OFFICE OF INTERGOVERNMENTAL AFFAIRS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 Independence Avenue, SW
Room 630F
Washington, DC 20201

FAX COVER SHEET

DATE:	October 20, 1995	**TIME:**	8:26 AM
TO:	Diana Fortuna	**PHONE:**	**456-5570**
		FAX:	456-7028
FROM:	John Monahan Director	**PHONE:** **FAX:**	**690-6060** 690-5672
RE:			
CC:			

Number of pages including cover sheet: 4

Message:

The attached is for your information.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

October 19, 1995

To: Kevin Thurm
John Monahan ✓
Jerry Klepner
Claudia Cooley

From: Bruce Vladeck

Attached is the summary of Oregon's response to our proposal.

OREGON HEALTH PLAN PREMIUM PROPOSAL

- On June 30, 1995, Oregon submitted a number of amendments to the Oregon Health Plan (OHP) waiver. One of the amendments would impose premiums on "new eligibles," i.e., those people whose incomes areis below the Federal Poverty level (FPL), but who do not meet other eligibility criteria for Medicaid. The premiums would apply to all "new eligibles," including those already participating, except pregnant women and children born after September 30, 1983. The proposed premium structure is:

Family Income (% of FPL)	Monthly Premiums Number of "new eligibles" in Family 1	2	3	4 or more
0-49%	$6	$6.50	$7	$7.50
50-65%	$15	$18	$20	$22
66-85%	$18	$21	$24	$26
86-99%	$20	$23	$26	$28

- The State expects to collect $14.8 million from these new premiums over its two year budget. The projected number of individuals subject to the premium are shown below:

% of FPL	Average number per month
0 - 49	80,200
50 - 65	8,600
66 - 85	17,200
86 - 100	17,200

- Once an individual is determined to be eligible for the OHP, he or she would maintain eligibility for a full 6-month period, regardless of whether premiums were paid. However, further eligibility would be denied until any back premium payments were made.

- During the transition to premiums, Oregon will provide a three-month grace period for currently eligible individuals who receive their first billing the first month that premiums are required, and will also: (1) not require households whose redetermination of eligibility is due in November or December 1995 to be current in their payments in order to be redetermined eligible, and (2) require only the minimum premium amounts at the 0-49% FPL level from all households until January 1996, to assure accurate computations of the ratio of household incomes to the FPL.

- **HHS Concerns** -- HHS is concerned that the premiums will present a hardship to very low-income individuals. Even at the levels proposed by the State, premiums may be unaffordable for some families, and may deter many needy people from seeking coverage. The Department views the State's plan to preserve access through Oregon's transition plan insufficient to prevent loss of coverage, especially in contrast to a similar proposal we've received from Tennessee, which contains much lower premiums but more thorough and thoughtful protections for low-income beneficiaries.

- **HHS Proposal to the State** -- Despite these concerns, HHS proposed to permit the State to impose the premiums on the condition that the State develop a plan for waiving disenrollment for hardship cases. This offer was conveyed to the State on Wednesday October 18, and immediately rejected by them.

- **Oregon's Response** -- The State was unwilling to consider the HHS proposal, but we expect to hear further from them today.

October 19, 1995

3/22/95, 3/23/95, 3/30/95, 5/3/95, 5/4/95, 5/5/95, 5/22/95). There was public notice of these hearings and work sessions, and many consumer advocates and other members of the public gave testimony on the specific changes related to the OHP Medicaid Demonstration, including the change in the benefit package.

In the following section there is a summary of the condition/treatment lines that will no longer be covered for demonstration participants following approval from DHHS. For a complete list and explanation of the condition/treatment lines that will be dropped from coverage, see **Attachments 2 and 3**. In the judgement of the Health Services Commission these are the least important funded lines on the prioritized list and according to state statute the first to not be funded if there is a change in the benefit package.

The last section of this document addresses the estimated changes in the costs of the program resulting from moving the funding line from line 606 to line 581.

CONDITION/TREATMENT LINES 582 THROUGH 606

The legislature has determined the funding line is to be moved to 581 on the February 10, 1995 list. As a result, 25 fewer condition/treatment lines will be funded under the Oregon Health Plan Medicaid Demonstration. As one examines the lines in question, there is a simple grouping which allows for the identification of the type of condition and the impact of the line item not being covered.

Four lines (582-585) relate to mental health conditions. These lines include Impulse Disorders, Sexual Dysfunction, Severe Conduct Disorder, and Somatization Disorder. Adults are not generally treated for these conditions in the public mental health system, and many children and adolescents with the diagnoses of impulse disorder and severe conduct disorder may have a comorbid mental health condition above line 581, entitling them to treatment.

Five lines, (587, 588, 600, 603, and 606) relate to infectious diseases. In all instances these diseases are self-limited. Reiter's Disease (603), on rare occasions, will result in additional complications of conjunctivitis or arthritis at which time treatment would be available at another line.

Six lines (590, 593, 594, 595, 604, and 605) relate to disorders of joints and bones. Lines 594 and 595 contain certain congenital anomalies and childhood diseases, with the recommended treatment of a surgical nature. Not all treatments would result in the correction of the conditions. The other four lines occur later in life with marginal improvement in the condition after surgery.

Lines 591, 596, 597, and 598 are conditions in which treatment is focused on relieving symptoms. There are currently effective over-the-counter medications for these conditions. These conditions occur after the onset of puberty.

Lines 586, 589, 599, and 601 are conditions which require surgery and/or modification devices for the relief of symptoms for which there are differences of opinion on the success of treatment. These illnesses seldom occur in children.

Line 602, Foreign Body Accidentally Left During a Procedure, would be covered by the institution or provider who left the foreign body or as a complication of the surgical intervention reimbursable at another line.

Rhizotomy for Spastic Diplegia (Line 592) is rarely performed in limited centers around the country. This would be used to stop constant jerking and rocking motions which are the result of cerebral palsy. Cerebral palsy is one of the conditions that is considered on the dysfunction lines, and treatments for this condition might still be covered in order to address a dysfunction in communication, posture and movement, reason and judgement, or eating, elimination and respiration.

The Health Services Commission can make technical revisions to the list if specific codes are identified that were not paired appropriately. The Commision can initiate such technical revisions, or they can be brought to the Commission's attention by external sources such as providers, advocates, or state agencies. The hearings and comorbidity determinations related to the unfunded lines are reviewed to determine if a pattern has developed that indicates a need for a technical revision to the list.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

NOV 21 '95

FINAL

The Honorable John Kitzhaber, M.D.
Governor of Oregon
Salem, Oregon 97310-0001

Dear Governor Kitzhaber:

I am glad we had the opportunity today to talk directly about the two remaining changes you have proposed to the Oregon Health Plan (OHP) -- charging premiums to the newly eligible population under 100 percent of the federal poverty level (FPL) and reducing the number of health services covered under the OHP.

Your proposal to begin collecting premiums from "new" enrollees (i.e., those not currently eligible for Medicaid under current law) with incomes below 100 percent of the poverty line is approved. Clients required to pay premiums will be advised each month of the monthly premium amount. This approval is contingent upon our understanding that no one will have their period of guaranteed eligibility interrupted based on nonpayment of premiums during the six-month eligibility period. It is further understood that, prior to the time at which any enrollee would lose coverage or be denied access to new coverage due to nonpayment of the premium, your staff will continue to work with ours to ensure that an appropriate exceptions procedure for hardship cases is in place. Oregon will be required to monitor the impact of premium collections on clients' continued enrollment in the OHP and to make adjustments to policy as necessary. While we believe we have offered two reasonable proposals to protect coverage in cases of financial hardship, we are open to discussing other options. One of our proposals, to increase premiums for higher income individuals and reduce the burden on the lowest income beneficiaries, was also easily administrable. I am committed to developing a process that meets your two objectives: additional financing for OHP; and a limited exceptions policy that is humane and not administratively burdensome.

You have suggested that we should approve your original amendment to impose premiums, which could lead to some disenrollments of individuals below the federal poverty level, because we have approved other amendments that could lead to disenrollments. Those individuals covered by the approved amendments -- college students, individuals with liquid assets over $5,000, and others whose income exceeds 100 percent of the federal poverty level over a three-month period -- are likely to have a greater ability to pay for health care coverage or, in

the case of college students, have access to health care on campus or health insurance policies for students. In contrast, the group of OHP individuals between 0-100 percent of the federal poverty level, who lack liquid assets, are the poorest of the poor. If your projections prove accurate that the numbers of these individuals who cannot pay and would have to disenroll is only a "few," we believe that a limited exceptions policy will provide a needed safety net while having minimal impact on the State's expected increase in revenues related to the premiums. As I indicated in the paragraph above we believe you should go ahead with your premium strategy with the clear understanding that no one would be cut off in the first six months until we have a hardship policy agreement.

With respect to changes in the benefits package, the Department is not opposed in principle to changes in this package based on decisions made by Oregon's Legislature. However, prior to providing approval of your requested change, the Department will need to review the responses to the questions raised in our letter of October 30, 1995 which we have just received. Because of its innovative and complex nature, Oregon's original proposal received careful legal and policy scrutiny, including a review by the Office of Technology Assessment on the issue of covered services. Because of some of the concerns raised by that review, we required specific itemized approval of any subsequent changes as one of the conditions of the waiver approval. We must determine to what extent some of the 25 items excluded under your current proposal may be of demonstrable benefit in reducing pain or disability for some beneficiaries. In order to reach closure on the benefits package changes, I would like to invite your staff, during the week of November 27, to join the HHS team in face to face meetings to fully discuss the changes. At that time, staff can also discuss the exceptions process related to charging premiums. Knowing that you are committed to implementing a revised package of benefits by January 1, 1996 and premiums by December 1, 1995, we will work with you on an expedited basis to resolve all questions related to the proposed changes. You will recall that we have previously agreed on a framework for reducing capitation rates at our meeting of October 25, 1995.

I know that you are anxious to proceed with changes in OHP. I hope you can appreciate the fact that when we have approved 1115 demonstrations, we have done so only when we believe the programs will maintain basic benefits for Medicaid eligibles and, where possible, improve health care coverage more broadly in a State. I know that we both want to ensure that the demonstration maintains appropriate benefits for Medicaid eligibles, and treats Oregon's poorest citizens fairly. At a time when the President is striving to protect guaranteed benefits for low income individuals, I know that you can appreciate our heightened concern.

I remain confident that the remaining issues surrounding your request can be quickly resolved through direct discussions, and we look forward to pursuing a process that will lead speedily to a mutually satisfactory outcome.

Sincerely,

Donna E. Shalala

EXPEDITE

FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

To: Diana Fortuna - WH/Domestic Policy
Emily Bromberg - WH/IGA

Organization: White House

From: Pat Woods
Intergovernmental Affairs

Date: 11/21/95

EXPEDITE

Intergovernmental Affairs
200 Independence Ave., SW
Room 630 F
Washington, DC 20201
phone: (202) 401-5879
fax: (202) 690-5672

Recipient's Fax Number:

Number of pages including this sheet: 4

Remarks: Please review quickly and give me your comments or (hopefully) clearance. We'd like to send (fax) this this evening - Thanks.

DRAFT

The Honorable John Kitzhaber, M.D.
Governor of Oregon
Salem, Oregon 97310-0001

Dear Governor Kitzhaber:

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You have suggested that we should approve your original amendment to impose premiums, which could lead to some disenrollments of individuals below the federal poverty level, because we have approved other amendments that could lead to disenrollments. Those individuals covered by the approved amendments -- college students, individuals with liquid assets over $5,000, and others whose income exceeds 100 percent of the federal poverty level over a three-month period -- are likely to have a greater ability to pay for health care coverage or, in the case of college students, have access to health care on campus or health insurance policies for students. In contrast, the group of OHP individuals between 0-100 percent of the federal poverty level, who lack liquid assets, are the poorest

DRAFT

of the poor. If your projections prove accurate that the numbers of these individuals who cannot pay and would have to disenroll is only a few, we believe that a limited exceptions policy will provide a needed safety net while having minimal impact on the State's expected increase in revenues related to the premiums. As I indicated in the paragraph above we believe you should go ahead with your premium strategy with the clear understanding that no one would be cut off in the first six months until we have a hardship policy agreement.

With respect to changes in the benefits package, the Department is not opposed in principle to changes in this package based on decisions made by Oregon's Legislature. However, prior to providing approval of your requested change, the Department will need to review the responses to the questions raised in our letter of October 30, 1995. Because of its innovative and complex nature, Oregon's original proposal received careful legal and policy scrutiny, including a review by the Office of Technology Assessment on the issue of covered services. Thus, HHS is conducting an analogous review. We must determine to what extent some of the 25 items excluded under your current proposal may be of demonstrable benefit in reducing pain or disability for at least some people. In order to reach closure on the benefits package changes, I would like to invite your staff, during the week of November 27, to join the HHS team in face to face meetings to fully discuss the changes. At that time, staff can also discuss the exceptions process related to charging premiums. Knowing that you are committed to implementing a revised package of benefits by January 1, 1996 and premiums by December 1, 1995, we will work with you on an expedited basis to resolve all questions related to the proposed changes. You will recall that we have previously agreed on a framework for reducing capitation rates at our meeting of October 25, 1995.

I know that you are anxious to proceed with changes in OHP. I hope you can appreciate the fact that when we have approved 1115 demonstrations, we have done so only when we believe the programs will maintain basic benefits for Medicaid eligibles and, where possible, improve health care coverage more broadly in a State. We want to ensure that any changes in Oregon's original approach do not erode benefits for Medicaid eligibles and drop from coverage the poorest citizens in the State. At a time when the President is striving to protect guaranteed benefits for low income individuals, I know that you can appreciate our heightened concern.

DRAFT

I remain confident that the remaining issues surrounding your request can be quickly resolved through direct discussions, and we look forward to pursuing a process that will lead speedily to a mutually satisfactory outcome.

Sincerely,

Donna E. Shalala

Dear Governor Kitzhaber:

I, too, am sorry that we have been unable to talk directly about the two remaining changes you have proposed to the Oregon Health Plan (OHP) -- charging premiums to the newly eligible population under 100% federal poverty level FPL and reducing the number of health services covered under the OHP. At our meeting October 25, I believed that we had reached agreement on the premium issue and, while we did not reach closure on reducing the list of covered benefits, we did approve reducing capitation rates.

Your proposal to begin collecting premiums from "new" enrollees with incomes below 100% of the poverty line (i.e., those not currently eligible for Medicaid under current law) is approved. Clients required to pay premiums will be advised each month of the monthly premium amount. It is understood that no one will have their period of guaranteed eligibility interrupted based on nonpayment of premiums during the six-month eligibility period. It is further understood that, prior to the time at which any enrollee would lose coverage due to an inability to pay the premium, your staff will continue to work with ours to ensure that an appropriate exceptions procedure for hardship cases is in place. Oregon will be required to monitor the impact of premium collections on clients' continued enrollment in the Oregon Health Plan and to make adjustments to policy as necessary. I am confident that we can develop a process that meets your objectives of additional financing for OHP while providing a limited exceptions policy that is both administrable and humane.

You have argued that we should approve your original amendment to impose premiums, which could lead to some disenrollments of individuals under 100% FPL, because we have approved other amendments that could lead to disenrollments. Those individuals covered by the approved amendments -- college students, individuals with liquid assets over $5000, and individuals whose income exceeds 100% FPL over a three month period -- are likely to have a greater ability to pay for health care coverage or, in the case of college students, have access to health care on campus or health insurance policies for students. In contrast, the group of OHP individuals between 0-100% FPL, who lack liquid assets, are the poorest of the poor. ~~If your~~ statement is true that the numbers of these individuals who cannot pay and would have to disenroll is only a "few," we believe that a limited exceptions policy will provide a needed safety net while having minimal impact on the State's expected increase in revenues related to the premiums.

The Department is not opposed in principle to changes in the benefit package based on decisions made by Oregon's Legislature. However, prior to providing approval of your requested change, the Department will need to review the responses to the questions raised in our letter of October 30, 1995. As your staff will recall, the original waiver proposal was subjected to line-by-line legal and policy scrutiny. We are concerned that some of the 25 items excluded under your current proposal may be of demonstrable benefit in reducing pain or disability for at least some

people. In order to reach closure on the benefits package changes, I would like to invite your staff, during the week of November 27, to join the HHS staff and other legal and clinical staff in a face to face meeting to discuss fully questions about the changes. We would urge you to submit the answers to the questions of October 30, 1995 in advance so that the meeting can be productive. At that time, staff can also discuss the exceptions process related to charging premiums. Knowing that you are committed to implementing a revised package of benefits by January 1, 1996 and premiums by December 1, 1995, we will work with you on an expedited basis to resolve all questions related to the proposed changes.

I know that you are anxious to proceed with changes in OHP. I hope you can appreciate the fact that when we have approved 1115 demonstrations, we have done so only when we believe the programs will maintain basic benefits for Medicaid eligibles and, where possible, improve health care coverage more broadly in a State. Oregon is proposing fundamental changes in its original approach that could erode benefits for Medicaid eligibles and drop from coverage the poorest citizens in the State. At a time when the President is striving to protect guaranteed benefits for low income individuals, I know that you can appreciate my heightened concern.

I remain confident that the remaining issues surrounding your request can be quickly resolved through direct discussions, and we look forward to pursuing a process that will lead speedily to a mutually satisfactory outcome.

We want to ensure ...

JOHN A. KITZHABER
GOVERNOR

November 17, 1995

Secretary Donna Shalala
Department of Health and Human Services
200 Independence Ave., SW
Washington, D.C. 20201

Dear Secretary Shalala:

I am sorry that we have been unable to connect by phone, but I understand the difficulty of making connections with my being in Asia and your dealings with the federal shutdowns. I am writing to express my concerns over our inability to reach agreement on approval for the two remaining changes in the Oregon Health Plan -- the charging of premiums to the "newly-eligible" population and the change in the benefit package. Trying to negotiate these issues has consumed an enormous amount of time from my small staff, and I must share with you my growing frustration with this process.

As you know, Oregon's Legislature in June approved a number of changes to the Oregon Health Plan (OHP), almost all of which were proposed in my budget. Prior to that time, staff at HCFA were well-aware of the potential changes. Our formal requests for modification to our demonstration were submitted in late June and early July. We received approval for a number of changes which impacted eligibility beginning in October. It is important to point out that the changes acceptable to HHS -- including an asset test and three-month income averaging -- will have the effect of dropping 15,000 people from coverage.

We are still awaiting approval for the last two changes which have the largest dollar impacts. These changes reflect the policy which lies at the heart of the Health Plan: namely that we need to make hard choices in an explicit manner and that persons should hold some financial responsibility for sharing in the cost of their care. It has been nearly a month since we met in Washington, D.C. and reached what I thought was an agreement on these issues. Clearly that is not the case.

Let me first address the issue of premiums. Our proposal was to require that those who are newly-eligible under the OHP (i.e. do not qualify for Medicaid under federal law) pay a modest amount, based on income, towards the cost of their care. These people continue to be guaranteed coverage for six months. At the end of that time, however, they would be required to pay the amounts past due before being considered for further eligibility. My understanding of our agreement was that, before anyone actually lost coverage due to an inability to pay the premium, we would set up some kind of review process. Although we

continue to believe that our initial proposal is reasonable, we have since put two specific proposals on the table to address HHS concerns, neither of which is apparently acceptable to the Department.

The verbal responses we have received from HHS are that they would like a process that would basically assure that anyone who believes they cannot pay would be allowed to continue. This does not reflect the understanding we reached in your office, nor is it a viable alternative. It would require enormous administrative support and, in the end, would be based on subjective (and unenforceable) judgments. Again, I would like to reinforce the fact that we are only proposing that premiums be applied to those who have no entitlement to Medicaid under federal law; these are people who, absent the Oregon Health Plan, have no health care coverage. The irony here is that the HHS staff are willing to approve changes which will eliminate 15,000 people from coverage, but resist modest premiums for people with no entitlement to care because a few might lose coverage.

Secondly, I am deeply concerned with the delays and lack of action on our request for a change in the benefit package. Although your staff were aware of the timelines assumed in our budget savings, it took almost four months for questions to be sent to us on this change. The letter we received on October 30 included four pages of line-by-line questions. What I find especially interesting is that, although there was a good deal of communication and negotiation which occurred around the process to develop the list prior to granting of the initial waiver, I do not believe we ever received any specific questions about services which were not covered beginning at that time. Now, with a program that is clearly working and which is improving the health of Oregonians, we are being subjected to a detailed analysis of each and every change we are proposing. This is the kind of illogical, bureaucratic contradiction that has contributed to the current lack of credibility of many of our federal agencies.

The latest suggestion we received from your staff was that we change the capitation rates for managed care plans, although they were not yet willing to allow us to change the benefit package. Such an approach would be directly contrary to the principles of the Health Plan, which require that we make explicit decisions on the benefits but pay the reasonable costs of providing those benefits. These principles have been embodied in statute since 1989 and were in place when the waiver was granted.

As you know, our legislative Emergency Board is meeting this week. This Board serves as an interim budget body and is co-chaired by the Senate President and House Speaker.

The Department of Human Resources is scheduled to present its "budget rebalance" to the Board at that time. Since we already have incurred costs due to the delays in receiving approval of the premium proposal, it will be necessary for the Department to report on the status of the negotiations with the federal government over these changes.

I had hoped that we could avoid reporting on the lack of action and instead report that the Administration had provided us approval to continue our demonstration with these changes. Since that is not the case, I have no choice but to report that the Clinton Administration's insistence on trying to preserve the status quo will result in more low-income Oregonians going without health care coverage. I understand that dropping people from all coverage is acceptable to the Administration, while using sliding scale premiums and modifying the benefit package is not. I respectfully disagree with this policy.

I am disappointed by the lack of action by your office and hope that these issues can be resolved without further delay.

Sincerely,

John A. Kitzhaber, M.D.

JAK:jit:jj
cc: President Clinton
Leon Panetta

On raising the line, we should reiterate our request for responses to our questions and state that we cannot make a decision before we receive the answers.

- We need to determine how approving this proposal would further erode coverage for traditional Medicaid eligibles by reducing the number of health care services covered under the Oregon Health Plan.

- As opposed to treatments excluded from coverage by prior drawings of the line by Oregon, some of the 25 items they would exclude under their current proposal may be of demonstrable benefit in reducing pain or disability for at least some people.

- We need to make certain that raising the line would not place the State in violation of the Americans' with Disabilities Act nor cause undue hardship for disabled enrollees.

No structural flaw

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

November 18, 1995

NOTE TO CAROL RASCO

From: Donna Shalala

Subject: Oregon proposal to charge premiums to individuals with income under the poverty level and to "raise the line" for health care services

We are currently at a stalemate with the State of Oregon on two proposed modifications to their 1115 waiver: (1) a proposal to charge premiums to the lowest income individuals covered by the waiver who would not otherwise be eligible for Medicaid -- those with income from 0 - 100 percent of the federal poverty line; and (2) a proposal to "raise the line" of health services covered under the demonstration for both the expansion population and categorically eligible low-income women and children.

Premiums

The premium charges would be as follows:

Income as percent of federal poverty level	Range of monthly premiums
0 - 49 percent	$ 6.00 - $ 7.50
50 - 65 percent	$15.00 - $22.00
66 - 85 percent	$18.00 - $26.00
86 - 99 percent	$20.00 - $28.00

I met with Governor Kitzhaber and agreed to approve the premium structure if the State would allow individuals who are facing true financial hardship to continue being covered by the Oregon Health Plan. Although the State is willing to postpone collection of premiums for persons with zero income, those individuals would incur a permanent debt that would be collectable through the State income tax refund process. The State has rejected providing any but some very narrowly-defined payment deferrals even for zero-income individuals and would disenroll persons who cannot afford premiums if they have incomes above zero percent of the federal poverty level. The State argues that it is administratively infeasible to apply anything but narrow, easy-to-define criteria. And, it argues that a broader hardship standard would result in decreased premium collections and undermine individual responsibility.

"Raising the Line"

The State submitted a proposal to raise the line of covered health services from item 606 to item 581 on its prioritized list of medical condition/therapeutic treatment pairs, thus eliminating 25 previously covered conditions/treatments. In his October 25th meeting with me, the Governor told me that managed care plans would continue to provide services needed by enrollees and that raising the line for managed care enrollees only meant approval to reduce the capitation rate. During that meeting, I agreed to raising the line for managed care plans, which provide coverage to 80 percent of the persons covered by the "line." I also told the Governor that we were not yet ready to make a decision on the issue of raising the line for fee-for-service enrollees until we had completed the necessary legal and medical reviews of the eliminated conditions/treatments.

The state is still pressing for a decision on raising the line for fee-for-service enrollees, but has not yet responded to questions we sent them on October 30th. I have indicated to the Governor that I am not opposed in principle to raising the line, but I do not want to make a decision before we get the answers to our questions. As with our initial review of the waiver, we must ask hard questions about whether reducing the number of covered services would cause undue hardship to enrollees, particularly disabled persons. I also must determine whether their proposal could violate the Americans with Disabilities Act. So that this review process does not drag on in a bureaucratic way, I am prepared to suggest that the Governor and I each put our experts in a room in Washington or Oregon to clarify all issues as soon as possible.

Recommendations

We feel strongly that the premium proposal should be disapproved:

- Approving this proposal would undercut the effort we are making, as part of the Reconciliation process, to protect the safety net for low income individuals, and to make the case that imposing premiums and cost sharing on low-income individuals is tantamount to denying them coverage. In Oregon, the State is proposing both to impose premiums on very low income individuals, and to disenroll them if they cannot pay.

- The primary reason we allowed Oregon to reduce covered Medicaid benefits, through its priority list, is that the State was expanding coverage to uninsured individuals. If the State imposes premiums and disenrolls many individuals who are unable to pay, it undermines the framework of our original agreement.

We should not acquiesce on premiums. We are willing to be flexible on charging premiums if the State provides a safety net for truly needy individuals. Net revenue loss to the State could be minimized or eliminated; we have offered to adjust premiums for paying persons to offset any budget losses from non-paying individuals. The principle of protecting coverage for low-income people is fundamental.

JOHN A. KITZHABER
GOVERNOR

To: Diana Fortuna

November 17, 1995

Secretary Donna Shalala
Department of Health and Human Services
200 Independence Ave., SW
Washington, D.C. 20201

Dear Secretary Shalala:

I am sorry that we have been unable to connect by phone, but I understand the difficulty of making connections with my being in Asia and your dealings with the federal shutdowns. I am writing to express my concerns over our inability to reach agreement on approval for the two remaining changes in the Oregon Health Plan -- the charging of premiums to the "newly-eligible" population and the change in the benefit package. Trying to negotiate these issues has consumed an enormous amount of time from my small staff, and I must share with you my growing frustration with this process.

As you know, Oregon's Legislature in June approved a number of changes to the Oregon Health Plan (OHP), almost all of which were proposed in my budget. Prior to that time, staff at HCFA were well-aware of the potential changes. Our formal requests for modification to our demonstration were submitted in late June and early July. We received approval for a number of changes which impacted eligibility beginning in October. It is important to point out that the changes acceptable to HHS -- including an asset test and three-month income averaging -- will have the effect of dropping 15,000 people from coverage.

We are still awaiting approval for the last two changes which have the largest dollar impacts. These changes reflect the policy which lies at the heart of the Health Plan: namely that we need to make hard choices in an explicit manner and that persons should hold some financial responsibility for sharing in the cost of their care. It has been nearly a month since we met in Washington, D.C. and reached what I thought was an agreement on these issues. Clearly that is not the case.

Let me first address the issue of premiums. Our proposal was to require that those who are newly-eligible under the OHP (i.e. do not qualify for Medicaid under federal law) pay a modest amount, based on income, towards the cost of their care. These people continue to be guaranteed coverage for six months. At the end of that time, however, they would be required to pay the amounts past due before being considered for further eligibility. My understanding of our agreement was that, before anyone actually lost coverage due to an inability to pay the premium, we would set up some kind of review process. Although we

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continue to believe that our initial proposal is reasonable, we have since put two specific proposals on the table to address HHS concerns, neither of which is apparently acceptable to the Department.

The verbal responses we have received from HHS are that they would like a process that would basically assure that anyone who believes they cannot pay would be allowed to continue. This does not reflect the understanding we reached in your office, nor is it a viable alternative. It would require enormous administrative support and, in the end, would be based on subjective (and unenforceable) judgments. Again, I would like to reinforce the fact that we are only proposing that premiums be applied to those who have no entitlement to Medicaid under federal law; these are people who, absent the Oregon Health Plan, have no health care coverage. The irony here is that the HHS staff are willing to approve changes which will eliminate 15,000 people from coverage, but resist modest premiums for people with no entitlement to care because a few might lose coverage.

Secondly, I am deeply concerned with the delays and lack of action on our request for a change in the benefit package. Although your staff were aware of the timelines assumed in our budget savings, it took almost four months for questions to be sent to us on this change. The letter we received on October 30 included four pages of line-by-line questions. What I find especially interesting is that, although there was a good deal of communication and negotiation which occurred around the process to develop the list prior to granting of the initial waiver, I do not believe we ever received any specific questions about services which were not covered beginning at that time. Now, with a program that is clearly working and which is improving the health of Oregonians, we are being subjected to a detailed analysis of each and every change we are proposing. This is the kind of illogical, bureaucratic contradiction that has contributed to the current lack of credibility of many of our federal agencies.

The latest suggestion we received from your staff was that we change the capitation rates for managed care plans, although they were not yet willing to allow us to change the benefit package. Such an approach would be directly contrary to the principles of the Health Plan, which require that we make explicit decisions on the benefits but pay the reasonable costs of providing those benefits. These principles have been embodied in statute since 1989 and were in place when the waiver was granted.

As you know, our legislative Emergency Board is meeting this week. This Board serves as an interim budget body and is co-chaired by the Senate President and House Speaker.

The Department of Human Resources is scheduled to present its "budget rebalance" to the Board at that time. Since we already have incurred costs due to the delays in receiving approval of the premium proposal, it will be necessary for the Department to report on the status of the negotiations with the federal government over these changes.

I had hoped that we could avoid reporting on the lack of action and instead report that the Administration had provided us approval to continue our demonstration with these changes. Since that is not the case, I have no choice but to report that the Clinton Administration's insistence on trying to preserve the status quo will result in more low-income Oregonians going without health care coverage. I understand that dropping people from all coverage is acceptable to the Administration, while using sliding scale premiums and modifying the benefit package is not. I respectfully disagree with this policy.

I am disappointed by the lack of action by your office and hope that these issues can be resolved without further delay.

Sincerely,

John A. Kitzhaber, M.D.

JAK:jit:jj
cc: President Clinton
Leon Panetta