioner, I would obviously abide by any final congressional or judicial action on this matter.

With respect to RU-486, I stated during my confirmation hearing and in response to the Committee's written questions that I was not involved either in the solicitation or the review of the RU-486 application.

I appreciate your willingness to consider my nomination. I would be pleased to meet with you to discuss these or any other issues at your convenience.

Sincerely,

Jane E. Henney, M.D.

DATE: 10-15-98

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVE., SW
WASHINGTON, D.C. 20201

PHONE: (202) 690-7627 **FAX: (202) 690-7380**

OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
ROOM 416-G HUMPHREY BUILDING

TO : Chris Jennings

OFFICE : White House

PHONE NO : 456-5560

FAX NO : 456-5557

TOTAL PAGES (INCLUDING COVER): 2

FROM:

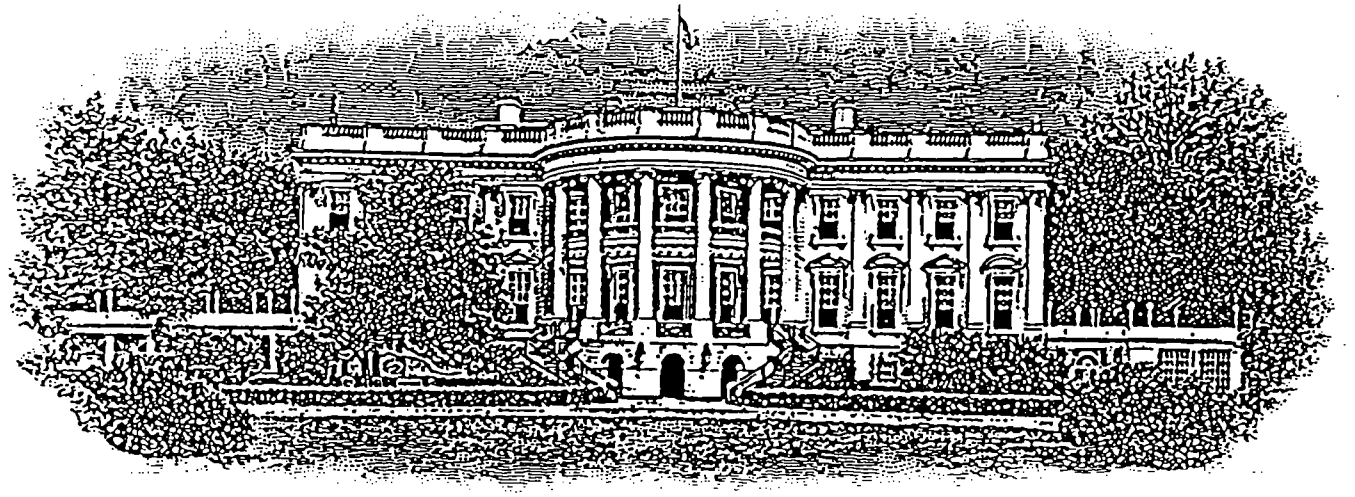
[X] RICHARD J. TARPLIN
[ ] HELEN MATHIS
[ ] KEVIN BURKE
[ ] SANDI EUBANKS BROWN
[ ] ROSR CLEMENT LUSI
[ ] ALICE ARTIS
[ ] HAZEL FARMER
[ ] EDWARD WHITLEY

REMARKS:

Final Version

States are not required to provide coverage of abortion services, including abortion services for which coverage is permissible under Title XXI of the Social Security Act, under any of the S-CHIP benefit package options in section 2103. No state will be denied approval of its S-CHIP plan because its benefit package under section 2103 does not include coverage of abortion services, including abortion services for which coverage is permissible under Title XXI.

The White House



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Holly

FAX NUMBER:

TELEPHONE NUMBER:

FROM: Devorah

TELEPHONE NUMBER: 456-5560

PAGES (INCLUDING COVER): * C + 3 *

COMMENTS: please fax back w/ changes.
Call with questions.
Thanks a lot!

The Honorable Don Nickles
Assistant Majority Leader
United States Senate
Washington, D.C. 20510

Dear Senator Nickles:

Thank you for your most recent letter and the opportunity to clarify our October 13, 1998 response concerning coverage of abortion services under the Title XXI State Children's Health Insurance Program (S-CHIP).

I would like to clarify my response to you concerning the conditions under which I would approve S-CHIP benefit packages. In general, our policy has been that a state must provide a benefit package that is equal to, or better than, Benchmark ~~or Benchmark-Equivalent~~ Coverage. In order to be approved In my letter to you yesterday, I stated that we have limited the exercise of our discretion under the Secretary-Approved Coverage option to cases in which the benefits offered under a state's ~~S-~~ non CHIP program are the same as under its Medicaid plan. Medicaid ~~Indeed, we decided as a matter of policy in devising our S-CHIP implementation process that this approach provided an important benefit option that states might not otherwise have~~. However, after asking staff to review our ~~administrative~~ records yesterday, it appears that we ~~may have considered for~~ approval at DOJ Secretary-Approved Coverage some benefit packages other than Medicaid. This occurred in instances ~~in~~ which a state provided benefits ~~that are~~ in excess of the statutorily defined Benchmarks. ~~Apparently, there was discussion in the Department that it might be desirable to use the Secretary-Approved Coverage option~~ for states that wanted to provide more benefits than required by law without requiring ~~them to submit~~ a formal actuarial estimate. In order to provide flexibili-

~~While it is clear under the law that benefit packages that are in excess of Benchmark Coverage must be approved, it is not clear whether they should be approved as Benchmark or Secretary-Approved Coverage.~~ As a result of this review of our ~~administrative~~ records and staff deliberations, I have decided that as long as a state proposes to provide benefits in excess of Benchmark Coverage, states will ~~not be required to~~ cover ing permissible abortion services under the Secretary-Approved Coverage option. ~~Thus, provided states comply with other applicable provisions of law, they are not required to cover permissible abortion services under any of the S-CHIP program options~~. We have already informed you that states are free to exclude coverage for permissible abortion services in their Benchmark (provided a state's Benchmark plan does not cover abortions) or Benchmark-Equivalent options. have the option of

69084Z5

I would also like to address the specific questions you raised in your October 13, 1998 letter.

1) On the basis of your letter dated October 13, 1998, is it the Department's view that the Hyde language contained in the S-CHIP program does not require states to provide abortion coverage in the circumstances where the abortion is necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (*See section 2105 (c)(1), 2105 (c)(7), 2110 (a)(16)*)?

As discussed above, states are not required to provide permissible abortion services under any of the ~~three S-CHIP~~ program options. However, to the extent that a state chooses a Benchmark package that covers abortion services, they must provide the services that are allowed under the S-CHIP statute.

non medicaid

2) Is it your contention that a state which covers elective abortions under Medicaid and which opts to offer "Secretary-approved coverage" under S-CHIP must cover elective abortions for teenage girls under its S-CHIP program?

As discussed above, states are not required to cover permissible abortion services in order to receive Secretary-Approved Coverage. States do, however, have to offer at least the scope of benefits provided in their Benchmark plan.

3) In light of your letter, is it your contention that abortion is no longer considered a "medically necessary" service under the Medicaid program (*See section 4707(e)(1)*)?

No. We do not believe that Section 4707(e)(1) affects whether abortion services are medically necessary services under Medicaid. As a general matter, this section of the law describes the intermediate sanction regime a state must put in place in implementing the law. It does not affect the scope of benefits required under a state plan. Specifically, Section (e)(1)(A) permits states to provide for sanctions against any Medicaid managed care organization contracting with a state if that organization fails substantially to provide medically necessary items and services under the law or the organization's contract. Accordingly, if a managed care entity has agreed by contract to provide those services and does not do so, it may be sanctioned by operation of this section of the law. Notwithstanding that provision, Section (e)(1)(B) instructs that there shall not be any sanction imposed on a managed care entity that has contracted with a state and that fails or refuses to provide abortion services, so long as the contract itself reflects no obligation to provide such services. Moreover, the inclusion of these provisions strongly indicates that abortion services are medically necessary services under the Medicaid program, otherwise an exception to the general rule would not have been included.

4) In what manner do you view abortion as "appropriate coverage for the population of targeted low-income <u>children</u> proposed to be provided such coverage" by Virginia or any other state which submits an application for Secretary-approved coverage *(See Section 2103(a)(4))*?

Abortion services may be covered under Section 2103(a)(4) to the extent that a state chooses to include coverage for permissible abortion services in its otherwise qualified plan. Limited abortion services qualify as covered services under Section 2110(a)(16) of the S-CHIP law.

I hope this information addresses your concerns. Please let me know if you would like to discuss this matter further.

please insert as 1st sentence:

Because of the many coverage options available, States have the flexibility to determine which services they consider part of to be appropriate coverage.

Sincerely,

Donna E. Shalala

~~worst~~

none of benefit options require abortions

no plan will be denied b/c not covering abortion.

---

because there is a strict legal interpretation for benchmark - equivalent.

TO THE HOUSE OF REPRESENTATIVES

I am returning without my approval H.R. 1757, the "Foreign Affairs Reform and Restructuring Act of 1998". I take this action for several reasons, most importantly, because this legislation includes unacceptable restrictions on international family planning programs. Current law, with which Administration policy is fully consistent, already prohibits the use of Federal funds to pay for abortion abroad and for lobbying on abortion issues. This bill would go beyond those limits. One provision would deny U.S. government funding for family planning programs carried out by foreign nongovernmental organizations (NGOs) that use their own funds to perform abortions even though the overall result of these NGO family planning programs is to reduce the incidence of abortion. Although the bill allows the President to waive this restriction, use of the waiver would also cripple many programs by limiting annual spending for international family planning to $356 million, $44 million below the amount available for Fiscal Year 1998.

A second provision would attempt to restrict the free speech of foreign NGOs by prohibiting funding for those that use their own funds to engage in any activity intended to alter the laws of a foreign country either to promote or to deter abortion. The bill would even ban drafting and distributing material or public statements on abortion. No waiver is provided for this restriction.

These restrictions and the funding limit would severely jeopardize the ability of the United States to meet the growing demand for family planning and other critical health services in developing countries. By denying funding to organizations that offer a wide range of safe and effective family planning services, the bill would increase unwanted pregnancies and lead to more abortions than would otherwise be the case.

I am also deeply concerned that this legislation ties unacceptable restrictions on international family planning to payment of legitimate U.S. arrears to the United Nations and other international organizations. There are strongly held beliefs on both ides of the debate over international population policy, and issues associated with this debate should be decided on their own merit.

Congressional insistence on this linkage, and thus its failure to pay U.S. arrears, undermines U.S. leadership and ability to achieve far reaching reforms at the United Nations.

The package authorizing arrears payments linked to UN reforms was the result of good faith negotiations between the Administration and Congress more than a year and a half ago. Unfortunately, due to the passage of time, some of these conditions are now outdated and are no longer achievable. While many of the UN reform benchmarks in the package remain acceptable, significant revisions are required, and we look forward to working with Congress next year to win the payment of our arrears and an achievable package of UN reforms.

H.R. 1757 also contains a number of provisions that raise serious constitutional concerns. These provisions include section 1809 that instructs U.S. representatives to the International Atomic Energy Agency as to positions that they must take on programs and projects in Cuba, section 1228 requiring denial of visas to certain classes of Haitians, and a part of section 1812 regarding U.S. policy on Jerusalem.

While the legislation contains important and carefully negotiated authority to reorganize the foreign affairs agencies and other basic authorities for the State Department, these important provisions have been included in the Omnibus Consolidated Appropriations Act for FY 1999, which will be presented to me for signature shortly..

Annette E. Rooney
10/20/98 04:24:19 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: Bruce K. Sasser/OMB/EOP, John D. Burnim/OMB/EOP, Rodney G. Bent/OMB/EOP, Michael Casella/OMB/EOP

Subject: Veto Message on HR 1757 - Foreign Affairs Reform and Restructuring Act

Attached is a draft veto message for this bill, which may be received at the White House -- and vetoed -- as soon as today. The principal basis for the veto is the bill's "Mexico City" abortion provision. The draft veto message is based on input from State and NSC.

Because of the possibility of Presidential action on this bill as soon as today, please give me any comments on the draft veto message by 6:00 today. Thank you.

HR1757VE.3

Message Sent To:

Sylvia M. Mathews/OMB/EOP
Robert D. Kyle/OMB/EOP
Daniel N. Mendelson/OMB/EOP
Charles E. Kieffer/OMB/EOP
Robert G. Damus/OMB/EOP
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Date:

FACSIMILE

PLEASE NOTIFY OR HAND-CARRY THIS TRANSMISSION TO THE FOLLOWING PERSON AS SOON AS POSSIBLE:

Name(s): Deborah Fuller

Department: _____

Phone#: _____

Fax#: _____

FROM: Rob Stewart

Assistant Secretary for Planning & Evaluation

FAX NUMBER (202) 401-7321

Number of pages being transmitted (including fax sheet): ____

COMMENTS: _____

RESPONSES FROM THE COMMONWEALTH OF VIRGINIA TO HCFA'S 10/5 QUESTIONS ABOUT VCMSIP, SPA 98-100

HCFA's Concerns: *Virginia has proposed to use Secretarial-approved coverage for its benefit package, with a coverage package based on the State's Medicaid benefits. In our fifth set of questions and answers, we stated that a State's Medicaid benefit package may indeed be Secretarial-approved coverage under a separate CHIP plan. However, this coverage must be the same coverage as provided under Medicaid for approval. With respect to abortion services, under federal law (specifically the Hyde Amendment) all states must provide medically necessary abortion services in three specific instances: where the life of the mother is at stake; in the case of pregnancy due to rape; or in the case of pregnancy due to incest. Although the state has not chosen to use federal funds to match payments for abortions performed in cases of rape or incest, this service is nonetheless a service required to be included under Medicaid. Therefore, in order for the state to meet the requirement for Secretarial-approved coverage it must provide exactly the same benefits of the Medicaid program, which the state has selected as its benefit package, and include the full coverage of the abortion services mandated under the Hyde amendment.*

DMAS RESPONSE:

HCFA previously indicated that in order for the Commonwealth to meet the requirement for Secretarial-approved coverage, it must provide "exactly the same benefits of the Medicaid program." We believe this is a HCFA-imposed constraint not required by the statute which created the new program. Furthermore, it is our understanding that Secretary Shalala has recently advised the Senate Assistant Majority Leader that:

> States are not required to provide coverage of abortion services, including abortion services for which coverage is permissible under Title XXI of the Social Security Act, under any of the S-CHIP benefit package options in Section 2103. No state will be denied approval of its S-CHIP plan because its benefit package under Section 2103 does not include coverage of abortion services, including abortion services for which coverage is permissible under Title XXI.

It is our understanding that this guidance resolves this issue.

In general, it is understandable that the Secretary might be reluctant to approve plans which exclude benefits if such exclusions lower the overall value of a plan. However, Virginia can assure the Secretary that the Title XXI benefit package it has submitted meets and indeed exceeds its Medicaid benefit package. This is because we have added substance abuse services which are not presently available under Medicaid. We believe that many more individuals will likely use these substance abuse treatment

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

DENNIS G. SMITH
DIRECTOR

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Facsimile Cover Sheet

To: DAN McCarthy
Company: HCFA
Phone:
Fax:

From:
Division: DMAS
Phone:
Fax: 371-4981

Date:
Pages including this cover page:

Comments:

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL | # of pages ▶

To	From
J. BONNET	D. McCARTHY
Dept./Agency	Phone #
Fax # 202-690-8168	Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

services than the comparatively few children who might seek access to the medical procedure not covered. The cost of substance abuse treatment would also generally exceed the cost of the medical procedure not covered.

As Medicaid benefits vary by states, the Secretary may also be reluctant to approve a Medicaid "look alike" without knowing its comparative value to other health insurance coverage available to children. Virginia provides a comprehensive benefit package under Medicaid and will under CMSIP. Our actuary, Barbara V. Scheil and Associates, Ltd., has determined that the Medicaid benefit package exceeds the value of all of the following plans, which could be considered to be "benchmark plans" under the statute:

Plan	Estimated Relative Value
Medicaid	109%
Medicaid/Options HMO Contract Benefits	100%
Sentara Optima HMO (largest commercial HMO in state)	86%
Key Advantage (state employees plan)	85%
Blue Cross/Blue Shield FEHBP	78%
Cost Alliance (state employees plan)	68%

As you know, the CMSIP Benefit Package is similar to the Medicaid benefit package with the addition of substance abuse services.

The above calculations were taken from "Kids' Care Preliminary Benchmark Plan Values (11/19/97)," which is attached. These calculations were made using the methodology mandated in Section 2103(c)(4). See the attachment labeled "Derivation of Medicaid Average Rate" for the "standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan (Section 2103(c)(4)(D))" used by our actuary. Our actuary used Medicaid utilization and prices as the "standardized set of utilization and price factors (Section 2103(c)(4)(C))." Barbara Scheil is a member of the American Academy of Actuaries (Section 2103(c)(4)(A). She used generally accepted actuarial principles and methodologies (Section 2103(c)(4)(B) and applied the same principles and factors in comparing the value of different coverage (Section 2103(c)(4)(E) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used (Section 2103(c)(4)(F).

Section 2103 of Title XXI also outlines the requirements for "categories of additional services" described as coverage of prescription drugs, mental health services, vision services and hearing services. These additional services must have an "actuarial

value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such (benchmark benefits) package." The agency has done a detailed comparison between the Medicaid benefits package and that of Key Advantage, the largest state employee health benefits plan and one of the possible benchmark plans. The benefit package for Virginia's Title XXI state plan is the Medicaid benefit package plus outpatient substance abuse services. The Title XXI mental health, prescription drug, vision and hearing benefits, therefore, should compare favorably to the benefits in Medicaid and Key Advantage (see attached charts comparing VCMSIP, Medicaid and Key Advantage Mental Health Benefits and Prescription Drugs, Vision and Hearing Benefits.

Kids' Care Updated Preliminary Benchmark Plan Values
(Using Key Advantage Data for Children Under 19)

Scenario 1
Cover Children up to 200% of Nominal FPL

	Estimated Relative Value	Estimated PMPM	
Medicaid FFS*	109%	$76.17	
Medicaid/Options	100%	$69.91	**
Key Advantage	85%	$59.42	
Cost Alliance	68%	$47.54	
BCBS FEHBP	78%	$54.53	
Optima	86%	$60.12	
Key Advantage No Copays	97%	$67.81	

Scenario 2
Cover Children up to 200% of Countable Income

	Estimated Relative Value	Estimated PMPM	
Medicaid FFS*	109%	$85.77	
Medicaid/Options	100%	$78.71	**
Key Advantage	85%	$66.91	
Cost Alliance	68%	$53.53	
BCBS FEHBP	78%	$61.40	
Optima	86%	$67.69	
Key Advantage No Copays	97%	$76.35	

** Assumes non-waivered and non-long term care population; includes DSH, GME & miscellaneous services not covered by MCOs.*

*** Estimated from Options FY98 rates and anticipated age distribution of Kids' Care*

Derivation of Medicaid Average Rate

Demographic Category	Eligibility Months	FY98 Options Rate PMPM
Medicaid		
ADC Under 1	248,339	$ 320.94
ADC Age 1-5	950,733	73.86
ADC Age 6-14	999,322	50.97
ADC Female 15-20	229,162	202.32 —
ADC Male 15-20	122,090	65.73
Weighted Average	2,549,646	$ 100.11
Scenario 1		
ADC Under 1	4,773	$ 320.94
ADC Age 1-5	23,575	73.86
ADC Age 6-14	78,670	50.97
ADC Female 15-20	17,482	85.45 *
ADC Male 15-20	17,482	65.73
Weighted Average	141,982	$ 69.91
Scenario 2		
ADC Under 1	13,073	$ 320.94
ADC Age 1-5	64,575	73.86
ADC Age 6-14	97,944	50.97
ADC Female 15-20	21,765	85.45 *
ADC Male 15-20	21,765	65.73
Weighted Average	219,122	$ 78.71

** Estimated as 1.3 x Male 15-20 (since most pregant women are already enrolled in Medicaid)*

Comparison of VCMSIP, Medicaid and Key Advantage Mental Health Benefits (including Substance Abuse)

VCMSIP (Title XXI)	Medicaid	Key Advantage
Inpatient Psych: 365 days covered Outpatient Psych: 26 visits (additional 26 visits if preauthorized) Inpatient Substance Abuse: one time for pregnant and post-partum women (330 day limit up to 60 days post partum) Outpatient Substance Abuse: 26 visits (additional 26 visits if preauthorized); 12 months of day treatment one time for pregnant and post partum women State Plan Option Services: Intensive in-home services, therapeutic day treatment Day Treatment/Partial Hospitalization 2+ hours per day limited to 780 units include diagnostic, medical, psychiatric, psychosocial treatment Psychosocial rehab 2+ hours per day limited to 936 units. Include assessment, education about and MI and meds Crisis Intervention-180 hours immedidate mental health care Intensive Community Treatment-26 sessions defined as medical psychotherapy, psychiatric assessment and medication management offered outside clinic, hospital or office setting Crisis Stabilization-limited to 15 day period, 60 days annually Mental Health Support Services Case Management	Inpatient Psych: 365 days covered Outpatient Psych: 26 visits (additional 26 visits if preauthorized) Inpatient Substance Abuse: one time for pregnant and post-partum women (330 day limit up to 60 days post partum) Outpatient Substance Abuse: 12 months of day treatment one time for pregnant and post partum women State Plan Option Services: Intensive in-home services, therapeutic day treatment Day Treatment/Partial Hospitalization 2+ hours per day limited to 780 units include diagnostic, medical, psychiatric, psychosocial treatment Psychosocial rehab 2+ hours per day limited to 936 units. Include assessment, education about and MI and meds Crisis Intervention-180 hours immedidate mental health care Intensive Community Treatment-26 sessions defined as medical psychotherapy, psychiatric assessment and medication management offered outside clinic, hospital or office setting Crisis Stabilization-limited to 15 day period, 60 days annually Mental Health Support Services Case Management	Inpatient Psych: 30 days covered Outpatient Psych: 50 visits Inpatient Substance Abuse: 90 days maximum lifetime benefit Outpatient Substance Abuse: 50 visits Other: Partial day treatment: 30 days as an alternative to inpatient hospitalization, including diagnostic services, outpatient detox, individual psychotherapy, group psychotherapy, psychological testing, counseling with family members, and electroconvulsive therapy Employee assistance program-4 visits free

Comparison of VCMSIP, Medicaid and Key Advantage Prescription Drugs, Vision and Health Benefits

VCMSIP (Title XXI)	Medicaid	Key Advantage
Prescription drugs are covered. Over-the-counter drugs are covered when ordered by a physician.	Prescription drugs are covered. Over-the-counter drugs are covered when ordered by a physician.	Prescription drugs are covered with a co-pay
Separate eye examinations and eyeglasses are covered when medically necessary.	Separate eye examinations and eyeglasses are covered when medically necessary.	Vision examination as part of preventive check up with PCP for children 0-5. Separate vision examinations and eyeglasses covered only under optional benefit package.
Separate hearing examinations and hearing aids are covered when medically necessary.	Separate hearing examinations and hearing aids are covered when medically necessary.	Hearing examination as part of preventive check up with PCP for children 0-5.

HCFAs Concerns: ***Section 1903(w)(3)(A)(i) of the Social Security Act defines a health care-related tax to mean a tax that is related to health care items or services, or to the provision of, the authority to provide, or payment for, such services. Health insurance premiums are payments for health insurance coverage. Health insurance coverage is related to the payment for health care services. Therefore, the Commonwealth's health insurance premium tax is subject to the requirements of section 1903(w) of the Act. ... (t)he Secretary shall approve such an application (for a waiver) if the State establishes to the satisfaction of the Secretary that the net impact of the tax and associated expenditure under Title XIX as proposed by the State is generally redistributive in nature and the amount of the tax is not directly correlated to Medicaid payments for items or services with respect to which the tax is imposed. ... (A)bsent further facts indicating that the Virginia insurance tax will not result in penalties under the Medicaid tax rules, HCFA cannot make a determination as to the sufficiency of the program budget submitted pursuant to section 2107(d) of the Act.***

DMAS RESPONSE:

We have had a chance to review your letter of October 5 and would like to take this opportunity to respond to your concerns related to the Commonwealth's health insurance premium tax laws. The Commonwealth disagrees with the assertion that the tax structure does not meet the uniformity requirements of section 1903(w)(3)(c) of the Social Security Act. We maintain our position that the tax is uniform within class of health insurance and do not believe that the federal regulations directly state that this type of tax structure is in violation of the federal law.

In addition, Title XXI law states that the provisions of the provider tax law are to be applied "in the same manner" for Title XXI plans as they are for Title XIX. If indeed a state is found to be in violation of the provider tax law the result under Title XIX is a loss in FFP, not disallowance of the state's Medicaid program. HCFA's position that the Title XXI plan cannot be approved until this issue is resolved because of concerns related to the adequacy of the Commonwealth's proposed budget is unfounded and unreasonable. It is the Commonwealth's responsibility to ensure that the necessary non federal funds are available and in compliance with federal law.

While the Commonwealth continues to disagree with HCFA's assertion that the Commonwealth's premium tax structure is not in compliance with the federal law, further analysis of Virginia's tax structure and its Medicaid program clearly shows that HCFA's concerns related to the tax are unfounded.

In the October 5 letter you state that the tax structure, if it is in violation of the broad based and/or uniformity requirements, will still be acceptable if "the State establishes to the satisfaction of the Secretary that the net impact of the tax and associated expenditures under Title XIX as proposed by the State is generally redistributive in nature

and the amount of the tax is not directly correlated to Medicaid payments for items or services with respect to which the tax is imposed." The tax in question is authorized in Section 58.1-2501 of the Virginia Code which imposes the premium tax on all Health Insurance Plans licensed under Title 38.2 Chapter 42 of the Virginia Code. Under Virginia law, Health Maintenance Organizations are defined and authorized under Title 38.2 Chapter 43 of the Virginia Code and therefore are not included in the premium tax. Furthermore, as a condition for participation in the Commonwealth's Medicaid capitated managed care programs (OPTIONS and MEDALLION II) DMAS requires that the contracting provider be a Health Maintenance Organization licensed with the State Corporation Commission under Chapter 43 of the Code. No health insurance plan licensed under Chapter 42 (the plans upon which the premium tax is collected) is enrolled with DMAS as a Medicaid provider. Since none of the plans paying the tax are receiving Medicaid payments, it is impossible for us to perform the tests described in section 42 CFR 433.68(e) as requested in your letter.

The "hold harmless" practices included in 42 CFR 433.68(f) and mentioned in your letter are totally irrelevant to the Virginia program. The regulation states that the tax would be found to have a hold harmless arrangement if at least one of the following three situations existed:

1) If the State which imposes the tax provides directly or indirectly for a non-Medicaid payment to those providers paying the tax and the amount of the payment is positively correlated to either the tax or to the difference between the Medicaid payment and the total tax.

2) If all or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the total tax payment.

3) The State imposing the tax provides, directly or indirectly, for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

There is absolutely no relationship or correlation between premium tax revenue and Medicaid's payments to its health insurance organizations. As stated above, the Health Maintenance Organizations enrolled as Medicaid providers are not included in the tax program.

Furthermore, all payments to the HMOs through the OPTIONS and MEDALLION II programs are made in accordance with federal regulations for Medicaid managed care programs. Under these guidelines, the payments to the HMOs cannot exceed what the Commonwealth would have paid under its Medicaid Fee-For-Service plans. These capitation rates have been calculated by an independent actuarial firm and have been certified by HCFA as being actuarially sound. Total payments to the HMOs are based

solely on the number of recipients enrolled in the HMO times the capitation rates which have been reviewed and approved by HCFA.