105TH CONGRESS
1st Session

COMMITTEE PRINT

S. PRT.
105–30

BALANCED BUDGET RECONCILIATION ACT OF 1997

COMMITTEE RECOMMENDATIONS AS SUBMITTED TO THE BUDGET COMMITTEE ON THE BUDGET PURSUANT TO H. CON. RES. 84

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

PETE V. DOMENICI, *Chairman*

JUNE 1997

Printed for the use of the Committee on the Budget

BALANCED BUDGET RECONCILIATION ACT OF 1997

105TH CONGRESS
1st Session

COMMITTEE PRINT

S. PRT.
105–30

BALANCED BUDGET RECONCILIATION ACT OF 1997

COMMITTEE RECOMMENDATIONS AS SUBMITTED TO THE BUDGET COMMITTEE ON THE BUDGET PURSUANT TO H. CON. RES. 84

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

PETE V. DOMENICI, *Chairman*

JUNE 1997

Printed for the use of the Committee on the Budget

U.S. GOVERNMENT PRINTING OFFICE
41–453 WASHINGTON : 1997

COMMITTEE ON THE BUDGET

PETE V. DOMENICI, New Mexico, *Chairman*

CHARLES E. GRASSLEY, Iowa
DON NICKLES, Oklahoma
PHIL GRAMM, Texas
CHRISTOPHER S. BOND, Missouri
SLADE GORTON, Washington
JUDD GREGG, New Hampshire
OLYMPIA J. SNOWE, Maine
SPENCER ABRAHAM, Michigan
BILL FRIST, Tennessee
ROD GRAMS, Minnesota
GORDON SMITH, Oregon

FRANK R. LAUTENBERG, New Jersey
ERNEST F. HOLLINGS, South Carolina
KENT CONRAD, North Dakota
PAUL S. SARBANES, Maryland
BARBARA BOXER, California
PATTY MURRAY, Washington
RON WYDEN, Oregon
RUSSELL D. FEINGOLD, Wisconsin
TIM JOHNSON, South Dakota
RICHARD J. DURBIN, Illinois

G. WILLIAM HOAGLAND, *Staff Director*
BRUCE KING, *Staff Director for the Minority*

CONTENTS

A. Overview

The FY 1998 Congressional Budget Resolution (H. Con. Res. 84) adopted by the U.S. Senate on June 5, 1997 was the first step in implementing the Bipartisan Budget Agreement approved by the President, the Speaker of the House, the Senate Majority and Minority Leaders on May 15, 1997. The second major step to implement the Agreement is embodied in the Balanced Budget Act of 1997 reported from the Senate Budget Committee on June 20, 1997.

The Balanced Budget Act of 1997 (reconciliation bill) includes reforms to federal programs within the jurisdiction of eight Senate authorizing committees. This legislation results from instructions included in H. Con. Res. 84 to these eight committees to make changes to laws within their jurisdictions that would reduce federal spending $137.2 billion over the next five years, including reductions of $59.4 billion in 2002. Savings from this reconciliation bill, combined with $138 billion in appropriation savings, and other legislation directed in the Agreement will place the country's fiscal books on a road to balance in 2002.

The figures included in this summary print are based on preliminary estimates for some of the reconciled committees. Based on these preliminary estimates, however, the reported reconciliation bill achieves savings of approximately $132.6 billion over the next five years slightly below the reconciliation instruction, but fundamentally following the blueprint of the Bipartisan Budget Agreement.

It is the stated intent of the Congressional Leadership and all parties to the Agreement to take such actions as are necessary to assure consistency with the Agreement. Such action may require amendments to the Balanced Budget Act of 1997 as reported by the Committee to comply with both the budget resolution's instructions and the Bipartisan Budget Agreement.

B. SUMMARY OF RECOMMENDATIONS

RECONCILIATION SUMMARY BY SENATE COMMITTEE

[Preliminary estimates in billions of dollars]

Committee		1998	1999	2000	2001	2002	Total
Instruction:							
Agriculture, Nutrition and Forestry.	OT	0.300	0.300	0.300	0.300	0.300	1.500
Banking, Housing and Urban Affairs.	DR	−0.136	−0.233	−0.365	−0.422	−0.434	−1.590
Commerce, Science and Transportation.	DR	—	−3.549	−3.549	−4.549	−14.849	−26.496
Energy and Natural Resources.	OT	—	−0.001	−0.002	−0.004	−0.006	−0.013
Finance	OT	−1.137	−12.681	−19.079	−26.838	−40.911	−100.646
Governmental Affairs	DR	−0.632	−0.839	−1.042	−1.185	−1.769	−5.467
Labor and Human Resources.	OT	−0.242	−0.247	−0.158	−0.088	−1.057	−1.792
Veterans Affairs	OT	−0.247	−0.540	−0.659	−0.606	−0.681	−2.733
Total instruction	DR	−2.094	−17.790	−24.554	−33.392	−59.407	−137.237
Reported:							
Agriculture, Nutrition and Forestry [1].	OT	0.190	0.300	0.350	0.350	0.300	1.490
Banking, Housing and Urban Affairs.	DR	−0.660	−0.206	−0.332	−0.409	−0.448	−2.055
Commerce, Science and Transportation.	DR	—	−1.749	−3.449	−3.249	−7.449	−15.896
Energy and Natural Resources [1].	OT	—	−0.001	−0.002	−0.004	−0.006	−0.013
Finance	OT	−2.797	−13.459	−22.845	−24.912	−42.067	−106.080
Governmental Affairs [1]	DR	−0.632	−0.845	−1.049	−1.192	−1.809	−5.527
Labor and Human Resources [1].	OT	−0.239	−0.233	−0.155	−0.085	−1.080	−1.792
Veterans Affairs	OT	−0.247	−0.540	−0.659	−0.606	−0.681	−2.733
Total reported	DR	−4.385	−16.733	−28.141	−30.107	−53.240	−132.606
Reported compared to instruction:							
Agriculture, Nutrition and Forestry.	OT	−0.110	—	0.050	0.050	—	−0.010
Banking, Housing and Urban Affairs.	DR	−0.524	0.027	0.033	0.013	−0.014	−0.465
Commerce, Science and Transportation.	DR	—	1.800	0.100	1.300	7.400	10.600
Energy and Natural Resources.	OT	—	—	—	—	—	0.000
Finance	OT	−1.660	−0.778	−3.766	1.926	−1.156	−5.434
Governmental Affairs	DR	—	−0.006	−0.007	−0.007	−0.040	−0.060
Labor and Human Resources.	OT	0.003	0.014	0.003	0.003	−0.023	—
Veterans Affairs	OT	—	—	—	—	—	—
Total comparison	DR	−2.291	1.057	−3.587	3.285	6.167	4.631

[1] Final CBO Estimates.

Note: OT=outlays, DR=deficit reduction. Staff estimates unless otherwise indicated.

C. Reconciliation Process and Procedures

Overview

Section 310 of the congressional Budget Act (the Budget Act) authorizes the inclusion of reconciliation instructions in the budget resolution. The Budget Committee is not required to include such instructions, but will include them when changes in existing direct spending and revenue laws are necessary in order to implement the budget resolution.

When the budget resolution contains reconciliation instructions, the Budget Committee specifies, to each committee to be reconciled, the total amount by which direct spending or revenues under existing laws is to be changed. The Committee may also specify the total amount by which the statutory limit on the public debt is to be changed. Each committee is then instructed to recommend the appropriate legislative changes to meet the instructions and to report those recommendations to the Senate Committee on the Budget. Once all of the committee's recommendations are received, the Budget Committee consolidates the legislative language into a single piece of legislation and reports it to the Senate, without substantive change.

Reconciliation Instructions in the FY 1998 Budget Resolution

Section 104(a) of the budget resolution for fiscal year 1998 (H. Con. Res. 84, 105th Congress, 1st Session) sets out reconciliation instructions to 8 Senate committees calling for spending reductions totaling $137.24 billion over 5 years (1998 through 2002). Committees were to report their recommendations to the Committee on the Budget by June 13, 1997. The Committee on the Budget consolidated, without substantive change, the recommendations submitted and ordered the matter reported on June 20, 1997. As of the printing of this document, preliminary scoring by the Congressional Budget Office indicated that all committee had complied with their instructions with the exception of the Committee on Commerce.

Reconciliation Procedures

In General

Section 310 of the Congressional Budget Act of 1974 sets forth expedited procedures for the consideration of a reconciliation measure in the Senate. These procedures provide for a limited period of consideration and restrict the content of amendments offered from the floor. In particular, section 313 (known as the ''Byrd Rule'') prohibits the inclusion of ''extraneous'' provisions in the legislation (and any amendments thereto or conference report thereon).

Motion to Proceed and Time Limits

Since the reconciliation legislation is a privileged matter, the motion to proceed to the consideration of a reconciliation bill is not debatable. Total debate on a reconciliation bill is limited to 20 hours. Note that this is a limit on overall debate time, not overall consideration. The time is controlled by and divided equally between the majority leader and the minority leader or their designees. The 20

hours does not include time consumed for the reading of amendments, quorum calls immediately preceding a roll call vote, or roll call votes. Debate on debatable motion or appeal is limited to 1 hour. The proponent of an amendment or motion is entitled to one-half of the allotted time. The time in opposition is controlled by the majority leader or his designee unless he or she supports the amendment or motion. If so, the time in opposition is controlled by the minority leader or his designee.

Compliance with Reconciliation Directives

Section 104(a) of the fiscal year 1998 budget resolution instructed Senate committees to submit legislation to the Budget Committee to reduce direct spending for two time periods: (i) the five-year period of 1998–2002 and (ii) the last year, 2002. Compliance with reconciliation directives is measured by the amount of savings the Congressional Budget Office (CBO) estimates will result from the enactment of the legislative recommendations submitted by the committees.

The Budget Committee is responsible for scoring reconciliation bills and any amendments thereto and will make these determinations based upon cost estimates provided by the Congressional Budget Office. Because the Budget Committee must report the committee's recommendations without any substantive change, any action to bring a committee into compliance must occur on the Senate floor. If a committee fails to meet its instructions, one possible remedy is the making of a motion to recommit with instructions to report back forthwith with an amendment that brings the committee into compliance. The text of such an amendment need not be germane to the underlying bill. A committee could also be brought into compliance by the offering of a simple floor amendment. This amendment, however, would have to be germane.

Restrictions upon the Content of Amendments

The Budget Act provides for a number of restrictions upon the content of amendments offered from the floor to a reconciliation bill: section 305(b) requires that amendments be germane; section 310(d) requires that amendments be, in effect, deficit neutral; section 310(g) prohibits amendments that effect the Social Security Trust Fund; and section 313 prohibits amendments which are extraneous to the reconciliation instructions. All of these restrictions are enforced in the Senate by points of order which require 60 affirmative votes to waive or overturn the ruling of the Presiding Officer by an appeal.

Germaneness

Section 305(b)(2) imposes a germaneness requirement upon all amendments offered to a reconciliation bill. Germaneness is determined pursuant to the precedents of the Senate and rulings will be made by the Presiding Officer of the Senate with the advice of the Parliamentarian. Germaneness is a much more narrow concept than "relevance" which generally requires a mere subject matter relationship. There are, however, 4 classes of amendments which the precedents of the Senate deem to be per se germane: (i) committee amendments; (ii) amendments which only strike language

from the bill; (iii) amendments which change numbers or dates; and (iv) amendments containing non-binding or precatory language within the jurisdiction of the committee which reported the bill. *Note:* amendments which fall into one of the per se germane classes are still subject to points of order set out in other sections of the Budget Act. Therefore, for example, while amendments containing non-binding language within the jurisdiction of a reporting committee may be per se germane, such language by its very nature has no budgetary effect and consequently violates section 313(b)(1)(A) as explained below.

If an amendment does not fall within one of the classes of per se germane amendments discussed above, germaneness is determined on a case-by-case basis. Members are encouraged to consult with the Parliamentarian to determine if any particular amendment is germane.

Deficit Neutrality

Section 310(d) of the Budget Act provides that an amendment to a reconciliation bill is out of order in the Senate if it would reduce outlay reductions or revenue increases below the level called for by the reconciliation instructions *unless* the amendment also provides offsetting outlay reductions or revenue increases. In other words, an amendment may not increase spending or cut taxes unless it is ''paid for''—that is, it may not worsen the deficit.

It must be noted, however, that 310(d) provides that ''a motion to strike a provision shall always be in order''. This language thus permits language to be removed from a bill regardless of the budgetary effects.

Social Security

Section 310(g) provides that an amendment to a reconciliation bill (or the bill itself) is not in order if it contains ''recommendations with respect to the old age, survivors, and disability insurance program established under title II of the Social Security Act''. This language generally has been interpreted to prohibit the consideration of any legislation in the reconciliation process which affects the receipts (taxes paid) into or the outlays (benefits paid) from the OASDI trust fund. As discussed below, a violation of 310(g) also constitutes a violation of section 313(b)(1)(F).

Extraneous Matter: section 313, the Byrd Rule

The Byrd rule provides a point of order against extraneous provisions in a reconciliation bill, an amendment thereto, and the conference report thereon. It is unique in that it permits a point of order to be raised against a ''provision''. Consequently, unlike other points of order which would lie against the bill or conference report in its entirety, a Byrd rule point of order, if sustained, will result in the offending language being stricken from the bill or the conference report. The Byrd rule provides a specific definition of ''extraneous'' in subsection 313(b). A provision will be considered extraneous if it:

produces no change in outlays or revenues, unless it is a term or condition of a provisions which produces such a change—section 313(b)(1)(A);

increases outlays or reduces revenues if the reporting committee has failed to comply with its reconciliation instruction—section 313(b)(1)(B);

is within the jurisdiction of another committee—section 313(b)(1)(C);

produces changes in outlays or revenues which are merely incidental to the non-budgetary components of the provision—section 313(b)(1)(D);

causes the committee's work product to worsen the deficit in any year beyond those reconciled for—section 313(b)(1)(E); and

affects the receipts into or outlays from the OASDI trust fund in violation of section 319(g)—section 313(b)(1)(F).

D. Additional Views

DISSENTING VIEWS OF SENATOR PAUL S. SARBANES

This spending reconciliation bill is plagued by the same misplaced priorities that characterize the FY98 budget plan as a whole. In particular, this bill, when combined with the tax breaks approved by the Senate Finance Committee and the House Ways and Means Committee, places a disproportionate share of the burden of deficit reduction on ordinary citizens. Such citizens will be impacted by the program cuts in this bill while those at the top end of the income and wealth scale will reap large tax benefits.

Given the objective of a balanced budget, the inclusion of tax cuts in the budget plan necessitates program reductions substantially greater than would be needed to eliminate the deficit if tax breaks were not a part of the budget plan.

The math is simple. The budget resolution provides for $85 billion in net tax cuts over the next five years and $250 in net tax cuts over the next 10 years. In the framework of a balanced budget, these tax cuts require additional program reductions of $85 billion over the next five years and $250 billion over the next 10 years over what would otherwise be required. The structure of the bills reported out by the tax Committees make it clear that those at the very top of the income pyramid will receive very substantial tax breaks (thereby absenting themselves from the deficit reduction effort, indeed shifting the burden to others), while ordinary people will carry a greater burden of program reductions to compensate for the tax breaks.

May programs important to working people—e.g., Medicare and Medicaid—are being reduced to pay for capital gains tax cuts, inheritance tax cuts, and IRA expansion that will benefit the wealthiest people in the nation. Indeed, the tax bills reported from the Committees give the top 1% of the income scale the same percentage of the tax reductions as the bottom 60 of the income scale.

I cannot support the priorities reflected by these choices. For every dollar lost to the treasury in tax cuts, one dollar must be added to the treasury through reductions in programs that are essential to many of our citizens. Therefore, in assessing the spending reconciliation bill before us, we should ask ourselves: Whether providing tax breaks to the very well-to-do should be a higher priority than adequate funding for programs essential to the wellbeing of ordinary citizens.

I think not and therefore vote no on the measure before us.

Paul S. Sarbanes.

ADDITIONAL VIEW OF SENATOR PATTY MURRAY

Today the Budget Committee is scheduled to report out the Budget Reconciliation spending bill. Unfortunately, I was unable to be present for the final vote, but had I been here I would have voted "Aye."

Several months ago, I made a commitment to the graduating class at North Seattle Community College, that I would be honored to be their 1997 commencement speaker. This commitment was extremely important to me and the graduating class, I simply could not back out at the last minute. Today's Budget Committee mark up was not finalized until last night.

I am extremely troubled by some of the provisions within the reconciliation package as I believe that they violate the bi-partisan balanced budget agreement that was recently adopted. I am also disappointed that the Committee will not have final legislative language and final CBO numbers on parts of the Finance Committee sections. It is difficult to understand why the leadership is in such a rush to complete action on major changes to Medicare and Medicaid. This rush to bring this bill to the floor does jeopardize our efforts to enact a balanced budget.

As we all know the Budget Committee cannot amend the reconciliation legislation. This will be done on the floor next week. At that time I will be supporting amendments that ensure this package is in compliance with the agreement and that it does not violate our commitment to our nation's senior citizens and our children. We must seize on this unique opportunity to balance the budget, reform Medicare and expand health benefits for children. Unfortunately, as it stands now it does not appear that the current reconciliation language will achieve these goals.

Today's action by the Budget Committee is an important step in the process which is why I would have voted to report the measure to the full Senate. This does not mean that the package is one I will support when it reaches the floor. I am simply acting to move us closer to achieving a balanced budget.

I am disappointed that this legislation does violate the agreement that we worked so hard to achieve. But, I am hopeful that significant improvements will be made on the floor and that we can send to the President a bill that he can sign.

PATTY MURRAY.

E. TITLE-BY-TITLE ANALYSIS

The following is a title-by-title analysis of the legislation. In each case, the analysis is that of the respective committee and is presented as it was submitted to the Budget Committee without revision. In certain cases, the final Congressional Budget Office estimate was not available when the committee made its submission. Where that occurred, the Budget Committee has included that CBO estimate at the end of the committee's analysis.

United States Senate
COMMITTEE ON
AGRICULTURE, NUTRITION, AND FORESTRY
WASHINGTON, DC 20510-6000
202-224-2035

June 13, 1997

Honorable Pete Domenici
Honorable Frank Lautenberg
Committee on the Budget
Washington, DC 20510

Dear Pete and Frank:

In accordance with the terms of the Conference Report on H.Con.Res. 84, attached is the reconciliation submission of the Committee on Agriculture, Nutrition, and Forestry. As requested in the Budget Committee's letter of May 30, 1997, our submission contains three items in addition to this letter: (1) legislative language which was reported from the Agriculture Committee on June 10; (2) report language; and, (3) a cost estimate from the Congressional Budget Office which conforms to the instruction given to the Agriculture Committee.

We look forward to continuing to work with you in your historic effort to achieve a balanced budget.

Sincerely,

Richard G. Lugar
Chairman

Tom Harkin
Ranking Member

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

June 19, 1997

Honorable Richard G. Lugar
Chairman
Senate Committee on Agriculture
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommendations of the Senate Committee on Agriculture, as approved on June 10, 1997.

The estimate shows the budgetary effects of the committee's proposals over the 1998-2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. The estimate assumes that the reconciliation bill will be enacted by October 1.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Dorothy Rosenbaum, who can be reached at 226-2820.

Sincerely,

for June E. O'Neill

Enclosure

cc: Honorable Tom Harkin
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Reconciliation recommendations of the Senate Committee on Agriculture (Title I)

Summary: The Senate Agriculture Committee reconciliation recommendations would increase federal Food Stamp spending by $1.5 billion over the 1998 to 2002 period.

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 limited Food Stamp receipt to a period of three months in any 36-month period for able-bodied adults who do not have dependent children and who are not working or participating in an appropriate training or work activity. The title would allow states to exempt some individuals from this limitation and would provide additional federal Food Stamp Employment and Training funds to states.

This title contains an intergovernmental mandate as defined in the Unfunded Mandates Reform Act of 1995 (UMRA). CBO estimates that the costs of complying with the mandate would not be significant. The title does not contain any private-sector mandates as defined in UMRA.

Estimated cost to the Federal Government: The estimated budgetary impact of the title for the 1998–2002 period is shown in the following table. The appendix table shows the budgetary impacts through 2007.

The effects of this legislation fall within budget function 600 (Income Security).

ESTIMATED BUDGETARY IMPACT OF THE RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON AGRICULTURE

	Outlays by fiscal years, in millions of dollars—					
	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Food Stamp Spending Under Current Law	23,794	24,450	25,884	27,226	28,645	29,417
Proposed Changes:						
Section 1001: Hardship exemption	0	110	110	110	120	130
Section 1002: Additional funding for employment and training	0	80	190	240	230	170
Total Changes	0	190	300	350	350	300
Spending Under Title I	23,794	24,640	26,184	27,576	28,995	29,717

Basis of estimate: The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 limited Food Stamp receipt to a period of three months in any 36-month period for able-bodied adults who do not have dependent children and who are not working or participating in an appropriate training or work activity. An individual can reestablish eligibility for another three-month period after a month of working or participating in an allowable employment or training program. The Secretary of Agriculture can provide a waiver from the provision for areas that have an unemployment rate greater than ten percent or insufficient jobs. The Department of Agriculture estimates that currently about 35 per-

cent of the people who otherwise would be affected by this provision live in areas that are covered by a waiver.

Title I contains two provisions that address this component of current law. The first would allow states to exempt a certain number of individuals from the requirements. The second provides additional federal money for Food Stamp Employment and Training.

Section 1001: Exemption

Under this provision, each state would be allowed to continue food stamp benefits past the three month limit for 15 percent of the state's covered individuals, as estimated annually by the Secretary of Agriculture based on Food Stamp Program administrative data. Covered individuals would be defined as individuals who are covered by the time-limit provision by virtue of their age, work status, and household circumstances, do not live in an area that is covered by a waiver, and are not receiving benefits under a three-month period of eligibility.

Based on CBO's analysis of the Food Stamp administrative data and projections of Food Stamp participation, CBO assumes that approximately 1.1 million Food Stamp recipients would, in fiscal year 1998, be able-bodied, between the ages of 18 and 50 with no children in the home, and not working or complying with an appropriate work activity. Of these individuals, CBO assumes that 75 percent would not be in a three-month period of eligibility and, of the remainder, 65 percent would not reside in a waiver area.

Under these assumptions, the Secretary would identify approximately 550,000 individuals nationwide as covered individuals, and would distribute the number among the states. States could, therefore, allow a total of about 82,000 people (15 percent) to receive food stamps each month who would otherwise be ineligible. CBO assumes that only about 74,000 people would actually continue to receive benefits because a few states would choose not to implement the exemption. Continuing food stamps for these newly exempt individuals (at an average cost of about $120 a month) would increase Food Stamp outlays by $100 million in 1998, $130 million in 2002, and $580 million over the 1998–2002 period.

Section 1002: Additional funding for employment and training

Under current law, the Food Stamp Employment and Training component of the Food Stamp Program has two federal funding sources. The federal government provides a stated amount annually in funds that do not require a state match. States may also draw down an unlimited amount of additional funds at a 50 percent match rate. In 1996, the federal government provided about $75 million dollars in federal-only funds and about the same amount as a match to state funds.

Section 1002 would increase the federal-only Food Stamp Employment and Training funds by $140 million in each of fiscal years 1998 to 2001 and by $80 million in fiscal year 2002. In addition to the increase in federal-only employment and training funds, CBO estimates that this section would increase Food Stamp benefits and slightly reduce federal matching funds for employment and training. In total, CBO estimates that Section 1002 would increase federal outlays by $910 million over the 1998–2002 period.

The bill would create new procedures for states to use in drawing down federal-only funds. Under current law, states draw down money based on their costs, regardless of who they serve in what type of employment and training service. Under the bill, the Secretary of Agriculture would set two levels of reimbursement rates, and states would receive federal funding on a per-placement basis. The federal government would pay a state the higher amount when it placed an individual who is subject to the 3-month time limit in the type of activity that would allow him to retain his food stamps. The federal government would pay the lower amount when a state placed the same individual in another type of service, or when it served any person who is not subject to the time limit. The type of reimbursement the state received would not depend on whether the individual lived in an area covered by a waiver. The bill also would require that states spend at least 75 percent of the federal-only money on the types of employment and training services that would receive the higher reimbursement rate. Furthermore, in order to receive any federal-only funds a state must continue to spend state funds at a minimum of 75 percent of its fiscal year 1996 level.

The requirement that states spend 75 percent of the federal-only money on designated services would induce states to spend more on these types of services. By 2000, CBO estimates that states would spend an additional $100 million on such services. In the first few years, however, states would draw down less than the full amount of federal-only money because many would have to restructure their Employment and Training programs to focus on the types of services that would be eligible for the higher rate. The amount that a state does not drawn down would be available for reallocation in future years and to other states.

Additional spending for employment and training services will also result in payment of additional Food Stamp benefits. CBO assumes that states would spend 50 percent of the new money in areas that are not covered by a waiver in fiscal year 1998, and 70 percent by fiscal year 2000 and later. CBO assumes that the Secretary of Agriculture would set the higher reimbursement rate at about $90 per placement per month and the lower rate at half that amount. Under these assumptions, CBO estimates that 20,000 individuals in an average month would remain eligible for Food Stamps at a cost of $25 million in fiscal year 1998. By 2001, CBO expects that 60,000 individuals would remain eligible at a cost of about $90 million. In 2002 the amount of new federal funds is somewhat lower, so fewer people would remain eligible (55,000) at a lower cost ($85 million).

Because the bill would require states to maintain their effort at only 75 percent of their 1996 amount and provides such a large amount of new federal funds, CBO expects that the aggregate states would withdraw about 20 percent of what they otherwise would have spent on employment and training services. Because these funds would have received a federal match, CBO estimates that federal outlays would be lower by $17 million in 1998 and $19 million in 2002.

Estimated impact on State, local, and tribal governments: This title contains an intergovernmental mandate as defined in UMRA,

but CBO estimates that the cost of complying would not exceed the threshold established in that act ($50 million in 1996, adjusted annually for inflation). The bill would require states to continue spending at least 75 percent of FY 1996 expenditures for employment and training and workfare programs under Food Stamps in order to continue receiving federal funding for those programs. Under current law, CBO estimates that state spending, in aggregate, would meet this maintenance-of-effort requirement and therefore the total cost of this mandate would not be significant. States meeting this new requirement would receive additional funds for Food Stamp employment and training programs totaling $140 million in fiscal year 1998 and $640 million over the period 1998 to 2002.

Estimated impacts on the private sector: The bill contains no private-sector mandates as defined in UMRA.

Comparison to other estimates: On June 16, CBO prepared an estimate of the House Agriculture Committee's reconciliation recommendations. That bill also contains a new exemption and additional funds for employment and training. The cost estimate of the exemption provisions are the same in the two estimates. The estimates of the changes to federal spending resulting from the additional employment and training funds differ because of key differences in the policies.

First, the House increases Food Stamp Employment and Training funding but does not change the program's structure: states would continue to be reimbursed based on their actual costs. The CBO baseline assumption about per-placement costs is $100 per month per person. In the Senate bill, the Secretary of Agriculture would set two reimbursement amounts that states would draw down on a per-placement basis. CBO assumes that the Secretary would set that rate at $90 a month for the higher rate and $45 per month for the lower rates. These amounts are lower than the CBO baseline amount because the Administration assumes a lower amount in its legislative proposal on the provision, which is similar to the Senate provision.

Second, the House bill requires that 75 percent of the federal-only funds be spent on people subject to the time limit. The Senate bill requires that 75 percent of the federal-only funds be spent on people subject to the time limit in the types of services that would allow them to retain Food Stamp eligibility. This difference results in lower federal spending in the first few years, as states must restructure their employment and training services in order to draw down all the federal-only money, and in higher Food Stamp outlays in later years because more people retain benefits.

Third, the House bill requires that states maintain their spending at their 1996 level in order to receive any of the additional federal-only funds provided in this bill. The Senate requires that states maintain 75 percent of their 1996 level in order to receive any federal-only funds. This difference results in lower spending in the Senate version because states would withdraw more of their effort.

Estimate prepared by: Federal Cost: Dorothy Rosenbaum; Impact on State, Local, and Tribal Governments: Marc Nicole; and Impact on the Private Sector: Ralph Smith.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

APPENDIX TABLE—FEDERAL BUDGETARY EFFECTS OF TITLE I

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total 1998–2002	Total 1998–2007
DIRECT SPENDING												
Section 1001: Hardship Exemption:												
Budget authority	110	110	110	120	130	130	130	140	140	140	580	1,260
Outlays	110	110	110	120	130	130	130	140	140	140	580	1,260
Section 1002: Additional funding for Employment and Training:												
Budget authority	150	190	210	210	150	120	130	130	130	130	910	1,550
Outlays	80	190	240	230	170	120	130	130	130	130	910	1,550
Total, Direct Spending:												
Budget authority	260	300	320	330	280	250	260	270	270	270	1,490	2,810
Outlays	190	300	350	350	300	250	260	270	270	270	1,490	2,810

TITLE I—AGRICULTURE

DESCRIPTIVE LANGUAGE

Section 1001. Hardship exemption

A state agency may provide a hardship exemption for a portion of those individuals in a state who are no longer eligible to receive food stamp benefits due to the work requirement time limits under section 6(o)(2) of the Food Stamp Act.

The average monthly number of hardship exemptions a state agency may grant is limited to 15 percent of the estimated number of individuals in the state to whom the work requirement time limits apply. These "covered individuals" are defined as those: not excepted (e.g., because of age, disability, etc.); not living in an area for which a waiver has been granted under section 6(o)(4) of the Food Stamp Act; not complying with the work requirement; and not in their first (or second) 3 months of eligibility under the work requirement. If a state chooses to provide exemptions under this new rule, it can do so in any way—including defining categories of recipients who will be exempted—so long as it adheres to the 15 percent limit.

For FY 1998, the Secretary will determine the estimated number of covered individuals from which each state may exempt 15 percent, using the FY 1996 survey conducted under the Integrated Quality Control System and other information deemed necessary by the Secretary due to the timing of the survey and its limitations. The estimate will reflect adjustments for those covered by current-law exceptions (e.g., age, disability), those covered by waivers, those complying with the work requirement, and those in their first or second 3-month periods of eligibility. In later fiscal years, the number of covered individuals in a state from which the state may exempt 15 percent will be estimated by adjusting the FY 1998 number to reflect changes in the state's food stamp caseload in the prior year and the Secretary's estimate of changes in the proportion of food stamp recipients living in areas covered by waivers.

If a state's food stamp participation, during a fiscal year, varies from the prior year's caseload by more than 10 percent, the Secretary will adjust, upward or downward accordingly, the estimated number of covered individuals which the state may exempt to reflect the increase or decrease.

If a state exempts more or less than an average of 15 percent of individuals who are no longer eligible to receive food stamp benefits in a fiscal year, the Secretary must decrease or increase the number of allowable exemptions, in the next fiscal year, to compensate for the number of the state's exemptions over or under 15 percent in the previous year.

The Secretary can require documentation from states to ensure compliance with the rules governing the hardship exemption.

The Committee intends to give states flexibility in administering the 15 percent hardship exemption. States would not, for example, be required to terminate individuals from the food stamp program prior to awarding them exemptions. Persons completing their third month of benefits could be given exemptions for the fourth month without first having their food stamp benefits terminated.

Those states wishing to grant the exemptions provided under this legislation may benefit from assistance from the Department as to the effect of exempting certain categories of food stamp recipients. To help states evaluate options available to them, the Committee encourages the Department to prepare technical assistance materials that give examples of criteria that states might wish to apply in granting hardship exemptions, together with the Department's best estimate of the percentage of the caseload that would be covered by each of these criteria. The Committee encourages the Department to provide states with as much information of this kind as possible before the beginning of fiscal year 1998. The Committee also encourages the Department to continue reviewing information from states and update the information it provides to the states.

Section 1002. Additional funding for employment and training

New money is added to the existing mandatory unmatched federal grants to states for the Employment and Training program for food stamp recipients. Current grant levels—totaling $81 million for FY 1998, $84 million for FY 1999, $86 million for FY 2000, $88 million for FY 2001, and $90 million for FY 2002—are increased to $221 million in FY 1998, $224 million in FY 1999, $226 million in FY 2000, $228 million in FY 2001 and $170 million in FY 2002. The amounts provided are to remain available until expended, so as to facilitate reallocation of unused funds.

The total grant amounts noted above (including "old" and "new" money) will be allocated to state agencies using a formula, determined by the Secretary, that reflects each state's proportion of able-bodied adults without dependents subject to the work requirement time limits who are not excepted (e.g., because of age, disability, etc.) under section 6(o)(3) of the Food Stamp Act. The Secretary will base state agencies' allocations on information from the FY 1996 survey conducted under the Integrated Quality Control System (and other factors deemed necessary by the Secretary due to the timing of the survey and its limitations), adjusted to reflect changes in the state's food stamp caseload in the prior year.

To the extent state agencies do not use all of the unmatched federal grant money allocated for a fiscal year, the Secretary will reallocate the unexpended amounts to other states. Unexpended amounts from one fiscal year may be reallocated for use in the following fiscal year.

States will be paid specific amounts based on the average monthly number of recipients placed in employment and training activities. Payment rates will be set by the Secretary to reflect the reasonable cost of efficiently and economically providing the appropriate services, as periodically adjusted by the Secretary.

A higher payment rate will be paid in the case of able-bodied adults without dependents subject to work requirement time limits

who are placed in workfare or in employment and training programs supervised or operated by a state or political subdivision requiring participation for 20 hours or more per week—but not including job search or job search training (or Job Training Partnership Act or Trade Adjustment Assistance programs). A lower payment rate will be paid in the case of recipients placed in other, less rigorous, employment and training activities. The Committee encourages the Department to set the payment rates so as to allow for the creation of the maximum number of work/training opportunities.

State agencies will be required to use 75 percent of their unmatched federal grant money to serve food stamp recipients subject to work requirement time limits who are placed in employment and training programs qualifying for the higher payment rate.

In order to receive their unmatched federal grant money, state agencies must maintain their federally matched expenditures for employment and training program administrative/operating costs at no less than 75 percent of the FY 1996 level.

Federal matching money for any employment and training activities will continue to be available for all support costs (e.g., transportation, child care). But in the case of administrative/operating costs, federal matching money will only be available for costs incurred to place individuals for whom unmatched federal grant money has not been used.

United States Senate
COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS
WASHINGTON, DC 20510-6075

June 18, 1997

The Honorable Pete V. Domenici
Chairman
The Honorable Frank R. Lautenberg
Ranking Member
Committee on the Budget
SD-621
United States Senate
Washington, D.C. 20510

Dear Chairman Domenici and Senator Lautenberg:

The Committee on Banking, Housing, and Urban Affairs is pleased to transmit its reconciliation submission approved earlier today by unanimous vote.

We should note that the Committee has exceeded its five year savings target of $1.59 billion under the Budget Resolution. As approved by the Committee, the entire package will raise in excess of $2 billion, or approximately $400 million more than our instructions. This was accomplished by incorporating into the reconciliation measure language to address HUD's most serious policy and financial problem -- Section 8 renewals. The so-called "mark-to-market" solution would save taxpayer funds while maintaining the affordability and availability of decent and affordable housing.

The package, designed as Title II of the reconciliation measure, consists of the following components: (1) statutory language, (2) report language, and (3) a CBO (preliminary) cost estimate on the legislative package.

Sincerely,

Alfonse M. D'Amato
Chairman

Paul S. Sarbanes
Ranking Member

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

June 20, 1997

Honorable Alfonse M. D'Amato
Chairman
Committee on Banking, Housing, and Urban Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommendations of the Senate Committee on Banking, Housing, and Urban Affairs.

The estimate shows the budgetary effects of the committee's proposals over the 1998-2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. This estimate assumes the reconciliation bill will be enacted by October 1, 1997; the estimate would change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Susanne S. Mehlman (for the FHA single-family provision), who can be reached at 226-2860, and Carla Pedone (for all other provisions), who can be reached at 226-2820.

Sincerely,

for June E. O'Neill

Enclosure

cc: Honorable Paul S. Sarbanes
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Reconciliation Recommendations of the State Committee on Banking, Housing, and Urban Affairs (Title II)

Summary: This bill would permanently prohibit the Federal Housing Administration (FHA) from providing foreclosure avoidance relief to mortgagors who have defaulted in making payments on FHA-insured single-family mortgages. The bill would also authorize a so-called Mark-to-Market approach for the restructuring of certain FHA-insured multifamily mortgages and for renewing section 8 contracts; section 8 contracts would be renewed at market rents for FHA-insured projects that currently receive above-market rents, and mortgages would be written down to levels that could be supported by those lower rents. The bill would also make several other changes to the section 8 program that would reduce costs. First it would establish minimum rents of up to $25 per month for all section 8 project-based programs. Second, it would eliminate federal preference rules for admitting new recipients into units with project-based assistance. Third, it would generally prohibit rent increases for projects assisted under the section 8 new construction and substantial or moderate rehabilitation programs, if their assisted rents exceeded the fair market rent (FMR) established by the Department of Housing and Urban Development (HUD) for that housing area. Finally, the bill would limit rent increases for units without tenant turnover.

This title contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995 (UMRA) and would impose no costs on state, local, or tribal governments.

Estimated cost to the Federal Government: CBO estimates that the committee's proposals would reduce direct spending by about $2.1 billion over the 1997–2002 period. The estimated budgetary effects of these proposals by program over the 1997–2002 period are shown in table 1. Table 2 shows the estimated changes in direct spending by provision through 2007.

TABLE 1: ESTIMATED BUDGETARY IMPACT OF THE RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
FHA Single-Family Mortgage Insurance Fund						
Spending under current law:						
Estimated budget authority	−772	−977	−1,226	−1,221	−1,109	−1,095
Estimated budget outlays	−772	−977	−1,226	−1,221	−1,109	−1,095
Proposed changes:						
Estimated budget authority	0	−136	−161	−183	−183	−183
Estimated outlays	0	−136	−161	−183	−183	−183
Spending under Title II:						
Estimate budget authority	−772	−1,113	−1,387	−1,404	−1,292	−1,278
Estimate outlays	−772	−1,113	−1,387	−1,404	−1,292	−1,278
FHA Multifamily Mortgage Insurance Fund						
Spending under current law:						
Estimated budget authority	41	1,357	1,688	1,555	1,419	1,300
Estimated outlays	−357	1,566	1,897	1,764	1,628	1,509

TABLE 1: ESTIMATED BUDGETARY IMPACT OF THE RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS—Continued

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
Proposed changes:						
Estimated budget authority	−533	0	0	0	0	0
Estimated outlays	−533	0	0	0	0	0
Spending under Title II:						
Estiamted budget authority	−492	1,357	1,688	1,555	1,419	1,300
Estimated outlays	−890	1,566	1,897	1,764	1,628	1,509
Capital Grants						
Spending under current law:						
Estimated budget authority	0	0	0	0	0	0
Estimated outlays	0	0	0	0	0	0
Proposed changes:						
Estimated budget authority	0	218	528	340	76	47
Estimated outlays	0	16	56	84	91	96
Spending under Title II:						
Estimated budget authority	0	218	528	340	76	47
Estimated outlays	0	16	56	84	91	96
Section 8 Rental Assistance						
Spending under current law:[1]						
Estimated budget authority	3,550	10,286	12,295	14,424	16,085	17,461
Estimated outlays	15,941	16,360	17,025	17,717	18,402	19,121
Propsed changes:						
Estimated budget authority	0	−2	−2	−2	−113	0
Estimated outlays	0	−6	−101	−234	−320	−366
Spending under Title II:						
Estimated budget authority	3,550	10,284	12,293	14,422	15,972	17,461
Estimated outlays	15,941	16,354	16,924	17,483	18,082	18,755
Total Changes in Direct Spending						
Estimated budget authority	−533	80	365	155	−220	−136
Estimated outlays	−533	−126	−206	−333	−412	−453
CHANGES IN REVENUES						
Civil money penalties	([2])	([2])	([2])	([2])	([2])	([2])

[1] CBO's baseline with annual adjustments for anticipated inflation.
[2] Less than $500,000.

The budgetary effects of this legislation fall within budget functions 600 (income security) and 370 (commerce and housing credit).

Basis of estimate

Elimination of FHA's single-family assignment program

Under current law, FHA's assignment program has been suspended through fiscal year 1997. Section 2002 would permanently eliminate the assignment program, enabling FHA to foreclose more quickly on properties that would otherwise enter the assignment program. CBO estimates that more rapid foreclosure would reduce FHA's costs by decreasing the amount of taxes and other expenses that FHA would pay while holding these properties. Early foreclosures also would expedite the receipt of sales revenues that FHA would collect on the affected properties. CBO estimates that 16 percent of all claims from new loan guarantees will eventually enter the assignment program if it continues in place. Based on information provided by FHA, we estimate that eliminating the program would increase FHA's recoveries on such defaults by an average of 30 to 40 percent.

CBO estimates that the decrease in FHA's costs from defaults would reduce direct spending by $846 million over the next five years. These estimated savings represent the net decrease in subsidy costs of new loan guarantees expected to be made by FHA over the 1998–2002 period. Under current law, FHA guarantees of new single-family mortgages result in offsetting receipts on the budget because the credit subsidies are estimated to be negative. (That is, guarantee fees for new mortgages more than offset the costs of expected defaults.) Eliminating the assignment program would make such subsidies more negative and the estimated change in those subsidy receipts would be recorded in the years in which new loans are guaranteed. For example, estimated savings for 1998 represent the present value (subsidy) savings of avoided costs in all future years associated with the new guarantees made in 1998.

Mark-to-market provisions for FHA-insured multifamily housing mortgages

The Federal Housing Administration (FHA) currently insures the mortgages of about 850,000 rental units in projects that also receive project-based rent subsidies under section 8 of the United States Housing Act of 1937. About 58 percent of these units have rents that exceed those for comparable unassisted units. The original section 8 contracts attached to these projects were written for periods typically ranging from 15 to 40 years, and most will expire over the next five to ten years. HUD does not have the authority to renew these contracts at more than 120 percent of the fair market rent. The vast majority of these projects could not survive if their rental income was reduced to market levels and would therefore default on their mortgages, generating large losses to the FHA insurance fund and possibly displacing many of the tenants in these projects. Indeed, CBO's baseline for this fund includes estimated net losses for these projects of $7.6 billion over the 1998–2010 period, under the assumption that the rental income of these projects would be reduced to market levels at contract expiration.

Subtitle B of the bill—often referred to as the Mark-to-Market provisions—would generally direct the renewal of section 8 contracts for above-market units at market rents. In cases where the market rents would be so low that a project could not meet its operating and other expenses, even if the mortgage were extinguished, the bill would authorize exception rents that would be set at the level necessary to cover project expenses, including a return to the owner.

The bill would authorize a variety of tools to prevent defaults on the FHA-insured mortgages once rents were reduced. In particular, the bill would authorize a bifurcation of the current mortgage into a first mortgage that could be supported by the lower rent and a so-called soft second mortgage that would be repaid over a 50-year period, starting after the first mortgage was paid off. During the period that the first mortgage was being paid, the second mortgage would accrue interest at the applicable federal interest rate. One purpose of this provision is to prevent a tax liability that owners would incur if that part of the current mortgage was simply forgiven. In that way, the provision also intends to encourage those owners whose section 8 contracts expire after the program would

sunset, at the end of fiscal year 2001, to have their mortgages restructured early rather than choosing to default on their mortgages later. The bill would also authorize the insurance fund to pay for the credit subsidies that would be associated with any FHA-insured first mortgages or with the second mortgages, which would typically be held by HUD in the form of direct loans. For projects that could not support any mortgage, the fund would pay off the entire mortgage.

The bill also would authorize the insurance fund to pay for part of the cost of repairs to the projects, not to exceed $5,000 per unit. In addition, Section 2201 would authorize a capital grant program that would reduce the restructuring cost to the insurance fund. Annual grant payments could be used by owners, for example, to help them pay for repairs through loans obtained from private lenders rather than through grants paid for by the fund. Funding for this capital grant program would not be derived from the insurance fund.

CBO estimates that the Mark-to-Market provisions of the bill would save a total of $240 million over the 1997–2002 period, as shown in Table 2. Restructuring mortgages would reduce the annual cash flows from the FHA-insurance fund over the next 15 to 20 years relative to CBO's baseline, which assumes mortgage defaults for the projects whose mortgages would be restructured under the bill. Under credit reform, that reduction in annual cash flows is scored on a net present value basis in the year the legislation would be enacted. Assuming that the bill is enacted before October 1, 1997, CBO estimates that those savings would amount to $533 million, recorded in fiscal year 1997. Rent reductions are estimated to save $50 million for existing Section 8 contracts. The capital grant program would increase direct spending by an estimated $343 million. The budgetary impact of the proposal would represent the net result of a number of factors, some of which make the cost of restructuring more expensive and others that make it less expensive than the cost of defaults.

FHA Insurance Fund. One factor that would make the cost of restructuring more expensive to the FHA-insurance fund is the timing of the restructuring. To the extent that owners would have their mortgages restructured before the time that they would be expected to default, the FHA insurance fund must make payments at an earlier date. That shift in timing increases the cost of restructuring on a net present value basis. CBO estimates that this impact would not to be very large, however, because the bill's provisions may entice relatively few owners whose contracts expire after 2001 to have their mortgages restructured because most might face large tax liabilities at the time of restructuring. Based on conversations with staff of the Joint Committee on Taxation, CBO assumes that, when there is a realistic possibility that the mortgage would be repaid, the Internal Revenue Service (IRS) would consider the soft second mortgages as valid indebtedness because they would accrue interest at the federal rate. On the other hand, if the economic circumstances of a project were such that the project was highly unlikely to ever pay off that debt, the IRS has the authority to recharacterize the mortgage as a forgiveness of indebtedness, in which case it would become taxable at the owner's personal income

tax rate. That tax could be substantially higher than the tax owners would have to pay if they defaulted on their current mortgage years later, because (1) the unpaid mortgage balance would be lower at such a later date and (2) that unpaid balance would be taxed after default and foreclosure at the capital gains tax rate, which could be much lower than the owner's marginal personal income tax rate.

Available data suggest that mortgages covering only about 22 percent of all units that could receive the soft second mortgages (representing about 8 percent of all debt outstanding in the form of these mortgages) would likely be repaid. For the purposes of this estimate, CBO assumes that all owners in that category whose section 8 contacts expire after the program sunsets would have their mortgages restructured but that only 10 percent of the remaining 78 percent would. In addition, CBO assumes that none of the owners whose mortgage would be written off completely would come in prior to the expiration of their contracts.

A second factor that would increase the cost of restructuring is the credit subsidies associated with any new FHA-insured first mortgages. CBO assumes that the great majority—85 percent—of the first mortgages would need credit enhancement in the form of FHA insurance because of the relatively high risk associated with these mortgages. Those credit subsidies are estimated to add about $131 million to the cost of restructuring.

A factor that would make the cost of restructuring less expensive than the cost of defaults is avoidance of the frictional costs associated with the default and foreclosure process. CBO assumes that restructuring would reduce losses to the fund by 4 percent of the unpaid mortgage balance compared with the cost of a default. Another factor is the use of the soft second mortgages instead of the outright payment of claims under a default on the current mortgage. Although most of these mortgages are expected not to be repaid, CBO estimates that HUD would be able to recover about 8 percent of their total unpaid balance upon default.

Capital Grants Program. The availability of funds from the capital grant program would reduce the cost of restructuring to the FHA fund, but increase the cost of the proposal to the government over the long run. CBO estimates that those funds alone would reduce the restructuring cost to the fund by $531 million on a net present value basis. However, the annual payments of these grants would generate direct spending of $343 million over the 1998–2002 period, and would continue for as long as 15 years thereafter.

Reduction in Rents for Units Subject to Mortgage Restructuring. For projects participating in the mark-to-Market provisions, rents received by project owners would be reduced at the time that the mortgage was restructured from their current high levels to the going market rent for comparable unassisted units. The bill also would authorize the state and local government entities that would carry the mortgage restructuring process to take over the administration of the section 8 contracts from HUD. Thus, the savings in federal subsidies from the rent reductions would be offset to some extent by the cost of fees that HUD would have to pay the administering agencies.

The Mark-to-Market provisions would result in savings from existing section 8 appropriations because of the rent reductions in properties that have their mortgages restructured prior to the expiration of their section 8 contracts. CBO estimates that outlays for existing contracts would be reduced by $50 million over the five-year period. In 1998, average net savings relative to CBO's baseline would range from $825 to over $1,800 per unit per year, depending on the type of section 8 program under which a unit is assisted. That estimate includes the added cost of administrative fees, which are assumed to be set at the same level as those received by public housing agencies under the section 8 certificate and voucher programs—7 percent of the two-bedroom FMR. Because few owners are expected to restructure their mortgage prior to contract expiration, CBO estimates that savings would be incurred for at most 29,000 units, or 20 percent of all units with contracts expiring after 2001.

Other decreases in the Federal cost of section 8 housing

Under the section 8 rental assistance program, the federal government generally pays the difference between a maximum rent that owners receive and 30 percent of a tenant's income. The bill would modify several other aspects of the section 8 program that would affect spending from previous appropriations. CBO estimates that those provisions would save the government $977 million on subsidies for existing contracts over the 1998–2002 period (see Table 2). They would also reduce the amounts of budget authority that would need to be appropriated for renewals of expiring contracts in future years.

Minimum Rents. Section 2202 would allow HUD to set minimum rents of up to $25 per month for all project-based section 8 programs. Based on data provided by HUD, CBO estimates that this provision would affect less than 4 percent of assisted families and would increase their rent contributions on average by about $12 per month. As a result, outlays for existing contracts are estimated to decline by about $18 million over the five-year period.

Repeal of Preferences. Section 2203 would repeal federal preference rules for admitting new recipients of section 8 project-based assistance. Current rules give priority to applicants on waiting lists who have the most severe housing problems and who typically have much lower incomes than other eligible families. If this provision were enacted, CBO expects that private owners of assisted projects would offer a portion of their newly vacant units to working families with somewhat higher incomes to serve as role models. Because such tenants would pay a larger share of the rent, federal spending for existing contracts would decline by an estimated $47 million over the five-year period.

Freeze Rents for High Cost Units. Starting in fiscal year 1999, section 2003 would bar rent increases in projects assisted under the section 8 new construction and substantial rehabilitation or moderate rehabilitation programs, if their assisted rents exceed the higher of the local market rents for similar unassisted units or the fair market rent, which is set by HUD at the 40th percentile of local rents. CBO estimates that this provision would reduce spending for existing contracts by $773 million over the five-year period.

We estimate that provision would initially affect about three-quarters of all units assisted under these programs. That proportion would decrease by about 4 percent per year, as some of the assisted rents would begin to fall below the market rents or the FMR. In addition, the number of units affected would decline sharply each year as contracts expire. In all, CBO estimates the average number of affected units to decline from about 787,000 in 1999 to 418,000 in 2002.

Reduce Rent Increases for Stayers. Starting in fiscal year 1999, Section 2004 would reduce by 1 percentage point rent increases for units occupied by the same families at the time of the last annual rent adjustment. (Such families are oftened referred to as stayers.) This provision would reduce outlays for existing contracts by and estimated $151 million over the five-year period. CBO estimates that, in a given year, this provision would affect between 80 and 85 percent of assisted units that receive an annual rent adjustment. (The provision would generate no savings from units that would be affected by section 2003.) Because of expiring contracts, the number of affected units is estimated to decline from about 430,000 in 1999 to about 230,000 in 2002.

Interaction Effects. Implementing the Mark-to-Market provisions would reduce the savings from the two provisions that would limit rent increases. CBO estimates that this interaction effect would reduce overall savings to the section 8 program by about $12 million over the five-year period. For example, when a unit's rent is reduced to market level under the Mark-to-Market provisions, that unit would no longer be affected by the rent freeze.

Civil money penalties

Sections 2313, 2320, and 2321 would provide for civil penalties for varous violations of the section 8 and FHA programs. Payments of these civil penalties would be recorded as miscellaneous receipts to the Treasury. CBO expects that any increase in penalty collections would be insignificant.

Intergovernmental and private-sector impact: This bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995, and would not impose any costs on state, local, or tribal governments. If they choose, a state housing finance agency or a local housing agency would be allowed to act as the designee for HUD in implementing mortgage restructuring for FHA-insured multifamily housing.

Previous CBO estimates: On June 13, 1997, CBO provided an estimate for the reconciliation recommendations of the House Committee on Banking and Financial Services (Title II), as approved on June 11, 1997. The House and Senate reconciliation recommendations contain identical FHA single-family assignment reform and section 8 rental adjustment provisions. The Senate reconciliation recommendations also include provisions for restructuring FHA-insured multifamily mortgages and two more provisions that would affect the federal cost of the section 8 program. As a result of these additional provisions, the budgetary effects of this bill differ from those in the House version.

Estimate prepared by: FHA Single-Family Mortgage Insurance—Susanne S. Mehlman; All Other Provisions—Carla Pedone.

Estimate approved by: Paul V. Van de Water, Assistant Director for Budget Analysis.

TABLE 2. ESTIMATED CHANGES IN DIRECT SPENDING OF TITLE II

[In millions of dollars]

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998–2002 total	1998–2007 total
FHA SINGLE-FAMILY ASSIGNMENT REFORM													
Estimated budget authority	0	−136	−161	−183	−183	−183	−183	−183	−183	−183	−183	−846	−1,761
Estimated outlays	0	−136	−161	−183	−183	−183	−183	−183	−183	−183	−183	−846	−1,761
FHA MULTIFAMILY MARK-TO-MARKET PROVISIONS													
FHA Insurance Fund:													
Estimated budget authority	−533	0	0	0	0	0	0	0	0	0	0	−533	−533
Estimated outlays	−533	0	0	0	0	0	0	0	0	0	0	−533	−533
Capital grants:													
Estimated budget authority	0	218	528	340	76	47	42	40	35	30	25	1,209	1,381
Estimated outlays	0	16	56	84	91	96	101	106	111	116	121	343	898
Reduce rents to market rents prior to contract expiration:													
Estimated budget authority	0	−2	−2	−2	−113	0	0	0	0	0	0	−119	−119
Estimated outlays	0	[1]	−1	−1	−13	−35	−33	−14	−7	−5	−4	−50	−113
Subtotal mark-to-market provisions:													
Estimated budget authority	−533	216	526	338	−37	47	42	40	35	30	25	557	729
Estimated outlays	−533	16	55	83	78	61	68	92	104	111	117	−240	252
OTHER SECTION 8 PROVISIONS													
Minimum rent up to $25 per month for families with project-based section 8:													
Estimated budget authority	0	0	0	0	0	0	0	0	0	0	0	0	0
Estimated outlays	0	−3	−5	−4	−3	−3	−2	−2	−2	−1	−1	−18	−26
Eliminate preference rules for project-based section 8:													
Estimated budget authority	0	0	0	0	0	0	0	0	0	0	0	0	0
Estimated outlays	0	−3	−7	−10	−13	−14	−15	−16	−17	−18	−20	−47	−133
Freeze rents for high cost units:													
Estimated budget authority	0	0	0	0	0	0	0	0	0	0	0	0	0
Estimated outlays	0	0	−71	−182	−248	−272	−268	−245	−239	−237	−235	−773	−1,997
Reduce rent increases for stayers by 1 percentage point: [2]													
Estimated budget authority	0	0	0	0	0	0	0	0	0	0	0	0	0
Estimated outlays	0	0	−17	−37	−46	−51	−53	−55	−62	−69	−76	−151	−466
Interaction of mark-to-market with freeze and stayers provisions:													
Estimate budget authority	0	0	0	0	0	0	0	0	0	0	0	0	0

Estimated outlays	0	(1)	(1)	(1)	3	9	10	3	2	0	0	12	27
Subtotal other section 8 provisions:													
Estimated budget authority	0	0	0	0	0	0	0	0	0	0	0	0	0
Estimated outlays	0	−6	−100	−233	−307	−331	−328	−315	−318	−325	−332	−977	−2,595
TOTAL PROPOSED CHANGES IN DIRECT SPENDING													
Estimated budget authority	−533	80	365	155	−220	−136	−141	−143	−148	−153	−158	−289	−1,032
Estimated outlays	−533	−126	−206	−333	−412	−453	−443	−406	−397	−397	−398	−2,063	−4,104

[1] Less than $500,000.
[2] Estimate includes effects of interaction with freeze provision.

EXPLANATION OF PROVISIONS

Subtitle A—Mortgage Assignment and Annual Adjustment Factors

Sec. 2002. Extension of foreclosure avoidance and borrower assistance provisions for FHA single family housing mortgage insurance program.

This section extends the foreclosure avoidance and borrower assistance provisions enacted in 1995. The original Federal Housing Administration (FHA) single family mortgage assignment program was created in 1959, but was not operational until 1976 after a court consent decree required the Department of Housing and Urban Development (HUD) to implement the program. Subsequent modifications to the temporary mortgage assistance program and the assignment program required HUD to accept defaulted FHA borrowers into the program. As a condition for assignment, a borrower's default was be based on circumstances beyond his or her control, such as sickness or loss of employment and a reasonable expectation that the borrower will resume normal and regular mortgage payments and correct any loan deficiencies within a reasonable time. The program allows up to 36 months in forbearance in anticipation that a mortgagor will be able to resume his or her mortgage payments. Since the majority of assigned loans are insured under the FHA Mutual Mortgage Insurance Fund (MMIF), the cost of the assignment program was borne by the Fund.

The Committee noted in 1995 that if the well-intentioned objectives of the current assignment program are not achieved, it could cause some $1.6 billion in future losses to the FHA MMIF. A General Accounting Office (GAO) study indicated that there were currently 71,500 loans in the program and that it "operates at a high cost to FHA's Fund and has not been very successful helping borrowers avoid foreclosures in the long run." Approximately 30% of assigned borrowers eventually become current and graduate out of the FHA assignment program, thereby indicating a current failure rate at approximately 70%. Thus, FHA borrowers were paying higher premiums to meet the capital ratio standards of the MMIF as well as to cover the exorbitant costs of the assignment program. The Committee, therefore, chose to replace the existing program.

The replacement assignment program continued in the Committee's proposal provides HUD with authority to pay partial mortgage insurance claims limited to the amount equivalent to or less than twelve monthly mortgage payments. As a condition for accepting a partial claim payment, the lender agrees, on a short term basis, to modify the terms of the loan to a level where the borrower has the ability to pay and retain the loan in its portfolio. In some circumstances, however, where the default and modification may be for a longer period of time, the replaced program allows HUD to pay the mortgage insurance claim and accept the borrower into a

new assignment program. It is expected that HUD will use private sector sources for servicing and foreclosure activities.

Sec. 2003. Adjustment of maximum monthly rents for certain dwelling units in new construction and substantial or moderate rehabilitation projects assisted under section 8 rental assistance program.

Under the Section 8 new construction, substantial rehabilitation, and moderate rehabilitation programs, the Department of Housing and Urban Development (HUD) pays the owner of a rental housing property the difference between 30 percent of the tenant's income and a contract rent that was established when the project was built. Under the program, owners are provided an increase in the contract rent each year to cover the effects of inflation on the costs of operating the property. The rent increase is known as the annual adjustment factor (AAF).

This proposal would limit the application of AAFs to only that portion of the contract rent attributable to the operating costs of the project. This restraint in the annual growth in the rents paid to owners will only apply to high-cost projects with current contract rents in excess of 100 percent of the fair market rent for the area. Since the portion of the rent goes to pay debt generally will remain fixed each year, it should not increase with inflation. This proposal will still permit increases sufficient to cover the costs of operating and maintaining a development in decent, safe, and sanitary condition.

Sec. 2004. Adjustment of maximum monthly rents for non-turnover dwelling units assisted under section 8 rental assistance program.

For section 8 units for which there has been no resident turnover since the preceding annual rental adjustment, this section would reduce the AAF by one percent.

Subtitle B—Multifamily Housing Reform

PART 1—FHA-INSURED MULTIFAMILY HOUSING MORTGAGE AND HOUSING ASSISTANCE RESTRUCTURING

The Committee recognizes that the cost of renewing expiring section 8 rental assistance contracts will begin to grow substantially. The Committee believes that the expiration of Section 8 contracts should be seized as an opportunity to reduce the present costs of the assisted housing programs while maintaining the long-term availability and affordability of this important federal housing resource. The Federal Government has invested billions of dollars in creating and maintaining this housing as an important public resource. Since 1994, the Committee has recognized that reforming the assisted and insured multifamily housing programs of the Federal Government would be an enormous challenge due to the program complexities, budgetary costs, and social policy implications. The Committee also recognized that the inevitable expiration of thousands of housing assistance payment contracts could not be ignored and that delays would risk a loss of the affordable housing supply as well as tenant displacement.

In response to this problem, the Committee is incorporating S. 513, the Multifamily Assisted Housing Reform and Affordability Act of 1997, which represents a major effort to address the escalating budgetary costs and operational inefficiencies affecting the nation's assisted and insured housing programs. This bill continues the Committee's serious effort to reform Federal housing programs while ensuring that residents continue to be provided decent, safe, and affordable housing.

The Committee bill reduces the ongoing costs of operating the Department of Housing and Urban Development's (HUD) insured multifamily rental housing portfolio that receive project-based rental assistance from HUD's Section 8 programs through a restructuring process called "mark-to-market." In addition, it expands the enforcement authorities of the Federal Government to ensure that the public interest is safeguarded and that the assisted housing programs serve their intended purposes.

In 1996, the Committee introduced S. 2042 to authorize HUD to reduce oversubsidized contract rents to market rent levels by simultaneously restructuring the underlying FHA-insured debt. This legislation was reintroduced in the 105th Congress as S. 513. In crafting this legislation, the Committee has made a great effort to obtain and incorporate the views of those involved in rental assisted housing programs, including the Administration, private sector apartment owners and managers of assisted housing properties, residents, community groups, and state and local governments. The Subcommittee on Housing Opportunity and Community Development has held three hearings on reforming the federal assisted housing programs.

Project-based section 8 assistance for these properties is provided under housing assistance payment contracts that are generally 20 years in duration. In many cases, contract rents on these properties far exceed market-area rents. Between 1996 and 2004, Section 8 project-based assistance contracts on over 800,000 units will expire. Most of these contracts assist properties whose mortgages are insured by the Federal Housing Administration (FHA). The combination of insurance and rental assistance makes this matter extremely complicated and difficult since changes to either program can impact the other. The failure to continue Section 8 assistance will impede the borrower's ability to meet its debt service payment. The failure to meet debt service payments will then result in substantial costs to the FHA insurance funds since FHA insurance guarantees lenders the repayment of project debts if borrowers default. However, if the government attempts to reduce its insurance liabilities by increasing Section 8 subsidies, the cost and commitment of future Section 8 assistance is increased. In other words, this situation has created a dilemma where the Federal Government will end up paying for this housing either through the continuation of direct rental subsidies or through claim payments from the mortgage insurance funds.

Continuing Section 8 assistance at current subsidy levels, however, will be extremely difficult in an era of shrinking federal resources as indicated in recent appropriation actions. Further, the recent budget resolution adopted by the Congress places rent limitations on contract renewals that would not be adequate for a sig-

nificant portion of the FHA-insured inventory to meet its operating costs and debt service payments. Estimates indicate that if project-based housing assistance contracts were renewed under existing rent levels, the budgetary cost would grow from $1.2 billion in fiscal year 1997 to almost $8 billion by fiscal year 2006. The Committee also recognizes that the Section 8 program has allowed project owners to receive more Federal dollars in rental assistance than is necessary to maintain properties as decent and affordable rental housing. The Department has estimated that almost two-thirds of assisted properties have rent levels that are higher than comparable market rents. Therefore, renewing expiring contracts at current levels is not only unacceptable from a housing policy standpoint, but in an era of diminishing Federal resources, it is not practical.

The Committee also recognizes that the assisted housing inventory of almost 8,500 properties is a valuable Federal investment. This housing currently provides decent, safe, and affordable housing to almost 1.6 million families. Although federally assisted housing provides much needed affordable housing for lower income families and persons, a significant portion of this stock is physically and financially distressed.

Compounding these problems is HUD's inability to administer and oversee its portfolio of multifamily housing properties. Despite the Administration's recent efforts to correct its management deficiencies, the current HUD management structure fails to guarantee the viability of the housing stock and does not provide adequate assurance to the American taxpayer that funds are being spent appropriately. The General Accounting Office and the HUD Office of Inspector General (IG) have found that even though HUD has various enforcement tools to ensure that properties are properly maintained, poor management information systems and ineffective oversight of properties have impeded HUD's ability to identify problems and pursue enforcement actions in a timely fashion. HUD is further hampered by the lack of adequate staffing and inadequately trained staff.

In response to these problems, the Committee developed a comprehensive reform proposal that reduces the growing costs of providing Section 8 rental assistance while protecting existing residents and maintaining the affordability and availability of the housing stock. The bill would focus on the most significant problems affecting this portfolio, that is, oversubsidized housing properties and housing of poor quality. Oversubsidized housing properties would have their rental subsidies reduced to the level of market comparables or to the minimum level necessary to support proper operations and maintenance. To achieve these lower rent levels without forcing loan defaults, the bill would provide a variety of tools that would reduce the project's debt service such as refinancing and restructuring the mortgage. In response to the long recognized problems with HUD's capacity, the Committee has also designed a new administrative and oversight structure to ensure the long-term viability of this important housing resource. The Committee has proposed to alter significantly the administration and management of this portfolio by shifting these responsibilities from HUD to capable public entities such as State and local hous-

ing finance agencies that have demonstrated expertise in affordable housing and management. The Committee bill would also terminate the government's relationship with owners who have failed to comply with federal requirements such as housing quality standards and prevent the continued subsidization of properties that are not economically viable.

Sec. 2101. Findings and purposes.

The Committee believes that the assisted and insured rental housing programs are too costly, inefficiently administered, and too often exposed to mismanagement by private owners. The Committee believes that the operational flaws need to be corrected in order to protect the financial liability of the Federal Government and to ensure that the housing stock provides long-term affordable, decent, and safe housing.

The findings and purposes contained in this section describe the problems affecting the current assisted and insured rental housing programs and the solutions that will make the programs more efficient and effective at the least cost to the American taxpayer.

The Committee recognizes that there exists a need for decent, safe, and affordable housing throughout the Nation and that the inventory of assisted and insured rental housing is an important resource for meeting some of this need. HUD's ''Worst Case Housing Needs'' report found that the number of households with unmet worst case needs for housing assistance rose to an all-time high of 5.3 million households in 1993. The study also found that the private market stock of extremely low-rent units declined by 478,000 units between 1985 and 1993. The Committee recognizes that this housing represents a substantial and significant Federal investment in meeting the affordable housing needs of an estimated 2 million lower income families and persons. The Committee, however, observes that federally assisted housing properties are plagued by high subsidy costs and mismanagement.

The Committee finds that the subsidy costs of most of the assisted and insured housing inventory are substantially greater than those of comparable, unassisted rental units in the same housing market. Many of the contracts for this subsidy will expire during the next several years. It is estimated that if the Federal Government renews these contracts at the same rent levels, then the cost of renewing all expiring project-based rental assistance contracts will increase from $1.2 billion in fiscal year 1997 to almost $8 billion by fiscal year 2006. As a result, these costs will require an increasingly larger portion of the discretionary budget authority of the Department.

The Committee recognizes, however, that many of these rental assistance contracts are attached to properties whose mortgages are insured by the Federal Housing Administration (FHA). Therefore, if these contracts are not renewed or reduced to market levels, FHA's mortgage insurance funds will be exposed to huge claims, potentially resulting in tenant disruption and forcing HUD to act as the landlord for these properties.

A portion of the federally assisted housing inventory is also plagued by mismanagement and some properties are physically or financially distressed. These problems have been affected by the

Department's lack of capacity to administer and manage its housing portfolio.

The Committee finds that the public interest and the interests of the housing stock and its residents and communities will be served by a system that: reduces the cost of Section 8 rental assistance to these properties by reducing the debt service and operating costs while retaining the low-income affordability and availability of this housing; addresses the physical and economic distress of this housing and the failure of some project managers and owners to comply with management and ownership rules and requirements; and transfers and shares many of the loan and contract administration functions and responsibilities of the Secretary to capable State, local, and other entities.

Therefore, it is the intent of this legislation: (1) to preserve low-income rental housing affordability and availability while reducing the long-term costs of project-based rental assistance; (2) to reform the design and operation of Federal rental housing assistance programs to promote greater project operating and cost efficiencies; (3) to encourage owners of eligible multifamily housing projects to restructure their FHA- insured mortgages and project-based rental assistance contracts before the expiration of the housing assistance contract; (4) to streamline and improve project oversight and administration; (5) to resolve the problems affecting financially and physically troubled housing projects through cooperation with residents, owners, State and local governments, and other interested parties; and (6) to grant additional enforcement tools to use against those who violate agreements and program requirements, in order to ensure that the public interest is safeguarded and that the Federal multifamily housing programs serve their intended purposes.

Sec. 2102. Definitions.

Under this section, the Committee bill defines what types of multifamily housing properties would be eligible for "mark-to-market." This would focus portfolio restructuring on only a segment of the assisted and insured housing inventory—specifically, assisted properties with contract rents above market rent levels.

The Committee has elected to address only the assisted portfolio with contract rents above market rents for the following reasons. One, the costs of Section 8 rental assistance attached to these properties are much greater than those in the below market assisted inventory and the budgetary costs to maintain this inventory is greater. Therefore, greater budgetary savings will be realized on the oversubsidized stock. Further, most of the Section 8 contract rents on the below market assisted stock are regulated on a budget-based process. In other words, the rents are already set at the minimum level necessary to meet operating and debt service expenses. On the other hand, the above market assisted stock, which is generally newer assisted properties, have contract rents that are higher than prevailing market rates due to the initial construction costs and automatic rent increases that have been provided during the term of the assistance contract regardless of operating needs.

Two, restructuring the debt on the below market and older assisted portfolio would likely achieve only minimal Section 8 subsidy savings since the unpaid principal balance (UPB) on the remaining

mortgage is small. Older assisted properties have an average UPB of $14,000 per unit compared to an average UPB of $35,000 per unit for newer assisted properties. Therefore, allowing below market assisted properties for debt restructuring would not be cost beneficial especially when considering the time and transaction costs of such a process.

Sec. 2103. Authority of participating administrative entities.

The Committee believes portfolio restructuring is being undertaken to reform and improve the programs from a financial and operating perspective, but not to abandon the long-term commitment to resident protection and ongoing affordability. Balancing the fiscal goals of reducing costs with the public policy goals of maintaining affordable housing requires an intermediary accountable to the public interest. In light of the Department's capacity and management problems documented by the Inspector General and the General Accounting Office, the Committee believes that capable public entities should act as participating administrative entities (PAEs) on behalf of the Federal Government. The Committee believes that State housing finance agencies (HFAs), local HFAs, public housing agencies, and other State and local housing and community development entities have the capacity to implement the mortgage restructuring program outlined in this bill.

The Committee expects many public entities to volunteer and establish working agreements with the Secretary to implement "mark-to-market." The Committee believes that State and local HFAs can carry out portfolio restructuring consistent with the public interest for three primary reasons: (1) State and local HFAs already have a track record of working with HUD through the multifamily loan risk-sharing programs created under the 1992 Housing and Community Development Act, multifamily mortgage sales program, and the multifamily property disposition demonstration program; (2) many State and local public entities have experience with the Section 8 programs as contract administrators and bond financiers of Section 8 assisted properties and various other multifamily affordable housing programs such as the Low Income Housing Tax Credit program and HOME; and (3) HFAs are publicly accountable and closely scrutinized by their respective governments.

This section provides the Secretary with the authority to select capable public entities that are determined to meet specific criteria related to management capacity, financial performance and strength, and expertise in affordable housing. Further, public entities that qualified under the mortgage risk-sharing and fiscal year 1997 demonstration had to meet similar criteria, which the Secretary had to determine, to ensure that only capable entities could act on behalf of the Federal Government. For example, the 1997 demonstration provided the Secretary with the authority to determine and select capable public entities. In fact, HUD has selected 42 state and local housing finance agencies. By allowing these qualified entities to automatically qualify, the Committee believes that it will streamline HUD's efforts in implementing this legislation in a timely manner.

These criteria would form the basis for determining if the public entity had the capacity, experience, and management capability to

implement portfolio restructuring in a manner that balances the social and fiscal goals of the legislation. The first criterion requires that the entity is located in the State or local jurisdiction in which the eligible multifamily housing project or projects are located. The Committee believes that this criterion will ensure that the public entity has some knowledge of the local markets and local housing needs. The second, third, and fourth criteria, as discussed below, are those used by rating agencies to evaluate the financial, administrative, and management performance of public entities. The second selection criterion requires that the entity has demonstrated expertise in low-income affordable rental housing. The entity also has to have a history of stable, financially sound, and responsible administrative performance. In this context, historical financial performance, the experience and qualifications of the entity's personnel and financial management, and the quality and dependability of reporting and monitoring systems would be important factors. Lastly, the entity must demonstrate financial strength in terms of asset quality, capital adequacy, and liquidity. This would include revenue sources, cost controls, loan loss reserves, and various characteristics of its real estate assets such as underwriting and delinquency rates.

The Committee encourages qualified PAEs to create partnerships or subcontract with various other entities such as public housing agencies, private financial institutions, mortgage servicers including current mortgagees of FHA-insured mortgages, nonprofit and for-profit housing organizations, Fannie Mae and Freddie Mac, the Federal Home Loan Banks, and other State or local mortgage insurance companies or bank lending consortia. Further, coordination or partnerships among different State and local housing entities would be encouraged under this bill.

Under this bill, PAEs would be responsible for the entire universe of eligible multifamily housing properties in their jurisdiction. The Committee is very concerned about PAEs taking on the portfolio restructuring responsibilities for only those projects where little or no physical, financial, or management problems exist. The Committee, however, does not expect that a PAE would necessarily take on the entire portfolio in its jurisdiction if there are other qualified public entities in the jurisdiction that could share the portfolio responsibilities.

In cases where a qualified public entity is not available or does not volunteer, the Secretary would be allowed to either perform the restructuring in-house or use alternative administrators. Alternative administrators could be partnerships created out of private and public entities. The Committee believes that a public entity should be involved in all restructuring deals in order to protect the Federal government's investment.

The Committee bill authorizes PAEs to perform a variety of functions in order to reduce project rents, address troubled projects, and correct management and ownership problems. PAEs would be given portfolio restructuring program responsibilities through a working agreement with the Secretary called ''Portfolio Restructuring Agreements.'' The main elements of these cooperative agreements would (1) establish the obligations and requirements between the Secretary and the PAE, (2) identify the eligible multi-

family projects for which the PAE is responsible for, (3) require the PAE to review and certify comprehensive needs assessments, and (4) identify the responsibilities of both the Secretary and the PAE in implementing the portfolio restructuring program.

Under these agreements, PAEs would be authorized to take a number of actions in order to fulfill the goals of "mark-to-market." These actions would include the use of a number of tools to restructure the project's debt, screening out bad projects and bad owners from the renewal and restructuring process, creating partnerships with other housing and financial entities, and ensuring the project's long-term compliance with housing quality and management performance requirements.

Sec. 2104. Mortgage restructuring and rental assistance sufficiency plan.

Central to the Portfolio Restructuring Agreement is the "mortgage restructuring and rental assistance sufficiency plan." This plan would be developed at the initiative of the owner, in cooperation with the qualified mortgagee currently servicing the loan, and with the PAE before contract expiration.

Under these plans, owners who elect to continue Section 8 rental assistance would be required to determine the most cost-effective and efficient manner to reduce project-based assistance rents, determine the project repair and capital needs, and ensure that competent management is provided to the project. Each plan would also: require the owner to take such actions as necessary to rehabilitate, maintain adequate reserves, and maintain the project in decent and safe condition; require the owner to maintain affordability and use restrictions for the remaining term of the existing mortgage and, if applicable, the remaining term of the second mortgage; and meet subsidy layering requirements established by the Secretary. The PAE would establish appropriate affordability and use restrictions that are consistent with the post-restructuring rent levels, but in a manner that does not impact the physical and financial viability of the project. In other words, the Committee does not expect PAEs to set affordability and use restrictions that would compromise financial stability so that debt service and operating expense payments could not be met.

Resident and community participation

One of the most important elements of the Committee bill is the opportunity and ability of residents, local governments, and community groups to participate in the mortgage restructuring process. The Committee believes that those who are most affected by renewal and restructuring decisions—the residents, local governments, and communities—must be given the opportunity to provide meaningful input. Resident and community participation, however, should not be used to unduly delay the renewal and restructuring process.

Residents, local governments, and community entities would be provided an opportunity to participate meaningfully in the discussion of major issues such as physical inspections, a project's eligibility for restructuring or renewal, and the Portfolio Restructuring Agreement. Under the renewal and restructuring procedures, these

affected parties would be given: the rights to timely and adequate notice of proposed decisions, timely access to all relevant information, an adequate period of time to analyze and comment on all relevant information, and if requested by any of the parties, a meeting with the PAE and other affected parties.

The Committee bill also facilitates the participation of residents and community groups by authorizing an annual fund of $10 million for capacity building and technical assistance purposes. These funds are intended to be used by resident groups and nonprofit organizations to assist residents and community groups in understanding the renewal and restructuring process and to facilitate their participation in key decisions that affect their lives. Further, this fund could be used to assist residents and nonprofits in developing plans to acquire projects where owners have expressed an interest to sell.

Rent setting

One of the most important elements of restructuring is establishing the appropriate rent levels at the time of restructuring. In addition, the Committee was concerned about the administrative burden in rent setting. The rent level affects financing and the project's future viability due to the uncertainty facing future congressional appropriations for contract renewals. The Committee considered a variety of rent setting approaches such as using (1) a formulaic approach that would set the rents based on some percentage of HUD's fair market rent (FMR) system, (2) market rents based on comparable properties in the same locality, and (3) rents based on operating costs (budget-based).

The Committee bill reflects the belief that rents should be set at a reasonable level near or at market levels but through a process that will not require a significant amount of resources or time. The bill would set rents at comparable market rent levels where comparable rents are available and easily determined. The Committee believed that setting rents at comparable market rent levels was appropriate so that the Federal Government was not oversubsidizing properties and so that rent levels were not more than what the property could command on the market.

In addition, the Committee was concerned that HUD's existing FMR system is problematic in some respects and in specific cases results in either an over-estimate or under-estimate of prevailing market rents in metropolitan or regional areas. For example, in cities or states with rent regulated apartments, the controlled or stabilized rents have been included in the FMR calculations, despite their relative lack of relevance in determining the costs of operating or providing housing—resulting in an underestimate of prevailing market rents.

The Committee, however, recognized that many assisted properties were built in areas where the private market would not build properties because of the neighborhood conditions and low-income clientele. Also, the Committee was concerned about the inherent subjectivity in determining market rents and the past problems with other programs such as the Low Income Housing Preservation and Resident Homeownership Act. In cases where no comparable properties exist, the Committee bill would establish rents at 90

percent of the FMR. The Committee used 90 percent of FMR as a proxy for comparable market rents since the national median of comparable market rents is about 90 percent of FMR.

The Committee also recognized that a small portion of the inventory could not meet its operating expenses at market rent levels even if the entire debt service was eliminated. In these cases, the Committee bill would allow for exception rents set at the minimal level necessary for proper operations and maintenance. Exception rents would be set using a budget-based method. Budget-based exception rents would be capped at 120 percent of the FMR and only 20 percent of the inventory's units could receive these rents. The Committee established these limitations to minimize the administrative work for the PAEs or Secretary in determining these rents. A recent study by HUD indicated that about 20 percent of the inventory would need exception rents.

The Committee, though, is sensitive to the reality that many of the properties which may require budget-based exception rents may be concentrated in certain metropolitan or regional areas. To address this problem, the Secretary has the authority to waive the 20 percent limitation in any jurisdiction which can demonstrate a special need. The Committee expects that the Secretary shall utilize this important discretionary tool to address the unique circumstances of various communities and regions throughout the nation. The Secretary should consider relevant local or regional conditions to determine whether good cause exists in granting such a waiver. Such factors should include, but should not be limited to: (1) whether the jurisdiction is classified as a ''high cost area'' under other federal statutes or programs; (2) prevailing costs of constructing or developing housing; (3) local regulatory barriers which may have contributed to increased development costs; (4) State or local rent control or rent stabilization laws; (5) the costs of providing necessary security or services; high energy costs; the relative age of housing in a jurisdiction; or (6) other factors which may have contributed to high development or operational costs of affordable housing in a given jurisdiction.

The Committee believes that such waivers will be used on a limited basis. Nonetheless, the Committee firmly intends that the Secretary should grant due deference to the need to maintain affordable housing and preserve the federal investment in high cost areas. Therefore, the Committee instructs the Secretary to properly utilize this authority based on local factors. Such concerns should outweigh the federal desire for a ''one-size-fits-all'' solution which may be unworkable in practice in certain jurisdictions.

Exempt multifamily housing projects

In addition to the assisted and insured properties with rents below market rent levels, the Committee bill would exempt two other types of properties from debt restructuring. Properties with mortgages financed through obligations that prohibit a mortgage modification or rent reduction would be exempt from the Committee's restructuring program. Most of these properties receive Section 8 new construction or substantial rehabilitation assistance and are financed by State and local housing agencies. The Committee is sensitive to these contractual obligations and believes that the

Federal Government should honor those agreements. The Committee, however, is concerned about the high subsidy costs and rent levels of these properties and therefore, allows the Secretary to reduce the rents using a budget-based method, without affecting the financing. The other class of exempt properties would be those where restructuring would not result in significant Section 8 savings to the Federal Government. In these cases, the Committee expects the PAEs to perform a cost-benefit analysis of the estimated Section 8 savings compared to the transaction costs of conducting debt restructuring.

The Committee bill would not automatically renew the contracts on exempt properties. All properties would be subject to restructuring and renewal prohibition criteria. The Secretary and its designees would have to screen all properties with expiring contracts before a renewal decision is made. This would encompass reviewing the ownership, management, and economic viability of the properties to ensure that the Federal Government is only assisting viable properties that have been managed and operated well.

Sec. 2105. Section 8 renewals and long-term affordability commitment by owner of project.

Under this section, owners whose projects have been restructured under this program would be required to accept section 8 renewals for as long as the existing mortgage and if applicable, the second mortgage remains outstanding.

Sec. 2106. Prohibition on restructuring.

One of the most critical functions of portfolio restructuring will be screening owners and properties under the federal assistance programs. The Committee recognizes that the Federal Government did not adequately screen owners/developers and proposals for construction or rehabilitation at the outset of the assistance programs and as a result, a segment of the inventory has been fraught with waste, fraud, and abuse.

The Committee believes that the renewal and restructuring process provides the Federal Government an important opportunity to cleanse the inventory of bad project owners and properties which hurt residents and communities, and threaten the financial interests of the American taxpayer. Some owners and managers have engaged in practices which do not warrant continued federal assistance. Some properties are in such distressed physical condition that the costs of rehabilitation or assistance may be unfeasible. The Committee expects that those properties whose repair and rehabilitation estimates exceed $5,000 per unit be carefully examined before considering renewal or restructuring. It is highly questionable why a project would be in a physically or financially distressed condition when the assistance programs have provided high contract rent subsidies with generous automatic rent increases. In these cases, the Committee suspects that the property was either poorly managed or exists in a market where the housing is not sustainable.

The Committee bill lays out the criteria which PAEs would use to determine which properties would qualify for renewal and restructuring. These criteria would primarily focus on ownership and

management performance and the economic viability of the properties. All properties, whether FHA-insured or not, would be subject to this screening process. The Secretary may choose not to renew a contract or consider a mortgage restructuring if: (1) the owner has engaged in adverse financial or managerial actions, including the material violation of a law or regulation, the material breach of a Section 8 contract, the repeated failure to make mortgage payments, or the failure to maintain the property; (2) the owner fails to follow the procedures of this title; or (3) the poor condition of the property cannot be remedied in a cost-effective manner. Owners or purchasers who have been rejected would be provided an opportunity to dispute the basis for the rejection and an opportunity to remedy the problem.

The Secretary or PAE would be provided the discretion in affirming, modifying, or reversing any rejection. The Committee, however, expects that modifications or reversals should be carefully used. The Committee believes that owners should be provided a fair and reasonable process for challenging rejections but that the process should not be administratively burdensome or allow for repeated challenges.

Properties or owners that have been rejected under the prohibition criteria would be dealt with by the Secretary in a number of possible ways. One option would be to sell or transfer the project to a qualified purchaser. The Committee bill would give a preference to resident organizations and tenant-endorsed community-based nonprofit and public agency entities. If sale or transfer to a qualified purchaser is accepted, the project could then reenter the mortgage restructuring process. Another option that could be exercised by the Secretary would be partial or complete demolition of the project if the project is in such poor condition that rehabilitation would not be cost-effective. The Secretary could also exercise its foreclosure and property disposition powers to deal with troubled projects and owners. Under any circumstance where a project is disqualified from the restructuring process, residents would be protected with the provision of tenant-based assistance and reasonable moving expense funds.

The Committee expects that the Secretary or its intermediaries consult with all affected parties when considering a restructuring or renewal proposal or when dealing with owners or properties that may be disqualified. The Committee understands that the current HUD use of Special Workout Assistance Teams (SWAT) has done a fairly adequate job of consulting with all affected parties when dealing with troubled properties and owners. The Committee, however, expects that the SWATs or intermediaries to consider more creative options in resolving troubled properties rather than just converting all project-based assistance to tenant-based assistance. Some options such as transfers or sales to nonprofits and resident-sponsored entities would be one possibility.

Sec. 2107. Restructuring tools.

The Committee recognizes that restructuring a multi-billion dollar inventory is a challenging and risky task. Therefore, the Committee believes that those responsible for managing this inventory should have the maximum number of tools at its disposal. Since

the majority of assisted projects could not meet operating and debt service payments at or near market rent levels, the Committee bill authorizes a number of tools that would allow projects to operate at reduced rent levels without causing mortgage defaults or harm to residents. The restructuring tools would allow the Secretary or its intermediaries (PAEs) to reduce rent levels with a corresponding modification of the debt service. Tools would also be provided to the PAEs to facilitate the refinancing of new loans.

Refinancing of debt financed at high interest rates and the restructuring of debt through a bifurcation of the mortgage would be the two primary tools provided under the Committee bill. In some cases, projects developed with Section 8 new construction, substantial rehabilitation, or moderate rehabilitation assistance were financed with high interest rate loans. The Committee believes that a refinancing of part or all of the mortgage would reduce the debt service and therefore, reduce Section 8 contract rents and the long-term need for Section 8 rental assistance.

Debt restructuring

The second primary tool, bifurcation of the mortgage, would also be used to reduce debt service payments while preventing adverse tax consequences to owners. Under current tax law, debt forgiveness or restructuring could result in the triggering of a large income tax liability on the owners and investors without generating sufficient cash with which the owners and investors could pay the tax. As a result, an effective tax solution is needed to avoid resistance and delays from owners and investors. Debt forgiveness or restructuring can result in an event that reduces the outstanding mortgage that is owed by the owners and investors. This reduction in the mortgage amount will result in a tax liability—referred to as "cancellation of indebtedness" or COD. COD is generally treated as ordinary taxable income under the Internal Revenue Code. Based on these considerations, the Committee rejected debt forgiveness proposals, both to avoid a loss to the federal treasury and to avoid granting a windfall gain to owners and investors.

The Committee believes that the tax risks to debt restructuring can be addressed within the current Internal Revenue Code without requiring a statutory amendment using the approach provided under the bill. After consultation with Department of Treasury officials, and staff from the Joint Committee on Taxation and Senate Finance Committee, the Committee developed a "bifurcated" mortgage approach. Under this approach, the existing mortgage would be split into two obligations. The first piece would be determined on the amount the mortgage could be supported by the rental income stream. Payment on the second piece would be deferred until the first mortgage is paid off or from excess project income.

It is the Committee's firm intention that workouts utilizing mortgage bifurcation will be implemented in a manner which will not result in a cancellation of indebtedness. This approach will effectively achieve the Committee's goals of reducing the Section 8 subsidy needs while simultaneously reforming the program and the stock. The Committee points to the Section 223(f) refinancings which occurred during the mid-1970s, as well as other current industry mortgage bifurcation practices, as models for tax-neutral

debt restructuring. The Committee instructs the Department of Treasury and the Internal Revenue Service to view the mortgage bifurcation proposal in light of its goals of reducing costs while protecting the federal investment in affordable housing.

The Committee believes that, based on analogous structures, a bifurcated mortgage would not result in an immediate tax liability even if the second mortgage accrued at interest at a below-market rate. Section 7872 of the Code provides for exemptions to the Original Issue Discount (OID) rules for transactions, similar to the proposed bifurcation, where government funding is involved. Like these similar transactions (such as the Flexible Subsidy program), debt restructuring under ''mark-to-market'' encompasses (1) new government funding in the form of a payment from the FHA insurance fund, (2) public purpose in the transaction creating the new funding, (3) a process initiated and controlled by the Federal Government, and (4) applicability limited to HUD properties. Based on these elements, the Committee believes that the tax risks associated with ''mark-to-market'' can be prevented, and looks to the Treasury to confirm the validity of this approach.

Credit enhancement

The Committee bill also allows the use of FHA mortgage insurance and other forms of credit enhancement to facilitate the restructuring program. The Committee strongly believes that FHA mortgage insurance and other forms of credit enhancement are necessary for debt financing considering the short terms of Section 8 contract renewals that are being provided in recent appropriation acts. Without long term Section 8 contracts, debt financing would be extremely difficult for restructured projects. If no insurance is provided when mortgages are restructured, debt restructuring costs would likely be higher than if the mortgages were restructured with insurance because private lenders would set the terms of the loans to reflect the risk of default. In other words, if private financing was obtained without insurance, financiers would likely heavily discount the debt to reduce their risks. The Committee understands that these projects could not have been built or financed without the original FHA mortgage insurance due to the inherent risks in developing low-income housing and the areas that these projects were built in.

The Committee expects that the use of FHA mortgage insurance and other forms of credit enhancement will be explored carefully to minimize the default risk to the Federal government. In some cases, mortgage insurance may not be necessary when owners can obtain reasonable financing without insurance. Thus, the Committee bill provides broad discretion to explore and create new forms of credit enhancement that would reduce the default risk and credit subsidy costs to the Federal government. The Committee bill also includes the use of mortgage insurance under risk-sharing arrangements currently practiced under the mortgage risk-sharing programs enacted under the Housing and Community Development Act of 1992. Mortgage insurance under these risk-sharing arrangements would be encouraged by not applying the current statutory limitations on the number of units that can be made available for mortgage insurance under this program.

Residual receipts

Another important tool provided is the use of residual receipts funds. Certain project owners are restricted in the amount of profits they can receive from a project's annual surplus cash after expenses. Residual receipts are surplus funds in excess of profits. Project owners are required to deposit residual receipt funds into an account but are unable to use these funds except for certain circumstances such as repairs. Some housing industry experts believe that residual receipt accounts are quite significant and growing. For those projects that had residual receipts accounts, one property owner estimated that the average residual receipts account was about $3,500 per unit or $402,500 per project. On a national scale, the residual receipts balance could be as high as $300 million. The Committee would allow the Secretary and PAEs to acquire these funds for repair and maintenance purposes. Since these funds cannot be acquired before the mortgage is repaid, the Committee bill would allow the acquired funds to be expedited by providing an owner with a share of the receipts, not to exceed 10 percent of the account. Any acquired residual receipt funds would be used for providing rehabilitation grants.

Rehabilitation assistance

One of the most significant problems that the Committee bill addresses is the deferred maintenance and rehabilitation needs of some properties in the HUD inventory. A recent HUD study estimated that the deferred maintenance and rehabilitation needs are about an average of $9,000 per unit. HUD's finding, however, is questionable considering recent evaluations by the General Accounting Office and comprehensive needs assessments that are required under current law.

The Committee bill provides rehabilitation assistance but limits the amount to $5,000 per unit and requires a 25 percent match from the owner as discussed above. The purpose of this matching requirement is to encourage owners to invest their own funds in their properties and to reduce the risk to the Federal Government. This requirement is modeled after the Capital Improvement Loan program. Rehabilitation assistance would be provided either through project reserves, grants funded from acquired residual receipts, additional debt writedown as part of the mortgage restructuring transaction, or from the rehabilitation grant program established under section 2201.

GSEs' affordable housing programs

The purpose of subsection (b) is to provide technical assistance and other support under the current GSEs' affordable housing programs for maintaining the availability of affordable housing. This subsection should not be interpreted as to impose any new regulatory mandate on Fannie Mae or Freddie Mac to continue existing Section 8 contracts in their current subsidized form.

Sec. 2108. Shared savings incentive.

To maximize the participation of capable public entities into the portfolio restructuring program and to ensure that the American taxpayer is paying the least cost to maintain the affordable housing

stock, the Committee bill includes a shared savings incentive provision. Under this provision, the Secretary would be able to negotiate with public third parties to establish agreements where the Federal Government and third parties would share in any savings resulting from restructuring transactions.

Sec. 2109. Management standards.

Participating administrative entities would be required to establish and implement management standards related to conflicts of interest between owners, managers, and contractors with an identity of interest. These standards would be developed pursuant to guidelines established by the Secretary and consistent with housing industry standards.

Sec. 2110. Monitoring of compliance.

Under this section, each PAE would be required to establish contractual agreements with project owners to ensure long-term compliance with the provisions of this part. The agreements would provide for the enforcement of the provisions and remedies for breach of those provisions.

Sec. 2111. Review.

To ensure compliance with this legislation, HUD would be required to conduct annual reviews on the actions taken under ''mark-to-market'' and the status of every multifamily property. HUD would have to annually report the findings of this review to Congress.

Sec. 2112. GAO audit and review.

This section requires the Comptroller General of the United States to conduct an audit to evaluate a representative sample of all eligible projects and the implementation of portfolio restructuring. These reports would have to contain a description of the audit and any legislative recommendations.

Sec. 2113. Regulations.

This section requires HUD to use negotiated rulemaking procedures for developing regulations necessary to implement ''mark-to-market.'' The ''mark-to-market'' demonstration program enacted previously would be repealed.

Sec. 2115. Termination of authority.

The program established under this subtitle would be repealed on October 1, 2001, but would not apply to projects that have already entered into binding commitments.

PART 2—MISCELLANEOUS PROVISIONS

Sec. 2201.—Rehabilitation grants for certain insured projects.

This section establishes new authority for the Secretary to recapture interest reduction payment (IRP) subsidies from section 236 insured multifamily housing properties for purposes of providing

rehabilitation grants to properties that suffer from deferred maintenance.

Sec. 2202. Minimum rent.

The Secretary would be authorized to require project-based Section 8 assisted households to pay minimum rents up to $25 a month.

Sec. 2203. Repeal of Federal preferences.

This section repeals Federal preferences for all project-based Section 8 programs.

PART 3—ENFORCEMENT PROVISIONS

Part 3 of the Committee bill contains a number of provisions that will minimize the incidence of fraud and abuse of federally assisted programs. Such key provisions include (1) expanding HUD's ability to impose sanctions on lenders, (2) expanding equity skimming prohibitions, and (3) broadening the use of civil money penalties. Many of these provisions were included in previous legislative bills such as the 1994 "Housing Choice and Community Investment Act" (S. 2281), S. 1057, which was introduced in the 104th Congress, and the Administration's 1996 legislative proposal "The Housing Enforcement Act of 1996." These provisions will assist the Secretary in ensuring that federal funds are spent as intended.

Subpart A—FHA Single Family and Multifamily Housing

Sec. 2311. Authorization to immediately suspend mortgagees.

HUD conducts a number of loan servicing activities in order to ensure that FHA-insured projects are providing decent, safe, and sanitary housing. One of these activities is to review inspection reports from its mortgagees. According to HUD regulations, mortgagees are required to perform annual physical inspections of all HUD insured projects. Mortgagee inspections can be an effective and useful tool to not only ensure that projects are providing good housing, but also to minimize duplication of effort between mortgagees and HUD and to reduce HUD staff responsibilities. Unfortunately, the HUD Office of Inspector General has found numerous instances where inspections are either inadequate or not performed. Further, some mortgagees have failed to protect the financial interests of the Federal government by misappropriating mortgagor funds and failing to remit payments collected from mortgagors.

The Committee bill addresses these problems by allowing HUD's Mortgagee Review Board to immediately suspend mortgagees where there is adequate evidence that the mortgagee's actions are threatening or resulting in financial losses to the American taxpayer. Immediate suspension is currently available to other federal entities such as Ginnie Mae.

Sec. 2312. Extension of equity skimming to other single family and multifamily housing programs.

The Committee bill would extend the coverage of the equity skimming penalty to all multifamily and all single family programs. The equity skimming penalty would be extended to all insured, held, or acquired mortgages, Section 202 insurance program, and insured and held mortgages under the section 542 mortgage insurance programs. Equity skimming is the act, typically by an owner or management agent, of willfully using any project funds for purposes not attributable to operating or maintenance expenses. A similar provision was included in the Committee's 1994 housing legislation and S. 1057.

Sec. 2313. Civil money penalties against mortgagees, lenders, and other participants in FHA programs.

The National Housing Act is amended by S. 513 to authorize the Secretary to levy civil money penalties against persons or entities who knowingly submit false information, make false statements, or withhold information from the Secretary in connection with a FHA insured mortgage or title I application.

This provision would strengthen HUD's ability to deter unlawful actions by participants in FHA insurance programs. Civil money penalties will also strengthen the Secretary's ability to protect program abuses.

Subpart B—FHA Multifamily Provisions

Sec. 2320. Civil money penalties against general partners, officers, directors, and certain managing agents of multifamily projects.

The Committee bill also closes a loophole in the current statute regarding civil money penalties. Specifically, the Secretary would be authorized to use civil money penalties on general partners, officers, directors, and certain managing agents of multifamily mortgagors. Civil money penalties would also be expanded to cases where a mortgagor has failed to maintain the project in good condition and where a mortgagor has failed to provide adequate management.

Civil money penalties under current law has had limited impact since the term ''mortgagor'' has been interpreted to mean the entity (instead of the person) that owns the project.

Sec. 2321. Civil money penalties for noncompliance with section 8 HAP contracts.

Coverage of civil money penalties would also be extended to include all project-based section 8 assistance programs. This section would allow the Secretary to impose civil money penalties against project owners that have failed to comply with the rules and terms of section 8 contracts. This would assist the government's efforts in ensuring that owners maintain their assisted units in decent, safe, and sanitary condition.

Sec. 2322. Extension of double damages remedy.

This section amends section 421 of the Housing and Community Development Act of 1987 to include multifamily housing for the elderly and persons with disabilities under section 202 of the Housing Act of 1959. In addition, the double damages remedy would be extended to multifamily housing properties with mortgages insured under the risk-sharing programs authorized under section 542 of the Housing and Community Development Act of 1992.

Sec. 2323. Obstruction of Federal audits.

Section 2323 would expand the criminal penalties provisions under section 1516 of title 18 of the United States Code. This would address problems being experienced by HUD's Office of Inspector General in performing audits of HUD program participants.

United States Senate
COMMITTEE ON COMMERCE, SCIENCE,
AND TRANSPORTATION
WASHINGTON, DC 20510–6125

June 19, 1997

The Honorable Pete Domenici
Chairman
The Honorable Frank Lautenberg
Ranking Minority Member
Committee on the Budget
Washington, D.C. 20510

Dear Senators Domenici and Lautenberg:

In accordance with the terms of the Conference Report on H.Con.Res. 84, attached is the reconciliation submission of the Committee on Commerce, Science, and Transportation. This submission contains two items in addition to this letter: (1) legislative language which was reported from the Commerce Committee on June 17; and (2) report language. I understand that a cost estimate from the Congressional Budget Office is being submitted under separate cover by CBO.

Sincerely,

John S. McCain
Chairman

DISSENTING VIEWS OF SENATOR ERNEST F. HOLLINGS

The Committee has been tasked with a totally unrealistic objective in trying to meet our Reconciliation Instructions to raise over $26 billion in spectrum auctions. The underlying assumptions are without basis. There is no way the FCC can raise $26 billion from spectrum auctions. Yet, here we are once again being told that shortfalls in the budget can be made up by spectrum auctions—the Congress' favorite way to plug a budget number.

The assumptions in the Budget Resolution stand communications policy on its head. The best example of why the Congress should not micromanage the FCC's process was last fall's Omnibus Appropriations Act. The budget negotiators fell short on their projected receipts and decided to make up the difference through spectrum auctions. The problem, however, was that the Congressional Budget Office (CBO) told the budget negotiators what spectrum to auction, what limitations could be placed on its use and that the receipts from this specific auction had to be collected in FY 1997. The result, of course, is that Congress dictated the auction which netted only 13 million dollars—far less than the 2.8 billion dollars originally projected. Some licenses were assigned for only ONE DOLLAR!

When will the Congress learn from its own mistakes? The legislation reported by the Committee calls for the following auctions in an effort to meet its target:

1. *Auction of the returned analog spectrum*.—The budget proposal requires an auction of 78 MHZ of analog spectrum in 2002 with a return of the analog spectrum in 2006. There are many problems inherent in this. First, the proposal backloads a majority of the auction revenue for FY 2002 but the winning bidders will not have access to the spectrum for at least 4 years. In a effort to protect consumers from this short-sighted policy, the Committee adopted a provision that requires the FCC "to extend or waive this date for any station in any television market unless 95 percent of the television households have access to digital local television signals, either by direct off-air reception or by other means."

This provision is necessary because the transition to digital television is fraught with many uncertainties, such as tower construction, potential zoning delays, and most importantly, no one knows how quickly consumers will respond to the new technology. Even if local stations are transmitting digital signals, most consumers are not likely to go out and buy a new television set until their current sets are no longer needed. Most consumers keep their sets at least thirteen years with a nationwide average of 2.4 television sets per household.

2. *Auction of 36 MHz of spectrum from Channel 60–69*.—This spectrum was originally set aside for the transition to digital television. Again, here the Congress is micromanaging the job of the

FCC and codifying a policy that could have dire consequences to the American consumer. No one knows if the FCC computer model will actually work. The FCC's Table of Allocations likely will be challenged at the FCC and possibly in the courts. The budget deal will enshrine the FCC's plan before we know its implications and possible foreclose necessary revisions to the FCC's plan. Such a result is again unacceptably shortsighted. It is highly unlikely this proposal will result in a valuable block of spectrum by 2002.

3. "*Spectrum Penalty*".—The Budget Committee assumed a $2 billion "penalty fee" to be levied against broadcasters. The Commerce Committee deleted this provision because there was no basis for it other than to fill in a budget gap. This had to be one of the more incredulous proposals of all.

4. *Auction of additional 120 MHz*.—This proposal also falls short of reality. FCC Chairman Reed Hundt wrote the House Commerce Committee on June 9, 1997 informing the Committee that the FCC could not identify that amount of spectrum for an auction. Now, if the FCC submits on the record that there is no spectrum available, how can the Budget Committee second guess the expert agency?

Finally, the Committee eliminated several other proposals that were counter to sound communications policy, were totally unrealistic and obviously pulled out of "thin air." Unfortunately, it will be the American consumer who will not only pay the price for these shortsighted decisions in terms of bad policies, but when these auctions fail, we once again will prove that spectrum auctions are far too speculative and will not produce a balanced budget.

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

June 20, 1997

Honorable John McCain
Chairman
Committee on Commerce,
Science, and Transportation
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommendations of the Senate Committee on Commerce, Science, and Transportation (Title III).

The estimate shows the budgetary effects of the committee's proposal over the 1998-2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. This estimate assumes the reconciliation bill will be enacted by October 1, 1997.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are listed at the end of the estimate.

Sincerely,

Paul Van de Water
for June E. O'Neill

Enclosure

cc: Honorable Ernest F. Hollings
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Reconciliation recommendations of the Senate Committee on Commerce, Science, and Transportation (Title III)

Summary: Title III contains three subtitles aimed at providing budgetary savings from auctioning licenses for use of portions of the electromagnetic spectrum, imposing spectrum lease fees on certain users of the electromagnetic spectrum, and extending previously enacted increases in vessel tonnage duties. CBO estimates that enacting the provisions of Title III would produce note budgetary savings totaling $15.9 billing over the 1998–2002 period and $16.9 over the 1998–2007 period.

This title contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act of 1995 (UMRA) and would not impose any costs on state, local, or tribal governments. The title would extend an expiring private-sector mandate on owners or operators of vessels that enter U.S. ports. UMRA is unclear whether extension of an expiring mandate would impose new direct costs on the private sector. In any case, such costs would not exceed the $100 million threshold specified in UMRA.

Description of major provisions: Subtitle A contains several provisions relating to assignment of licenses for using the electromagnetic spectrum. It would instruct the Federal Communications Commission (FCC) to use competitive bidding to assign licenses for most mutually exclusive applications of the electromagnetic spectrum, and it would extend the FCC's authority to conduct such auctions through fiscal year 2007. Under current law, that authority expires at the end of fiscal year 1998. The subtitle would also broaden the commission's authority to use competitive bidding to assign licenses. Current law restricts the use of competitive bidding to those mutually exclusive applications in which the licensee would receive compensation from subscribers to a communications service.

In addition, Subtitle A would require the FCC and the National Telecommunications and Information Administration (NTIA), to make available blocks of spectrum for allocation for commercial use and to assign the rights to use those blocks by competitive bidding by the end of fiscal year 2002. The additional licenses to be assigned by competitive bidding would grant the right to use 145 megahertz (MHz) currently under the FCC's jurisdiction, of which 85 MHz must be located below 3 gigahertz (GHz), and an additional 20 MHz also below 3 GHz to be identified by the NTIA and transferred to the FCC's jurisdiction. The subtitle also would authorize federal users of the electromagnetic spectrum that have been identified by NTIA for relocation to receive compensation from the private sector to facilitate the relocation of the agency to another band of spectrum.

Under current law, a part of the spectrum currently reserved for television broadcasting will become available for reallocation as broadcasters comply (over the next several years) with the FCC's direction to adopt digital television broadcasting technology to replace the current analog technology. This subtitle would make available for licensing and assignment by competitive bidding certain frequencies that are currently allocated for analog television

broadcasting, including a part of the spectrum between 746 MHz and 806 MHz (frequencies currently allocated for primary use by ultra high frequency television broadcasting on channels 60 through 69).

Subtitle B would direct the FCC to allocate 12 MHz of spectrum available of a nationwide basis to private wireless services. The subtitle would direct the FCC to charge a lease fee, based on the value of the frequencies, to private wireless services granted access to the 12 MHz of reallocated spectrum. The subtitle stipulates that no fee would be imposed on licensees holding the right to use frequencies that are currently allocated to private wireless services. The subtitle also would prevent the FCC from using auctions to assign virtually any license for private wireless services. Private wireless services are land mobile telecommunications systems that are operated by private companies and nonprofit organizations for their internal use, rather than for the provision of telecommunications services to subscribers.

Subtitle C would extend previously enacted vessel tonnage duties through fiscal year 2002.

Estimated cost to the Federal Government: CBO estimates that the provisions of Title III would reduce direct spending by about $15.9 billion—$15.7 billion from spectrum auctions and $196 million from extending vessel tonnage fees—over the next five years. In addition, CBO estimates that enacting the title would increase costs to the FCC, subject to appropriation of the necessary funds, by less than $500,000 over fiscal years 2001 and 2002 for completing a study on conversion from analog to digital television. (Additional small discretionary expenses would be incurred for subsequent studies after 2002.) Table 1 summarizes the estimated budgetary impact of Title III over the 1998–2002 period, and Table 2 displays detailed estimates through 2007.

TABLE 1.—ESTIMATED BUDGETARY IMPACT OF THE RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

	By fiscal years, in millions of dollars—				
	1998	1999	2000	2001	2002
CHANGES IN DIRECT SPENDING					
Subtitle A: Spectrum Auctions: [1]					
Estimated budget authority	0	−1,700	−3,400	−3,200	−7,400
Estimated outlays	0	−1,700	−3,400	−3,200	−7,400
Subtitle C: Vessel Tonnage Fees:					
Estimated budget authority	0	−49	−49	−49	−49
Estimated outlays	0	−49	−49	−49	−49
Total Changes in Direct Spending:					
Estimated budget authority	0	−1,749	−3,449	−3,249	−7,449
Estimated outlays	0	−1,749	−3,449	−3,249	−7,449

[1] Including the effect of Subtitle B on auctions to be held under Subtitle A.

The budgetary effects of this legislation fall within budget functions 370 (commerce and housing credit), 400 (transportation), and 950 (undistributed offsetting receipts).

Basis of estimate

Spectrum auctions

CBO estimates that the federal government would collect $15.7 billion in offsetting receipts over the 1998–2002 period and $16.7 billion over the 1998–2007 period from enacting the provisions contained in Subtitles A and B. Assuming appropriation of the necessary amounts, CBO also estimates that the FCC would incur costs of less than $500,000 every two years, beginning in fiscal year 2001, to prepare the studies on digital television conversion required by the bill.

Broaden and Extend. CBO expects that extending and broadening the FCC's authority to auction licenses through 2002 (under section 3001) would increase receipts by $5.7 billion over the 1998–2002 period. Most of the estimated receipts would be generated by the auction of licenses permitting the use of frequencies above 3 GHz that have not been specifically designated for reallocation or auction under existing law. CBO anticipates that, in complying with its mandate to assign licenses for most mutually exclusive applications of the spectrum by competitive bidding, the commission will make available such frequencies under the general authority that would be extended by this section. This subtitle also would require the FCC to use competitive bidding to assign rights to use 165 MHz of spectrum below 10 GHz, of which 60 MHz may be located above 3 GHz. Our estimate for extending and broadening the FCC's auction authority includes the expected receipts from the reallocation of 60 MHz between 3 GHz and 10 GHz. Subtitle B also would restrict the FCC's discretion to auction licenses for private wireless services, and we have reduced our estimates of extending and broadening the FCC's auction authority granted in Subtitle A accordingly.

Reallocation of 105 MHz below 3 GHz. CBO estimates that the provisions of Subtitle A requiring the FCC to use competitive bidding to assign the rights to use 105 MHz of spectrum located below 3 GHz (85 MHz to be reallocated by the FCC and 20 MHz to be identified by NTIA) would generate $5.6 billion over the 1998–2002 period and $6.6 billion over the 1998–2007 period. CBO's estimate of receipts for future FCC auctions is based on the expectation that prices for FCC licenses will fall from the levels of recent years as more spectrum is brought to the market. CBO has further reduced its estimate for the 85 MHz of spectrum identified for auction in this subtitle because the legislation does not specify the location on the electromagnetic spectrum for 40 MHz of the 85 MHz under 3 GHz that it would require the commission to reallocate and auction. Some doubt exists as to whether sufficient spectrum that would be attractive to commercial users can be identified and auctioned to meet the 85 MHz target.

Subtitle A would authorize federal agencies scheduled for relocation by NTIA to receive compensation from a licensee entering the band in order to facilitate that relocation of the federal user. CBO would expect some licensees or service providers to compensate federal agencies for their relocation costs, but we are uncertain as to the extent and timing of the reimbursement. Because the funds paid by the private sector could be spent by the agencies without

further appropriations action, this provision would have no net budgetary impact.

Analog Return. CBO estimates that enacting section 3002, which pertains to the recovery and auction of frequencies now allocated for analog television broadcasting, would yield $2.7 billion in auction receipts. This section would require the FCC to delay the recovery of the frequencies used by analog TV broadcasters in a market beyond December 31, 2006, if more than 5 percent of households in that market do not have access to digital local television signals. The meaning of this legislative language is unclear. For the purposes of this estimate, CBO assumes "access to digital local television signals" means that households would need to possess the equipment necessary to receive digital signals in their home. Such a stipulation would introduce significant uncertainty as to when bidders would be able to use the frequencies and could reduce auction receipts by 50 percent or more. Our estimate reflects that uncertainty.

Channels 60–69. CBO estimates that enacting section 3003, which pertains to the allocation of current television frequencies between 746 MHz and 806 MHz for commercial and public safety uses, would yield $1.7 billion in auction receipts. Under this section the FCC would be required to auction 36 MHz of spectrum for commercial purposes in 1998, but the winners of the auction would not receive full use of the spectrum until 2006 or until 95 percent of the population has access to digital local television signals. Assuming that "access to the spectrum" means that households would need to possess the equipment necessary to receive digital signals in their home, CBO believes that bidders would be uncertain as to when they could fully utilize the spectrum and would discount their bids accordingly.

Spectrum Lease Fees. CBO estimates that the spectrum lease fees to be established under Subtitle B would produce no additional receipts. The FCC has indicated that in order to allocate 12 MHz of spectrum as required by the subtitle, incumbent services and licensees would have to be relocated to other bands. Under the principles of the commission's rules adopted in the emerging technology band proceeding, which made spectrum available for personal communications services, the licensees granted the right to use the 12 MHz of spectrum allocated for private wireless radio services would be required to cover the cost of relocating incumbent license holders. CBO anticipates that the cost of such relocation requirements would discourage would-be private wireless licensees from seeking licenses and, accordingly, that no fees would be collected.

Vessel Tonnage Duties

Subtitle C would extend, through fiscal year 2002, the increase in vessel tonnage duties that was enacted (and subsequently extended) in two earlier reconciliation acts. These earlier acts increased per-ton duties from $0.02 to $0.09 (up to a maximum of $0.45 per ton per year) on vessels entering the United States from western hemisphere foreign ports and from $0.06 to $0.27 (up to a maximum annual duty of $1.35 per ton) on those arriving from other foreign ports. As specified in earlier acts, the additional amounts collected would be deposited into the general fund as off-

setting receipts. Based on the current levels of shipping traffic at U.S. ports, CBO estimates that the enactment of this section would increase offsetting receipts by $49 million in each of fiscal years 1999 through 2002.

Estimated impact on state, local and tribal governments: This title contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act of 1995, and would not impose any costs on state, local, or tribal governments. Subtitle A would instruct the FCC to allocate a portion of the spectrum for public safety services. State and local governments would be eligible for licenses to that portion of the spectrum. Subtitle A also would allow state and local governments to use unassigned radio frequencies for public safety purposes under certain circumstances.

Estimated impact on the private sector: Subtitle C would impose a mandate on the private sector by extending the current vessel tonnage duty. CBO estimates that the direct costs of this mandate would not exceed the annual $100 million threshold specified in UMRA.

Under current law, the duty imposed on both domestic and foreign vessel owners at U.S. ports expires the end of the fiscal year 1998. At the time of expiration, this duty would revert to a prior lower amount. This bill would extend the current duty through fiscal year 2002.

The direct cost of this mandate would depend on what base case is used. Measured against the private-sector costs that would be incurred if current law remains in place and the amount of the duty declines, the total cost of extending this mandate would be $49 million annually beginning in fiscal year 1999. The cost to domestic vessel owners would be less than this amount, however, because owners of foreign vessels would incur a portion of those costs. In contrast, measured against current private-sector costs, the direct cost of this mandate would be zero, because duties would be extended at their current levels. UMRA is unclear about which comparison is required. In either case, the cost of the additional duties imposed on owners of domestic vessels would not exceed the statutory threshold for private-sector mandates.

Estimate prepared by: Federal Costs: Spectrum—Rachel Forward; David Moore and Perry Beider. Vessel Tonnage Fees—Deborah Reis. Impact on State, Local, and Tribal Governments: Pepper Santalucia. Impact on the Private Sector: Jean Wooster.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

TABLE 2. ESTIMATED 10-YEAR BUDGETARY EFFECTS OF TITLE III: RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

[Estimated budgetary effects of title III on direct spending, fiscal years 1997–2007

	By fiscal years, in million of dollars—											
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1997–2007 Total
SPECTRUM (Subtitles A & B)												
Auction Receipts Under Current Law:												
Estimated budget authority	−9,600	−7,100	−1,600	−550	−150	0	0	0	0	0	0	−19,000
Estimated outlays	−9,600	−7,100	−1,600	−550	−150	0	0	0	0	0	0	−19,000
Proposed Changes:												
Broaden and Extend: [1]												
Estimated budget authority	0	0	−800	−1,500	−1,700	−1,700	0	0	0	0	0	−5,700
Estimated outlays	0	0	−800	−1,500	−1,700	−1,700	0	0	0	0	0	−5,700
Reallocation of 105 MHz below 3 GHz:												
Estimated budget authority	0	0	−500	−800	−1,300	−3,000	−500	−500	0	0	0	−6,600
Estimated outlays	0	0	−500	−800	−1,300	−3,000	−500	−500	0	0	0	−6,600
Analog Return:												
Estimated budget authority	0	0	0	0	0	−2,700	0	0	0	0	0	−2,700
Estimated outlays	0	0	0	0	0	−2,700	0	0	0	0	0	−2,700
Channels 60–69:												
Estimated budget authority	0	0	−400	−1,100	−200	0	0	0	0	0	0	−1,700
Estimated outlays	0	0	−400	−1,100	−200	0	0	0	0	0	0	−1,700
Total Changes:												
Estimated budget authority	0	0	−1,700	−3,400	−3,200	−7,400	−500	−500	0	0	0	−16,700
Estimated outlays	0	0	−1,700	−3,400	−3,200	−7,400	−500	−500	0	0	0	−16,700
Auction Receipts Under Title III:												
Estimated budget authority	−9,600	−7,100	−3,300	−3,950	−3,350	−7,400	−500	−500	0	0	0	−35,700
Estimated outlays	−9,600	−7,100	−3,300	−3,950	−3,350	−7,400	−500	−500	0	0	0	−35,700
VESSEL TONNAGE FEES (Subtitle C)												
Vessel Tonnage Fees Under Current Law: [2]												
Estimated budget authority	−49	−49	0	0	0	0	0	0	0	0	0	−98
Estimated outlays	−49	−49	0	0	0	0	0	0	0	0	0	−98
Proposed Changes:												
Estimated budget authority	0	0	−49	−49	−49	−49	0	0	0	0	0	−196
Estimated outlays	0	0	−49	−49	−49	−49	0	0	0	0	0	−196

TABLE 2. ESTIMATED 10-YEAR BUDGETARY EFFECTS OF TITLE III: RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION—Continued

[Estimated budgetary effects of title III on direct spending, fiscal years 1997–2007

	By fiscal years, in million of dollars—											
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1997–2007 Total
Vessel Tonnage Fees Under Proposal:												
Estimated budget authority	−49	−49	−49	−49	−49	−49	0	0	0	0	0	−294
Estimated outlays	−49	−49	−49	−49	−49	−49	0	0	0	0	0	−294

[1] CBO estimates that receipts in 2002 from the ''broaden and extend'' authority included in Subtitle-A would be lower than they would otherwise be, because of restriction contained in Subtitle B regarding the auction of licenses for private wireless services. The amount shown in the table reflects that interaction between the subtitles.

[2] These amounts represent proceeds from the increase in tonnage fees originally mandated in the Ominbus Budget Reconciliation Act of 1990, which are recorded in the budget as offsetting receipts. The tonnage fees that were established prior to that time (and are still in effect) are recorded as governmental receipts (i.e., revenues); the proceeds from those fees (about $15 million a year) are not included in this table.

SUBTITLE A—SPECTRUM AUCTIONS

Section 3001. Spectrum auctions

Subsection 3001(a) would extend the FCC's authority to use auctions to assign licenses, set to expire in 1998, to the year 2007. The FCC's auction authority was established in the Omnibus Budget Reconciliation Act of 1993.

The subsection also would broaden the FCC's auction authority to include virtually any service in which mutually exclusive applications are filed for licenses. In addition, the FCC may postpone an auction if it determines that doing so would be more likely to recover for the public a fair portion of the value of the spectrum, as long as the auction is completed before the end of fiscal year 2002. Public safety, noncommercial public broadcasting, international satellite systems, digital television, and potentially all broadcasting services are exempt from auctions.

Subsection 3001(a) specifically provides for an exemption to the FCC's competitive bidding authority "for public safety radio services, including private internal radio services used by State and local government and non-government entities that protect the safety of life, health, or property and that are not made commercially available to the public." The reference to non-government uses recognizes that utilities, railroads, pipelines, and other industries use radio spectrum for public safety purposes. In addition, this exemption includes spectrum allocated for certain private mobile and special emergency radio services where public safety is the sole or primary purpose of the use, such as private ambulance services, volunteer fire departments, and automobile emergency road services.

Subsection 3001(b) requires the FCC to auction 45 megahertz (MHz) of spectrum located between 1,710–1,755 MHz no later than December 31, 2001, for commercial use. Government use of this band is to continue until December 31, 2003 unless such use is exempted from relocation.

Subsection 3001(c) directs the FCC, by September 30, 2002, to auction not less than 100 MHz of spectrum below 10 gigahertz (GHz), at least 40 of which must be located below 3 GHz. This 100 MHz of spectrum is to be reallocated from government to private use pursuant to joint efforts by the FCC and NTIA. The frequencies chosen by the FCC must not have been assigned or designated for assignment using auctions by the FCC prior to the date of enactment, nor reserved for government use under section 305.

This subsection provides that in using any license assigned under the subsection the licensee must avoid interference with space research uses and earth exploration satellite services authorized under notes 750A and US90 to section 2.106 of the FCC's rules, if such rules are in effect on the date of enactment.

In making its reassignments, the FCC must consider the cost of relocation to incumbent licensees. The FCC also must consider the needs of public safety and comply with international spectrum allocation agreements. Coordination with the Secretary of Commerce also is required under this subsection when government use is affected by the reassignments.

The subsection requires the FCC to submit a report to the President, the Senate Commerce Committee, and the House Commerce Committee recommending bands of frequencies for reallocation. The report must include relocation plans for displaced users.

Subsection 3001(c) provides that the FCC must notify the Secretary of Commerce when the FCC is unable to relocate incumbent licensees effectively. The notification must explain why the incumbents cannot be accommodated. With the assistance of NTIA, the FCC must submit a report to the Secretary of Commerce describing why incumbents cannot be accommodated in existing non-government spectrum. NTIA must review this report when determining if a commercial user can be relocated to government spectrum.

Subsection 3001(d) directs the Secretary to submit a report with the Secretary's recommendations to the President, the Congress, and the FCC if the Secretary receives a report from the FCC pursuant to subsection 3001(c)(6).

In addition, the subsection requires private parties causing federal entities to relocate to reimburse such entities for the costs of relocation . This will allow private industry to pay to move government users off valuable spectrum and speed relocation to less valuable spectrum at no cost to the taxpayer.

Subsection 3001(d) also requires a party seeking to relocate a federal government station that is located within a frequency band allocated for federal and non-federal use to file a petition for relocation with NTIA. The NTIA must limit or terminate the federal government station's license within 6 months when the stated requirements are met.

Subsection 3001(e) directs the Secretary to make available for reallocation a total of 20 MHz in a second report, for other than federal government use under section 305, that is located below 3 GHz and that meets the criteria set forth in section 113(a) of the National Telecommunications and Information Administration Organization Act.

Within 12 months after it receives the second report from the Secretary, the FCC must submit a plan to the President, the Senate Commerce Committee, and the House Commerce Committee to implement the report. The FCC must then implement its plan.

Section 3002. Digital television services

Section 3002 contains a definitive analog spectrum return date of December 31, 2006. This will maximize the value of analog television broadcast spectrum that will be auctioned in 2001 (although not actually reassigned until 2006 at the earliest, as incumbent television licensees finish converting to digital transmission). The Committee recognizes that digital conversion may not have taken place by this return date. Therefore, an extension or waiver of this section shall be granted for any station in a television market unless 95 percent of television households have access to digital television. The Committee notes that a television household can have access to a service without subscribing to it or buying it. For example, where a digital cable television system carries local signals and passes a television household, that household is considered to have access to digital television whether it subscribes to the service or not.

The section also provides that a commercial digital television license expires on September 30, 2003 and that the license will be renewed only if the licensee is transmitting programming in digital format in the 30 largest markets by November 1, 1999.

Under this section, the FCC is required to report to Congress, no later than December 31, 2001, and every 2 years thereafter, on the status of digital television conversion. The report must contain information on market penetration, percentage of television households with access to digital television, and the cost of purchasing digital television receivers or conversion equipment.

Section 3002 also requires the FCC to ensure that broadcasters return analog spectrum as the analog television licenses expire. Such analog spectrum must be auctioned by the FCC by July 1, 2001. The FCC is required to report the total revenues from the auctions by January 1, 2002.

The section further directs the FCC to encourage the transmission of digital television signals in the top 30 markets by November 1, 1999. This section is not intended to override any FCC rule or guideline on the digital conversion timetable.

Section 3003. Allocation and Assignment of New Public Safety and Commercial Licenses

Subsection 3003(a) provides for the reallocation, by January 1, 1998, of 24 MHz of spectrum between 746 MHz and 806 MHz for public safety use. The remaining 36 MHz is to be auctioned for commercial use.

Subsection 3003(b) directs the FCC to commence assignment of the public safety licenses no later than September 30, 1998. In addition, the FCC must begin auctioning the commercial licenses no later than March 31, 1998.

Subsection 3003(c) requires the FCC to waive any licensee eligibility and other requirements, including bidding requirements, in order to provide for public safety use of unassigned frequencies by a State or local government when such use is necessary and technically feasible without causing interference to existing stations.

Subsection 3003(d) provides for flexible spectrum use, subject to interference limits and any technical restrictions designed to protect full-service analog and digital television licenses during a transition to digital television. Under this subsection, licenses may be aggregated, disaggregated, or transferred to any other person qualified to be a licensee.

Subsection 3003(e) protects public safety users from interference from broadcasters.

Subsection 3003(f) directs the FCC to minimize the number of digital television allotments between 746 MHz and 806 MHz and maximize the amount of spectrum for public safety and new services. The FCC also must recover an additional 78 MHz of spectrum to be auctioned.

Subsection 3003(g) prohibits anyone holding an analog or digital television license between 746 and 806 MHz from operating at that frequency after the digital transition is complete. Such licenses must be returned immediately pursuant to FCC rules.

Subsection 3003(h) provides protection for low-power television stations by requiring the FCC to assign each station a frequency

below 746 MHz, as long as such action does not cause interference with primary licensees.

Subsection 3003(j) directs the FCC to provide for flexibility in spectrum use.

Section 3004. Private Wireless Spectrum Availability

Subsection 3004(a) would require the FCC, within 6 months of enactment, to implement a system of spectrum lease fees for private wireless service licenses. Such lease fees would supplement auctions in compensating the public for spectrum use. Certified frequency advisory committees would assist the FCC in determining and collecting the appropriate fee amounts. The FCC is to develop a formula for computing the fees.

Subsection 3004(a) also provides that the spectrum lease fees must be based on the approximate value of the assigned frequencies. The FCC is directed to consider several factors in assessing the value and is allowed to adjust its formula when necessary. The lease fees are capped so that, over a 10-year license term, the amount will not exceed revenues gained from the auction of comparable spectrum.

The subsection further directs the FCC to apply spectrum lease fees to private wireless systems.

Subsection 3004(b) allocates not less than 12 MHz located between 150 MHz and 1000 MHz to private wireless within 6 months after the date of enactment. Initial access to this spectrum should commence not later than 12 months after enactment.

Subsection 3004(c) authorizes the FCC to use a certified private frequency advisory committee for the computation and collection of the lease fees.

Subsection 3004(d) allows the FCC to consider whether the public interest might be better served by assigning private wireless licenses outside the auctions process where specific criteria set forth in this subsection are met. These criteria basically seek to identify those instances in which auction revenues in any event would be likely to be minimal.

Subsection 3004(e) requires all proceeds from spectrum lease fees to be deposited in the Treasury, except that a certified frequency advisory committee may retain a fair amount of the spectrum lease proceeds to cover its costs in administering the lease fee program.

United States Senate
COMMITTEE ON
ENERGY AND NATURAL RESOURCES
WASHINGTON, DC 20510-6150

June 13, 1997

The Honorable Pete Domenici
Chairman
Committee on the Budget
United States Senate
Washington, D.C. 20510

Dear Chairman Domenici,

On behalf of the Committee on Energy and Natural Resources, we hereby submit the legislative recommendation and report language for the reconciliation measure that was approved by a unanimous vote of the committee in its June 11, 1997 business meeting. H. Con. Res. 84, the concurrent resolution on the budget, instructs the Committee on Energy and Natural Resources to report changes in laws within its jurisdiction that reduce outlays by $6 million in fiscal year 2002 and $13 million for the fiscal years 1998 through 2002. Attached to this letter is a cost estimate from the Congressional Budget Office verifying that the recommended language will meet the requirements of the committee's instruction.

Sincerely yours,

Dale Bumpers
Ranking Minority Member

Frank H. Murkowski
Chairman

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Reconciliation recommendations of the Senate Committee on Energy and Natural Resources (Title IV)

Summary: Title IV would revise the terms under which the Department of Energy (DOE) could lease excess capacity of the Strategic Petroleum Reserve (SPR) to foreign governments and would allow the department to spend any proceeds collected after 2002 to purchase oil for the SPR without further appropriation. CBO estimates that enacting this legislation would reduce direct spending by a total of $13 million over the 1999–2002 period.

Title IV contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform act of 1995 (UMRA) and would have no impact on the budgets of state, local, or tribal governments.

Estimated cost to the Federal Government: This provision would remove some of the statutory impediments to leasing the excess capacity of the SPR to foreign governments. For example, products stored on behalf of foreign governments would not be considered part of the U.S. reserve and could be exported. Estimates of how much of the excess capacity (currently about 110 million barrels) would be leased are speculative, because the decision to lease resides with foreign governments, not DOE. At this time, most nations needing capacity either have plans for domestic storage or face regulatory barriers to using U.S. facilities. CBO expects, however, that one or more nations would chose to store small quantities of oil in the SPR to accommodate growth in their storage requirements or to satisfy other strategic objectives. We estimate that such leasing activity would generate receipts totaling about $13 million over the 1999–2002 period, assuming a storage fee of about $1.20 per barrel (in 1997 dollars). Beginning in 2003, this provision would no longer generate net receipts, because DOE would be authorized to spend the proceeds from leasing to purchase oil for the reserve without further appropriation.

Table 1 shows the estimated budgetary impact of enacting Title IV over the 1998–2002 period. Table 2 (at the end of this estimate) shows the estimated budgetary effects through 2007.

TABLE 1. ESTIMATED BUDGETARY IMPACT OF THE RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON ENERGY AND NATURAL RESOURCES

	By fiscal years, in millions of dollars—				
	1998	1999	2000	2001	2002
CHANGES IN DIRECT SPENDING					
Lease Excess SPR Capacity:					
Estimated budget authority	0	−1	−2	−4	−6
Estimated outlays	0	−1	−2	−4	−6

The effects of this legislation fall within budget function 270 (energy).

Intergovernmental and private-sector impact: Title IV contains no intergovernmental or private-sector mandates as defined in UMRA and would have no impact on the budgets of state, local, or tribal governments.

Previous CBO estimate: On June 16, 1997, CBO transmitted a cost estimate for the reconciliation recommendations of the House Committee on Commerce (Title III), which included provisions that would authorize DOE to lease the excess capacity of the SPR to foreign governments (Subtitle B). The estimated budgetary impact of the House and Senate proposals is the same.

Estimate prepared by: Federal Costs: Kathleen Gramp.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

TABLE 2. ESTIMATED 10-YEAR BUDGETARY EFFECTS OF TITLE IV: RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON ENERGY AND NATURAL RESOURCES

[In millions of dollars, by fiscal years]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998–2007 total
Lease of Excess SPR Capacity:											
Estimated budget authority	0	−1	−2	−4	−6	0	0	0	0	0	−13
Estimated outlays	0	−1	−2	−4	−6	−6	0	0	0	0	−19

TITLE IV—LEASE OF EXCESS STRATEGIC PETROLEUM RESERVE CAPACITY

REPORT LANGUAGE

The Committee's recommendation would add a new section 168 to EPCA that would authorize the Secretary to lease underutilized Strategic Petroleum Reserve facilities for the storage of petroleum owned by a foreign government or its representatives. If necessary or appropriate, lease terms could exceed the five-year limitation of section 649(b) of the Department of Energy Organization Act. The provision also provides that, after October 1, 2002, funds resulting from the leasing of SPR facilities shall be available to the Secretary, without further appropriation, to purchase petroleum products for storage in the SPR.

United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510-6200

June 19, 1997

The Honorable Pete V. Domenici
Chairman
Committee on the Budget
United States Senate
Washington, D.C. 20510

The Honorable Frank R. Lautenberg
Ranking Member
Committee on the Budget
United States Senate
Washington, D.C. 20510

Dear Pete and Frank:

We hereby submit the statutory language implementing the recommendations of the Committee on Finance for purposes of meeting the budget instructions provided for in Section 104(a)(5)(A) and 104(a)(5)(B) of H. Con. Res.84, the Concurrent Resolution on the Budget for Fiscal Year 1998. Also enclosed are materials which explain those provisions.

These statutory provisions will reduce the growth in direct spending for programs within the jurisdiction of the Committee on Finance by $40.911 billion in FY 2002, and $100.646 billion for the period of 1998 through 2002.

Sincerely,

William V. Roth, Jr.
Chairman

Daniel Patrick Moynihan
Ranking Member

Enclosures

DIVISION 1—MEDICARE

Subtitle A—Medicare Choice Program

CHAPTER 1—ESTABLISHMENT OF MEDICARE CHOICE

MEDICARE CHOICE PROGRAM

MEDICARE HEALTH PLAN OPTIONS

Present Law

Medicare beneficiaries have two basic coverage options. They may elect to obtain services through the traditional fee-for-service system under which program payments are made for each service rendered, or Medicare beneficiaries may enroll in a managed care organization that has a contract with the Health Care Financing Administration (HCFA).

There are two types of contracts: cost and risk. Under cost contracts, Medicare arranges to reimburse the organization in a different way for Medicare covered services but essentially pays the same amount as it would under the Medicare fee-for-service program. The Committee is not proposing to change the Medicare HMO cost contracting program. Therefore, the following description of current law for Medicare payments to HMOs refers only to Medicare risk contracts.

Organizations eligible to contract with HCFA on a risk basis must be organized under State laws and be either:

1. A Federally qualified health maintenance organization (HMO) as defined by section 1310(d) of the Public Health Service Act; or

2. An organization called a "competitive medical plan" (CMP) that meets the following requirements:

   a. Provides at least the following services to its enrollees:

      (1) Physician services;

      (2) Inpatient hospital services;

      (3) Laboratory, x-ray, emergency, and preventive services; and

      (4) Out-of-area coverage.

   b. Is compensated on a periodic, capitated basis without regard to the volume of services provided to members.

   c. Physician services are provided by physicians on salary or through contracts with individual physicians or groups of physicians.

   d. Assumes full financial risk on a prospective basis for the provision of health care services, except the organization may insure for:

      (1) Services exceeding $5,000 per member per year;

(2) Services provided to members by providers outside the network;

(3) Not more than 90 percent of costs which exceed 115 percent of income in a fiscal year; and

(4) Make arrangements with other providers to accept all or part of the risk.

e. Meets solvency standards satisfactory to the Secretary.

For Medicare purposes, the requirements for HMOs and CMPs are essentially identical. For simplicity, the term "Medicare HMO" is used in this document to refer to both HMOs and CMPs that have Medicare risk contracts.

ELIGIBILITY

Present Law

Any person entitled to coverage under Medicare Part A and enrolled under Medicare Part B, or enrolled under Medicare Part B only, except persons with end-stage renal disease, is eligible to enroll in a Medicare HMO that serves the geographic area in which the person resides. A Medicare beneficiary developing end-stage renal disease after having enrolled in a Medicare HMO may continue enrollment in that Medicare HMO.

ELECTION AND ENROLLMENT

Present Law

Persons are automatically enrolled in the Medicare fee-for-service system when they first become eligible for Medicare. Once enrolled in the Medicare program, persons wishing to enroll in a Medicare HMO must do so directly through the Medicare HMO.

Each Medicare HMO is required to have at least a 30 day annual open enrollment period for Medicare beneficiaries. Open enrollment periods are not coordinated. Secretary may waive open enrollment under certain conditions. Medicare HMOs must accept persons on a first-come basis up to plan capacity.

DISENROLLMENT

Present Law

Medicare beneficiaries enrolled in Medicare HMOs may disenroll at any time and return to the regular Medicare program or switch to another Medicare HMO at the time of that Medicare HMO's open enrollment period.

INFORMATION

Present Law

Information on Medicare HMOs must be obtained from the Medicare HMOs directly. The Health Care Financing Administration (HCFA) does not distribute any specific information on Medicare HMO options to Medicare beneficiaries.

Medicare HMOs are required to make available to enrollees at the time of enrollment, and at least annually thereafter, the following information:

1. The enrollee's rights to benefits from the organization;
2. The restrictions on Medicare payment for services furnished to the enrollee by other than the Medicare HMO's providers;
3. Out-of-area coverage provided by the Medicare HMO;
4. Coverage of emergency services and urgently needed care;
5. Appeal rights of enrollees; and
6. Notice that the Medicare HMO is authorized by law to terminate or refuse to renew its Medicare contract, and, therefore, may terminate or refuse to renew the enrollment of Medicare individuals.

MARKETING

Present Law

Medicare HMOs must submit any brochures, application forms, and promotional or informational material to the Secretary for approval 45 days before distribution of the material.

BENEFITS

Present Law

Medicare HMOs are required to provide all services and items covered by Part A and Part B of the Medicare program. Beneficiaries must receive all Medicare covered services from the HMO's providers, except in emergencies or unless the plan has an approved point-of-service option which allows some out of service use.

Medicare HMOs may adopt cost-sharing requirements that are different from the cost-sharing requirements in the Medicare program. However, the average total amount of cost-sharing per enrollee may not exceed the average total amount of cost-sharing per enrollee in the fee-for-service Medicare program.

Medicare HMOs may offer additional benefits. The additional benefits may be included in the basic package of benefits offered by the HMO, subject to the approval of HCFA. Or, additional supplemental benefits may be offered for an additional, separate premium payment. The same supplemental benefit options must be offered to all of the HMO's Medicare enrollees and premiums for supplemental benefits may not exceed what the Medicare HMO would have charged for the same set of services in the private market.

Medicare HMOs are required to include additional benefits in their basic benefit package to the extent that the HMO achieves a "savings" from Medicare. The "savings" is the amount by which the capitated payment from Medicare exceeds the estimated rate the HMO would charge for coverage in the private market (called the adjusted community rate, or ACR). The additional benefits may be in the form of:

1. Reduced cost sharing;
2. Expanded scope of benefits; or
3. Reduction in the premium charged to the beneficiary by the Medicare HMO.

Instead of offering additional benefits up to the full value of their "savings," Medicare HMOs may elect to have a portion of their "savings" placed in a benefit stabilization fund. This fund enables Medicare HMOs to continue to offer the same benefit package from year to year without concern about the degree of annual fluctuation in the Medicare payment amount.

BENEFICIARY PROTECTIONS AND HEALTH PLAN STANDARDS

Present Law

Quality assurance. Medicare HMOs are required to have an ongoing quality assurance program. Medicare HMOs are also required to contract with Medicare Peer Review Organizations (PROs) for external quality oversight.

Capacity and enrollment. Medicare HMOs must have at least 5,000 enrollees, unless the HMO serves a primarily rural area (specified in regulation as 1,500 enrollees).

50/50 Rule. No more than 50 percent of a Medicare HMO's enrollment may be Medicare or Medicaid beneficiaries (called the "50/50" rule). Medicare HMOs serving areas where more than 50 percent of the population qualifies for Medicare or Medicaid may receive a waiver of this rule.

Access. An HMO must make all Medicare covered services and all other services contracted for available and accessible within its service area, with reasonable promptness and in a manner that assures continuity of care. Urgent care must be available and accessible 24 hours a day and 7 days a week.

Emergency Services. Medicare HMOs must also pay for emergency services provided by nonaffiliated providers when it is not reasonable, given the circumstances, to obtain the services through the Medicare HMO.

Consumer Protections. Medicare HMOs may not disenroll or refuse to re-enroll a beneficiary because of health status or need for health care services.

Medicare HMOs must have meaningful grievance and procedures for the resolution of individual enrollee complaints. An enrollees who is dissatisfied with the outcome of the grievance procedure has the right to a hearing before the Secretary if the amount involved is greater than $100. If the amount is greater than $1,000, either the enrollee or the Medicare HMO may seek judicial review.

Medicare HMOs must also inform beneficiaries of the rights to appeal and of HCFA's appeals process.

Physician Incentive Policies. A Medicare HMO may not adopt physician compensation policies that may directly or indirectly have the effect of reducing or limiting services to a specific enrollee.

Contract Termination. A Medicare HMO terminating its contract with HCFA must arrange for supplementary coverage for its Medicare enrollees for the duration of any preexisting condition exclusion under the enrollee's successor coverage for the lesser of 6 months or the duration of the exclusion period.

If a Medicare HMO terminates its Medicare contract, other Medicare HMOs serving the same service area must hold a 30 day open enrollment period for persons enrolled under the terminated contract.

MEDICARE PAYMENTS TO HMOS

Present Law

Medicare HMOs are paid a single monthly capitation payment issued by Medicare for each enrolled beneficiary. In order to determine appropriate payments to HMOs, two key numbers are calculated: the adjusted average per capita cost, or AAPCC, and the adjusted community rate, the ACR.

The AAPCC is Medicare's estimate of the average per capita amount it would spend for a given beneficiary (classified by certain demographic characteristics and county of residence) who obtained services on the usual fee-for-service basis. Separate AAPCCs are established for enrollees on the basis of age, disability status, and other classes determined by the Secretary (which, by regulation, includes sex, whether they are in a nursing home or other institution, and whether they are also eligible for Medicaid) and the county of their residence. These AAPCC values are calculated in four basic steps:

1. Medicare national average calendar year per capita costs are projected for the future year under consideration. These numbers are known as the U.S. per capita costs (USPCCs). USPCCs are developed separately for Parts A and B of Medicare, and for costs incurred by the aged, disabled, and those with ESRD in those two parts of the program.
2. Geographic adjustment factors that reflect the historical relationship between each county's and the Nation's per capita costs are used to convert the national average per capita costs to the county level.
3. Expected Medicare per capita costs for the county are adjusted to a fee-for-service basis by removing both reimbursement and enrollment attributable to Medicare beneficiaries in prepaid plans.
4. The recalculated county per capita cost is converted into rates that vary according to the demographic variables enumerated above: age, sex, institutional status, and Medicaid status.

For each Medicare beneficiary enrolled in a Medicare HMO, Medicare will pay the Medicare HMO 95 percent of the rate corresponding to the demographic class to which the beneficiary belongs.

The ACR is an estimate of what each Medicare HMO would charge comparable private enrollees for the set of benefits the Medicare HMO will be furnishing to Medicare beneficiaries under its contract. The starting point for this estimate is the community rate that the HMO actually charges its non-Medicare enrollees. This figure is then adjusted to reflect differences between the scope of benefits covered under Medicare and those offered under private contracts, as well as expected differences in the use of services by Medicare enrollees as compared to other HMO members. The ACR is an estimated market price for those services and may include allowances for reserve funds or profits.

The degree to which the average Medicare payment rate to a Medicare HMO exceeds the Medicare HMO's ACR is the "savings" amount available to provide additional benefits to Medicare enrollees, beyond the basic services covered by Medicare.

PREMIUMS

Present Law

Section 1876 provides for requirements relating to benefits, payment to the plans by Medicare, and payments to the plans by beneficiaries. A Medicare beneficiary enrolled in an HMO/CMP is entitled to receive all services and supplies covered under Medicare Parts A and B (or Part B only, if only enrolled in Part B). These services must be provided directly by the organization or under arrangements with the organization. Enrollees in risk-based organizations are required to receive all services from the HMO/CMP except in emergencies.

In general, HMOs/CMPs offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some entities may require members to accept additional benefits (and pay extra for them in some cases). These required additional services may be approved by the Secretary if it is determined that the provision of such additional services will not discourage enrollment in the organization by other Medicare beneficiaries.

The amount an HMO/CMP may charge for additional benefits is based on a comparison of the entity's adjusted community rate (ACR, essentially the estimated market price) for the Medicare package and the average of the Medicare per capita payment rate. A risk-based organization is required to offer ''additional benefits'' at no additional charge if the organization achieves a savings from Medicare. This ''savings'' occurs if the ACR for the Medicare package is less than the average of the per capita Medicare payment rates. The difference between the two is the amount available to pay additional benefits to enrollees. These may include types of services not covered, such as outpatient prescription drugs, or waivers of coverage limits, such as Medicare's lifetime limit on reserve days for inpatient hospital care. The organization might also waive some or all of the Medicare's cost-sharing requirements.

The entity may elect to have a portion of its ''savings'' placed in a benefit stabilization fund. The purpose of this fund is to permit the entity to continue to offer the same set of benefits in future years even if the revenues available to finance those benefits diminish. Any amounts not provided as additional benefits or placed in a stabilization fund would be offset by a reduction in Medicare's payment rate.

If the difference between the average Medicare payment rate and the adjusted ACR is insufficient to cover the cost of additional benefits, the HMO/CMP may charge a supplemental premium or impose additional cost-sharing charges. If, on the other hand, the HMO does not offer additional benefits equal in value to the difference between the ACR and the average Medicare payment, the Medicare payments are reduced until the average payment is equal to the sum of the ACR and the value of the additional benefits.

For the basic Medicare covered services, premiums and the projected average amount of any other cost-sharing may not exceed what would have been paid by the average enrollee under Medicare

rules if she or he had not joined the HMO. For supplementary services, premiums and projected average cost-sharing may not exceed what the HMO would have charged for the same set of services in the private market.

ORGANIZATIONAL AND FINANCIAL REQUIREMENTS

Present Law

Under section 1876 of the Social Security Act, Medicare specifies requirements to be met by an organization seeking to become a managed care contractor with Medicare. In general, these include the following: (1) the entity must be organized under the laws of the State and be a Federally qualified HMO or a competitive medical plan (CMP) which is an organization that meets specified requirements (it provides physician, inpatient, laboratory, and other services, and provides out-of-area coverage); (2) the organization is paid a predetermined amount without regard to the frequency, extent, or kind of services actually delivered to a member; (3) the entity provides physicians' services primarily through physicians who are either employees or partners of the organization or through contracts with individual physicians or physician groups; (4) the entity assumes full financial risk on a prospective basis for the provision of covered services, except that it may obtain stop-loss coverage and other insurance for catastrophic and other specified costs; and (5) the entity has made adequate protection against the risk of insolvency.

Provider Sponsored Organizations (PSOs) that are not organized under the laws of a state and are neither a Federally qualified HMO or CMP are not eligible to contract with Medicare under the risk contract program. A PSO is a term generally used to describe a cooperative venture of a group of providers who control its health service delivery and financial arrangements.

CONTRACTS, ADMINISTRATION AND ENFORCEMENT

Present Law

Contracts with Medicare HMOs are for one year, and may be made automatically renewable. However, the contract may be terminated by the Secretary at any time (after reasonable notice and opportunity for a hearing) if the organization no longer meets the requirements for Medicare HMOs. The Secretary also has authority to impose certain lesser sanctions, including suspension of enrollment or payment and imposition of civil monetary penalties. These sanctions may be applied for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation.

The Secretary transmits to each Medicare beneficiary's selected plan a payment amount equal to the pertinent Medicare payment amount for that individual in that payment area. Payments occur in advance and on a monthly basis.

Payments to plans are made with funds withdrawn from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The allocation from each

fund is determined each year by the Secretary, based on the relative weight that benefits from each fund contribute to the determination of the Medicare payment amounts.

Reasons for Change

The existing Medicare HMO risk contracting program has enjoyed only limited success for a number of reasons. First of all, there has been no assertive effort by the Health Care Financing Administration to inform Medicare beneficiaries of the option of enrolling in a Medicare HMO and encourage them to do so.

Second, the current Medicare risk-contracting program is, for the most part, limited to closed panel health maintenance organizations and does not allow Medicare beneficiaries a choice of the full range of health plan options currently available to the non-Medicare population.

The greatest impediment to increased enrollment in Medicare HMO plans is the existing methodology for computing the amount that the Medicare program pays for enrollees in Medicare HMOs. The payments, which are the direct result of per capita spending in an area by the traditional Medicare program, vary greatly from county to county.

For example, in 1995, monthly payment amounts range across counties from $221 per month to $767 per month. Not surprisingly, most Medicare HMO activity is concentrated in high-payment areas.

Using the county as the geographic area also causes volatility of Medicare payment rates from year to year, especially in sparsely populated counties. Such unpredictable payment rates discourages HMOs from offering plans in many market areas.

Lastly, the Medicare program is not realizing any financial benefits from the enrollment of Medicare beneficiaries in private health maintenance organizations. The Medicare risk contracting program is structured so that any savings achieved by enrollment in private health plans are returned to the beneficiaries in the form of additional benefits.

Committee Provision

A new "Medicare Choice" program is created. Medicare Choice builds on the existing Medicare program which allows health maintenance organizations (HMOs) to enter into risk contracts with the Health Care Financing Administration. Under Medicare Choice, Medicare beneficiaries will have the opportunity to choose from a variety of private health plan options the health care plan that best suits their needs and preferences.

MEDICARE CHOICE PLAN OPTIONS

Medicare beneficiaries will be given the option of enrolling in the traditional fee-for-service Medicare program or enrolling in a Medicare Choice plan available in the area of their residence.

The types of health plans that may be available as Medicare Choice plans include:

(1) *Fee-for-service* indemnity health plans which pay providers on the basis of a privately determined fee schedule;

(2) *Preferred provider organizations (PPOs)* which offer enrollees the option to use providers with whom discounts have been negotiated;

(3) *Point-of-service plans (PoS)* which give beneficiaries in a coordinated care plan the option of using out-of-network providers;

(4) *Provider sponsored organization (PSOs)* plans, which are plans formed by affiliated providers and which enroll and treat beneficiaries for a capitated payment;

(5) *Health maintenance organizations (HMOs)* which are tightly closed networks of contracted or salaried providers which coordinate care and provide health services for a capitated payment;

(6) *Medical savings accounts (MSAs)* combined with high deductible health plans. (A limited option for a maximum of 100,000 Medicare beneficiaries and only from 1999 to 2002.); and

(7) Any other types of health plans that meet the standards required of Medicare Choice health plans.

ELIGIBILITY

Any person entitled to coverage under Medicare Part A and enrolled in Medicare Part B, is eligible to enroll in a Medicare Choice plan that serves the geographic area in which the person resides, except persons with end-stage renal disease (ESRD). However, a Medicare beneficiary developing end-stage renal disease after having enrolled in a Medicare Choice plan may continue enrollment in that Medicare Choice plan.

ELECTION AND ENROLLMENT

The Medicare Choice plans will be responsible for enrolling individuals. Plans must hold open enrollment during the month of November and during other specified times including when beneficiaries in the plan's area becomes newly eligible for Medicare, and when another plan's contract in the area is terminated. In addition to these specified times, plans may be open for enrollment at any other time. If an individual does not make an election upon initial enrollment, that individual will be deemed to have chosen the traditional fee-for-service Medicare plan.

Guaranteed Renewal. Medicare Choice plan sponsors may not cancel or refuse to renew a beneficiary except in cases of fraud or non-payment of premium amounts due the plan.

DISENROLLMENT

As under current law, Medicare enrollees will be able to disenroll from a Medicare Choice plan and enroll in another Medicare Choice plan or revert to the traditional Medicare program at any time. A beneficiary's disenrollment and reenrollment will become effective on the first day of the month following their notification to disenroll. There will be an exception for MSA plan holders who will only be able to enroll and disenroll in an MSA plan during the coordinated enrollment period and during certain other periods such

as when a plan's contract is terminated or when the beneficiary moves out of the area served by the plan.

INFORMATION

Information to be distributed by the Secretary. The Secretary of HHS is responsible for developing informational materials that include (1) General information about Medicare choice plans and (2) information describing and comparing the Medicare Choice plans available in each area. The materials will be mailed to each Medicare beneficiary no later than 15 days prior to the annual coordinated information period. And no later than 30 days prior to a beneficiary becoming eligible for Medicare. The Secretary of HHS may contract with private organizations to develop and distribute the informational materials. The Secretary will coordinate with the States, to the extent possible, in developing and disseminating any information that is provided to beneficiaries.

General Information. The general information distributed by the Secretary will include at minimum (1) The Medicare Part B premium rate for the upcoming calendar year (paid by all Medicare beneficiaries with Part B benefits); (2) instructions on how to enroll in a Medicare choice plan; (3) enrollees' rights and responsibilities in a Medicare Choice Plan, including appeal and grievance rights; (4) notice that Medicare Choice plan sponsors are authorized by law to terminate or refuse to renew their Medicare contracts, and, therefore, may terminate or refuse to renew the enrollment of Medicare individuals.

Comparative Information. The comparative informational material distributed by the Secretary will be in a standardized chart-like format, written in the most easily understandable manner possible, and include the information described below as well as any other information the Secretary determines is necessary to assist Medicare beneficiaries in selection of a Medicare Choice plan. The Secretary will develop this information in consultation with outside organizations, including groups representing the elderly, eligible organizations under this section, providers of services, and physicians and other health care professionals. The comparative information will be of a similar level of specificity as the information distributed by the Office of Personnel Management for the Federal Employees Health Benefits Program (FEHBP).

The comparative informational materials will contain at a minimum for each plan in the area:

(1) A description of the plan's covered items and services, including those that are in addition to those provided in the government-run Medicare fee-for-service plan;

(2) Supplemental benefits offered by the plan and premiums associated with such supplemental benefits;

(3) All cost-sharing amounts including premiums, deductibles, coinsurance, or any monetary limits on benefits;

(4) Special cost sharing and balance billing rules for medical savings account plans and private fee-for-service plans;

(5) Quality indicators for the traditional Medicare program and each of the Medicare Choice plans, including

disenrollment rates for the previous two fiscal years (excluding disenrollment due to death or moving outside a plan's service area) enrollee satisfaction rates, and health outcomes information;

(6) The plans' service areas;

(7) The extent to which beneficiaries may select the provider of their choice, including providers both within the network and outside the network (if the plan allows out-of-network services);

(8) An indication of beneficiaries' exposure to balance billing and the restrictions on payment for services furnished to the enrollee by other than the Medicare Choice plan's participating providers; and

(9) An overall summary description on how participating plan physicians are compensated.

MARKETING

Medicare Choice plans may prepare and distribute marketing materials and pursue marketing strategies so long as they accurately describe the benefits available from the plan in comparison to the traditional Medicare program. Marketing will be pursued in a manner not intended to violate the antidiscrimination requirements. Marketing materials will not contain false or materially misleading information, and will conform to all other applicable fair marketing and advertising standards and requirements.

Medicare Choice plan sponsors must submit any brochures, application forms, and promotional or informational material to the Secretary for review. Materials not disapproved by the Secretary within 45 days may be distributed. Marketing materials reviewed and not disapproved in one HHS regional office will be deemed approved for use in all other areas where the Medicare Choice plan is offered.

BENEFITS

Benefits and Cost-Sharing. All Medicare Choice plans, other than medical savings account plans, must offer, at a minimum, coverage for the same items and services as the traditional Medicare program. Medicare Choice plans may require cost-sharing that is different from the cost-sharing requirements in the Medicare program. However, the average total amount of cost-sharing per enrollee for Medicare covered items and services in a Medicare Choice plan may not exceed the average total amount of cost-sharing per enrollee in the traditional Medicare program. MSA plans and fee-for-service plans will be exempted from these cost-sharing requirements.

Additional Basic Benefits. Medicare Choice plans may include additional benefits as part of their basic benefit package offered to Medicare enrollees and included in the basic premium price.

Supplemental Benefits. Medicare Choice plans may offer optional, supplemental benefits to Medicare Choice plan enrollees for an additional premium. The supplemental benefits may be marketed and sold by the Medicare Choice plan separate from the Medicare Choice enrollment process. However, if the supplemental benefits are offered only to enrollees in the sponsor's Medicare Choice

plan(s) the same supplemental benefit options must be offered to all of the Medicare Choice plan sponsor's Medicare enrollees for the same premium amount.

National Coverage Determinations. If the Secretary of HHS makes a national coverage determination that will result in added costs for Medicare Choice plans, the Medicare Choice plans are not responsible for assuming responsibility for such coverage until the beginning of the next contract year. Medicare Choice plan enrollees may obtain any new benefits on a fee-for-service basis until the new coverage requirement goes into effect at the beginning of the next contract year.

Hospitalized at Time of Disenrollment. In the case of a Medicare beneficiary who is hospitalized at the time of enrollment or disenrollment from a Medicare Choice plan, responsibility for payment for the hospitalization is determined by the status of coverage at the time of admission to the hospital.

Medicare as Secondary Payor. Medicare Choice plans may recover payment for services provided to a plan enrollee which qualify for coverage under workers compensation, automobile, or other insurance policies of an enrollee.

BENEFICIARY PROTECTIONS AND HEALTH PLAN STANDARDS

Beneficiary Antidiscrimination. Medicare Choice plan sponsors may not discriminate against individuals on the basis of health status or anticipated need for health services during the enrollment, disenrollment, or provision of services.

Balance Billing. Current law balance billing restrictions will apply to all Medicare Choice plans except Medical Savings Account Plans and Fee-for-Service plans.

Information to be distributed by the Medicare Choice Plan upon enrollment.

(1) Benefits offered including exclusions from coverage;

(2) The number, mix, and distribution of participating providers;

(3) Out-of-area coverage;

(4) Optional supplemental coverage including the premium price for optional supplemental benefits;

(5) Prior authorization rules;

(6) Plan grievance and appeals procedures, including both general Medicare procedures and plan-specific procedures;

(7) Coverage of emergency services and urgently needed care;

(8) A description of the organization's quality assurance program;

(9) The organization's coverage of out-of-network services (if any); and

(10) The plan's service area.

In addition to the above material specified to be distributed by the Medicare Choice plan, all Medicare Choice plans must have available to distribute, at the request of any eligible Medicare beneficiary, the comparative and general information developed and distributed by the Secretary.

Also, at the request of a beneficiary, plans must provide information on utilization review procedures.

Access to Services and Specialists. Medicare Choice plans must make all Medicare covered services and all other services contracted for available and accessible within their service areas, with reasonable promptness and in a manner that assures continuity of care. All Medicare Choice plans must provide access to the appropriate providers, including specialists credentialed by the Medicare Choice plan sponsor, for all medically necessary treatment and services.

Emergency Services. Urgent care must be available and accessible 24 hours a day and 7 days a week. Medicare Choice plans must also pay for emergency services provided by nonaffiliated providers when a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Post-Stabilization Guidelines. A plan must comply with guidelines to be issued by the Secretary regarding post-stabilization care. These guidelines shall provide that a provider of emergency service shall make a documented good faith effort to contact the plan in a timely fashion from the point at which the individual is stabilized to request approval for medically necessary post-stabilization care. The plan shall respond in a timely fashion with a decision as to whether the services will be authorized. If a request is denied, the plan shall, upon request from the treating physician, arrange for a physician who is authorized by the plan to review the denial to communicate directly with the treating physician.

In the case of emergency services or urgent care provided outside of the Medicare Choice plan's service area to an enrollee of a Medicare Choice plan which utilizes an integrated network of providers, the provider will accept as payment in full from the Medicare Choice plan the amount that would be payable to the provider, under the Medicare program and from the individual enrolled in Medicare, if the individual were not enrolled in the Medicare Choice plan.

Ongoing Quality Assurance Program. Each Medicare Choice plan sponsor must have arrangements for an ongoing quality assurance program, including review by an external organization. The program must:

(1) Stress health outcomes;

(2) Provide written protocols for utilization review;

(3) Provide review by physicians and other health care professionals of the process followed in the provision of health services;

(4) Monitor and evaluate high volume and high risk services;

(5) Evaluate the continuity of care enrollees receive;

(6) Have mechanisms to identify underutilization and overutilization of services;

(7) Alter practice parameters after identifying areas for improvement;

(8) Take actions to improve quality;

(9) Make available information on quality and outcomes to facilitate beneficiary comparisons;

(10) Be evaluated on an ongoing basis as to its effectiveness;

(11) Include measures of consumer satisfaction; and

(12) Provide the Secretary with such access to information collection as may be appropriate to monitor and ensure the quality of care provided under this part.

Independent Accrediting Organizations. Medicare Choice plan sponsors will be accredited for meeting quality standards established by the Secretary of HHS. Medicare Choice plans accredited by external independent accrediting organizations, recognized by the Secretary of HHS as establishing standards at least as stringent as Medicare standards, will be "deemed" accredited for Medicare purposes.

Coverage Determinations. A Medicare Choice organization would be required to make determinations regarding authorization requests for nonemergency care on a timely basis. Appeals of denials would generally have to be decided within 30 days of receiving medical information, but not later than 60 days after the coverage determination. Physicians would be the only individuals permitted to make decisions to deny coverage based on medical necessity. Appeals of determinations involving a life-threatening or emergency situation would have to be made in an expedited manner and within 72 hours of denial.

Grievance and Appeals Procedures. Medicare Choice plan sponsors must have meaningful grievance procedures for the resolution of individual enrollee complaints. An enrollee who is dissatisfied with the outcome of the grievance procedure has the right to appeal through a hearing before the Secretary if the amount involved is greater than $100. If the amount is greater than $1,000, either the enrollee or the Medicare Choice plan sponsor may seek judicial review.

Independent Review of Certain Coverage Denials. The Secretary will contract with an independent, outside entity to review and resolve reconsiderations that affirm denial of coverage.

Confidentiality and Accuracy of Enrollee Records. A plan must have procedures to maintain accurate medical records, safeguard the privacy of the individuals' records, and make these records accessible to beneficiaries.

Ability to Service Enrollment. Medicare Choice plans must demonstrate the capacity to adequately serve their expected enrollment of Medicare beneficiaries.

50/50 Rule. During 1998, Medicare Choice plans must maintain at least as many commercial enrollees at any time as Medicare enrollees. (Medicare Choice plans will be relieved of the requirement to maintain a commercial enrollment equal to or greater than its enrollment of both Medicare and Medicaid enrollees.) This requirement may be waived if the Secretary determines that the plan meets all other beneficiary protections and quality standards. Beginning January of 1999, the 50/50 requirement will be repealed.

Rural access. If the Medicare Choice plan restricts coverage to services provided by a network of providers, primary care services in rural areas must be available within 30 minutes or 30 miles

from an enrollee's place of residence. The Secretary may make exceptions to this standard on a case-by-case basis.

Advance Directives. A Medicare Choice plan must maintain written policies and procedures respecting advance directives. Nothing in this section will be construed to require the provision of information regarding assisted suicide, euthanasia, or mercy killing.

Physician Incentive Plans. Medicare Choice plans may not operate physician incentive plans as an inducement for physicians to reduce or limit medically necessary services.

Provider Antidiscrimination. A Medicare Choice plan may not discriminate in participation, reimbursement or indemnification against a provider who is acting within the scope of his or her license or certification under applicable state law, solely based on such license or certification of the provider. This provision is not intended to prevent a plan from matching the number and type of health care providers to the needs of the plan's members or establish any other measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

PAYMENTS TO MEDICARE CHOICE ORGANIZATIONS

A Medicare payment amount will be established for each Medicare payment area (by county) within the United States. The same Medicare payment amount will apply to each Medicare beneficiary eligible for coverage within a Medicare payment area. The Medicare payment rates will be based on the current Medicare HMO payment methods with adjustments made so that the variation in Medicare payment amounts across geographic areas are reasonable.

A base Medicare payment amount will be established for each Medicare payment area. The link between traditional Medicare fee-for-service spending and the Medicare payment amounts will be broken. The base Medicare payment amount for an area will be determined through adjustments over 5 years.

Beginning in 1998, plans are to be paid the greatest of:

(1) A blended local/national rate (initially based on 1997 rates), updated by the nominal per capita growth in the gross domestic product (GDP) plus .5 percentage points;

(2) A minimum payment amount of up to 85% of the national average payment (to be determined annually depending on enrollment and other factors), for U.S. territories the minimum payment amount will equal 150% of the 1997 payment;

(3) 100 percent of the plan's 1997 payment.

Blended local/national rate. Blending of local and national rates will be phased in over five years beginning in 1998. Local rates of 90% in 1998, 80% in 1999, 70% in 2000, 60% in 2001, and 50% in 2002 will be blended with national rates of 10% in 1998, 20% in 1999, 30% in 2000, 40% in 2001, and 50% in 2002.

GME/DSH Payments. 100 percent of the amount of payments for indirect medical education, graduate medical education (GME), and disproportionate share (DSH) will be carved out of local rates over a four year period (1998–2001). Hospitals will be allowed to submit a Medicare claim for each Medicare Choice enrollee and receive the amount of medical education and DSH payments they would otherwise receive for a patient enrolled in traditional Medicare. During

the first 3 years, payments will be proportionate to the amount of the carve out.

Risk Adjustment. In making payments to Medicare Choice plans on behalf of Medicare beneficiaries, the Medicare payment amount will be adjusted by the Secretary to reflect demographic and health status factors applicable to the beneficiary.

Payments to Medicare Choice plans will also be adjusted for new enrollees by 5 percent for beneficiaries in their first year of enrollment, and then 4 percent, 3 percent, 2 percent and 1 percent in their second, third, fourth, and fifth years of enrollment respectively. Payments for beneficiaries who "age-in" to a Medicare Choice plan—i.e. beneficiaries who are already enrolled in a risk plan with a Medicare Choice contract upon turning 65 would not be subjected to this adjustment if the enrollee remained with the same sponsoring organization. New Medicare Choice plans in any county where the Medicare Choice payment is below the national average Medicare Choice payment will be exempt from the new enrollee adjustment during the 12 months after they enroll their first Medicare Choice beneficiary. The new enrollee adjustment would be discontinued when the Secretary has fully implemented a risk adjustment methodology that accounts for variations in per capita costs based on health status and which has been evaluated as effective by an independent actuary of the actuarial soundness of the risk adjuster.

Encounter Data Collection. The Secretary will require Medicare Choice organizations (and risk-contract plans) to submit, for periods beginning on or after January 1, 1998, data physician visits, nursing home days, home health visits, hospital inpatient days, and rehabilitation services.

Study on Input Price Adjustments. With the Medicare Payment Advisory Commission, the Secretary shall study appropriate input price adjustments for applying national rates to local areas—including the Medicare hospital wage index and the actual case mix of a geographic region. Recommendations shall be submitted in a report to Congress.

Payment areas with highly variable rates. In the case of a Medicare Choice payment area for which the AAPCC for 1997 varies by more than 20% from such rate for 1996, the Secretary, where appropriate, could substitute for the 1997 rate a rate that is more representative of the cost of the enrollees in the area.

Request for alternate Medicare Choice payment area. Upon request of a state for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary would redefine Medicare Choice payment areas in the state to: (1) a single statewide Medicare Choice payment area; (2) a metropolitan system (described in the provision); or (3) a single Medicare Choice payment area consolidating noncontiguous counties (or equivalent areas) within a state. This adjustment would be effective for payments for months beginning with January of the year following the year in which the request was received. The Secretary would be required to make an adjustment to payment areas in the state to ensure budget neutrality.

Analysis of Payment Variation. The Secretary will conduct an analysis, based on the developments in the Medicare Choice pro-

gram up to December 31, 2000, of the variation in Medicare payment amounts, taking into consideration measurable input cost differences, and the degree to which Medicare Choice payment amounts have enhanced or limited beneficiary choice of health plans in areas. The Secretary would report the findings to the appropriate committees of the Congress, and the public, not later than December 31, 2002.

PREMIUMS

Annual filing by Plan. Each Medicare Choice organization would be required annually to file with the Secretary the amount of the monthly premium for coverage under each of the plans it would be offering in each payment area, and the enrollment capacity in relation to the plan in each such area.

Monthly Amount. The monthly premium charged for a plan offered in a payment area would equal 1/12 of the amount (if any) by which the premium exceeded the Medicare Choice capitation rate. The organization would have to permit monthly payment of premiums.

Uniform Plan Premium. Premiums could not vary among individuals who resided in the same payment area.

Limitation on Cost Sharing. In no case could the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled with a Medicare Choice plan with respect to required benefits exceed the actuarial value of the deductibles, coinsurance, and copayments applicable in Medicare FFS. This provision would not apply to an MSA plan or a private fee-for-service plan. If the Secretary determined that adequate data were not available to determine the actuarial value of the cost-sharing elements of the plan, the Secretary could determine the amount.

Requirement for Additional Benefits. The extent to which a Medicare Choice plan (other than a MSA plan) would have to provide additional benefits would depend on whether the plan's adjusted community rate (ACR) was lower than its average capitation payments. The ACR would mean, at the election of the Medicare Choice organization, either: (I) the rate of payment for services which the Secretary annually determined would apply to the individuals electing a Medicare Choice plan if the payment were determined under a community rating system, or (ii) the portion of the weighted aggregate premium which the Secretary annually estimated would apply to the individual but adjusted for differences between the utilization of individuals under Medicare and the utilization of other enrollees (or through another specified manner). For PSOs, the ACR could be computed using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a plan.

If the actuarial value of the benefits under the Medicare Choice plan (as determined based upon the ACR) for individuals was less than the average of the capitation payments made to the organization for the plan at the beginning of a contract year, the organization would have to provide additional benefits in a value which was at least as much as the amount by which the capitation payment exceeded the ACR. These benefits would have to be uniform for all

enrollees in a plan area. (The excess amount could, however, be lower if the organization elected to withhold some of it for a stabilization fund.) A Medicare Choice organization could provide additional benefits (over and above those required to be added as a result of the excess payment), and could impose a premium for such additional benefits. A Medicare Choice organization could not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

Periodic Auditing. The Secretary would be required to provide annually for the auditing of the financial records (including data relating to utilization and computation of the ACR) of at least one-third of the Medicare Choice organizations offering Medicare Choice plans. The General Accounting Office would be required to monitor such auditing activities.

Prohibition of State Imposition of Premium Taxes. No state could impose a premium tax or similar tax on the premiums of Medicare Choice plans or the offering of such plans.

ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICARE CHOICE ORGANIZATIONS

State Licensure. Organizations eligible to contract with the Secretary of Health and Human Services (HHS) to offer Medicare Choice plans must be organized and licensed under state laws applicable to entities bearing risk for the provision of health services, by each state in which they wish to enroll Medicare beneficiaries.

Solvency Standards. Eligible Medicare Choice plan sponsoring organizations must meet solvency requirements satisfactory to the Secretary of HHS. Organizations licensed in states recognized by the Secretary of HHS as requiring solvency standards at least as stringent as those required by Medicare will be deemed to meet Medicare Choice plan solvency requirements.

Exceptions for Provider Sponsored Organizations (PSOs). To help facilitate the availability of Medicare Choice plans throughout the United States, a waiver process to temporarily certify PSOs to enroll Medicare beneficiaries without a state license is established.

Prior to January 1, 2001, PSOs would be granted a waiver which would allow them to contract directly with HCFA for Medicare enrollees without first obtaining a state license.

The Federal waiver would allow PSOs to circumvent the solvency requirements of the State, but other State requirements, including the State's patient protection standards, would be imposed upon the PSO through the Medicare Choice contracting process. The Secretary will enter into agreements with States to ensure adequate enforcement of State non-solvency standards. If the Secretary is notified by the State that the PSO is not in compliance, and the Secretary agrees that the PSO is not in compliance, the Secretary will terminate the PSO's Medicare Choice. Before termination of contract, the PSO must be allowed 60 days to reach compliance.

A PSO's Federal waiver will be effective until the State in which the PSO is located receives Federal certification that the State's solvency requirements for PSOs are identical to the Federal government's solvency standards for PSOs.

Federal solvency standards for PSOs will be developed through a negotiated rule-making process taking into consideration risk

based capital standards developed by the National Association of Insurance Commissioners. The target publishing date of the interim rule on Medicare Choice solvency requirements for PSOs is April 1, 1998. The rule will be effective immediately on an interim basis. The final rule will be published not later than April 1, 1999.

Beginning January 1, 2001, PSOs will be required to have state licenses to enroll Medicare beneficiaries.

The Secretary is required to report to Congress evaluating the temporary certification process by December 31, 1998. The report will include an analysis of state efforts to adopt regulatory standards that take into account health plan sponsors that provide services directly to enrollees through affiliated providers.

A PSO is defined as a locally, organized and operated entity that provides a substantial proportion of services directly through affiliated providers, and that is organized to deliver a spectrum of health care services. A provider is affiliated if through contract, ownership or otherwise (1) one provider, directly or indirectly, is controlled by, or is under common control with the other; (2) both providers are part of a controlled group of corporations; (3) each provider is a participant in a lawful combination under which the providers share substantial financial risk in connection with the PSO's operations; or (4) both providers are part of an affiliated service group.

Assume Full Risk. All Medicare Choice plan sponsoring organizations must assume full financial risk (except, at the election of the organization, hospice care) on a prospective basis for the provision of health care services, except the organization may insure or make arrangements for stop-loss coverage for costs exceeding an amount established by regulation and adjusted annually based on the consumer price index; services provided to members by providers outside of the organization; and for not more than 90 percent of costs which exceed 115 percent of income in a fiscal year. An organization may also make arrangements with providers to assume all or part of the risk on a prospective basis for the provision of basic health services.

Establishment of Other Standards and Interim Standards. The Secretary would be required to establish by regulation other standards for Medicare Choice organizations and plans consistent with this act. By January 1, 1998, the Secretary would be required to issue interim standards based on currently applicable standards for Medicare HMOs/CMPs. The new standards established under this provision would supersede any state law or regulation with respect to Medicare Choice plans offered by Medicare contractors to the extent that such state law or regulations was inconsistent with such standards.

CONTRACTS/ADMINISTRATION AND ENFORCEMENT

The Secretary will enter into a contract with every organization eligible to offer a Medicare Choice plan and certified by the Secretary as meeting Medicare Choice plan standards. The contracts may be made automatically renewable.

Minimum Enrollment. A Medicare Choice organization must have a minimum of 1,500 commercial enrollees, or no less than 500 commercial enrollees in rural areas. Provider sponsored organiza-

tions can include as commercial enrollees those individuals for whom the organization has assumed financial risk. This requirement will be waived for the first two years of a Medicare Choice contract.

Payments to Plans. The Secretary will transmit to each Medicare beneficiary's selected Medicare Choice plan a payment amount equal to the pertinent adjusted Medicare payment amount for that individual in that Medicare payment area. Payments will occur in advance and on a monthly basis, except in the case of an MSA plan which will be paid on an annual basis with the remainder of the premium being deposited into the holder's Medicare Choice Medical Savings Account on an annual basis. Monthly Medicare Choice payments for October 1, 2001 would be paid on the last business day of September, 2001.

Trust Fund Allocation. Payments to plans will be made with funds withdrawn from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The allocation from each fund will be determined each year by the Secretary of HHS, based on the relative weight that benefits from each fund contribute to the determination of the Medicare payment amounts.

Right to Inspect and Audit. The Medicare Choice contract will provide that the Secretary, or the Secretary's designee, will have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract; the facilities of the plan's sponsor; and the books and records of the plan sponsor that pertain to the ability of the sponsor to bear responsibility for potential financial losses. The Secretary will also require a Medicare Choice plan sponsor to provide notice to enrollees in the event of termination of the plan's contract and include in the notice a description of each enrollee's options for obtaining benefits.

Rate Disclosure. Each Medicare Choice plan must submit to the Secretary of HHS a table of its rates for all actuarial categories of beneficiaries prior to contract approval by the Secretary.

Risk of Insolvency. Medicare Choice plan sponsors must make adequate provision against the risk of insolvency, including provisions to prevent the plan's enrollees from being held liable to any person or entity for the plan sponsor's debts in the event of the plan sponsor's insolvency.

User Fees. The Secretary may require plans to share in the cost of disseminating information to beneficiaries.

Plan Service Areas. Medicare Choice plan service areas must correspond to Medicare payment areas. The Secretary of HHS may waive this requirement and approve service areas that are smaller than Medicare payment areas if the Secretary determines that the service areas are not defined so as to discriminate against any population.

Beneficiary Protection upon Contract Termination. A Medicare Choice plan terminating its contract with the Secretary of HHS must arrange for supplementary coverage for its Medicare enrollees for the duration of any preexisting condition exclusion under the enrollee's successor coverage for the lesser of 6 months or the duration of the exclusion period.

Prompt Payment. Medicare Choice plan sponsors must provide prompt payment for covered items and services to providers who are not under contract with the plan. If the Medicare Choice plan sponsor does not provide prompt payment, the Secretary may pay such providers directly and deduct the payment amount from the payments made to the Medicare Choice plan.

Intermediate Sanctions. The Secretary of HHS may impose certain lesser intermediate sanctions, including suspension of enrollment or payment and imposition of civil monetary penalties. These sanctions may be applied for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation.

Contract Termination and Due Process. A contract may be terminated by the Secretary of HHS at any time if the organization no longer meets the Medicare Choice plan requirements. Prior to terminating a contract for non-compliance on a Medicare Choice plan sponsor, the Secretary will provide the Medicare Choice plan sponsor with the opportunity to develop and implement a corrective action plan. The Secretary must also provide the Medicare Choice plan sponsor with the opportunity for a hearing, including the opportunity to appeal an initial decision, before terminating the contract.

Previous Termination. The Secretary may not enter into a contract with a Medicare Choice plan sponsor if a previous contract with the plan sponsor was terminated within the previous five years, except in circumstances that warrant special consideration.

OTHER PROVISIONS

Restrictions on Enrollment for Certain Medicare Choice Plans. A Medicare Choice religious fraternal benefit society plan could restrict enrollment to individuals who are members of the church, convention, or group with which the society is affiliated. A Medicare Choice religious fraternal benefit society plan would be a Medicare Choice plan that (i) is offered by a religious fraternal benefit society only to members of the church, convention, or affiliated group, and (ii) permits all members to enroll without regard to health status-related factors. This provision could not be construed as waiving plan requirements for financial solvency. In developing solvency standards, the Secretary would take into account open contract and assessment features characteristic of fraternal insurance certificates. Under regulations, the Secretary would provide for adjustments to payment amounts under section 1854 to assure an appropriate payment level, taking account of the actuarial characteristics of the individuals enrolled in such a plan.

A religious fraternal benefit society is an organization that (i) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code; (ii) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches; (iii) offers, in addition to a Medicare Choice religious fraternal benefit society plan, at least the same level of health coverage to individuals entitled to Medicare benefits who are members of such church, conven-

tion, or group; and (iv) does not impose any limitation on membership in the society based on any health status-related factor.

TRANSITION RULES

Existing Medicare HMO risk-contract plans are pre-approved as Medicare Choice plans and have up to three years to meet any new or different standards.

The Secretary would be prohibited from entering into, renewing, or continuing any risk-sharing contract under section 1876 for any contract year beginning on or after the date Medicare Choice standards are first established for Medicare Choice organizations that are insurers or HMOs. If the organization had a contract in effect on that date, the prohibition would be effective one year later. The Secretary could not enter into, renew, or continue a risk-sharing contract for any contract year beginning on or after January 1, 2000. An individual who is enrolled in Medicare part B only and also in an organization with a risk-sharing contract on December 31, 1998 could continue enrollment in accordance with regulations issued not later than July 1, 1998.

CHAPTER 2: PROVISIONS RELATING TO MEDICARE SUPPLEMENTAL INSURANCE

PORTABILITY AND OTHER CHANGES

Present Law

1. *Medigap Portability*. Medicare beneficiaries have a 6-month open enrollment period to purchase a Medigap insurance policy when they first turn 65. During this open enrollment period, medical underwriting (i.e. requiring a beneficiary to pass a physical exam in order to be able to purchase insurance) is prohibited. After this initial 6-month open enrollment period seniors maybe unable to purchase a Medigap policy if they are forced to change their Medigap insurer or if their employer stops providing retiree health benefits.

2. *Preexisting Condition Limitations*. A 6 month pre-existing condition limitation is currently allowed during the initial open enrollment period available to beneficiaries when they first become eligible for Medicare benefits.

3. *Medigap for the Medicare Disabled*. The 6 month open enrollment period available to Medicare beneficiaries to purchase a Medigap insurance policy without any medical underwriting applies only to beneficiaries turning 65 years old.

4. *Standard Benefit Packages*. Current law requires that all Medigap policies conform with one of ten authorized standard policies. These standard policies range from very basic cost sharing coverage to very rich cost sharing plus coverage plus coverage of extra benefits.

Reason for Change

When a Medicare beneficiary decides to leave the traditional Medicare program to try a Medicare Choice plan, they no longer need their supplemental coverage (Medigap) policy because most (if not all) Medicare Choice plans will cover the ''gaps'' that traditional

Medicare does not cover. However, Medicare beneficiaries who want to try a Medicare Choice plan may be discouraged from doing so because once they give up their Medigap policy to enroll in a Medicare Choice plan, they may never be able to purchase that policy at the same price again if they should decide to return to traditional Medicare. This is because their guaranteed issue period expired six months after becoming eligible for Medicare at age 65.

In addition, the 10 standardized Medigap policies all include first dollar coverage which creates an incentive for over-utilization of Medicare services. A Medigap policy option with a high deductible and lower premiums may help to reduce incentives for overutilization of Medicare services.

Committee Provision

Current Medigap Laws will be amended as follows:

1. *Portability.* Medigap insurers would be required to sell a Medigap insurance policy without underwriting during a 63 day period if:

(a) an individual covered under a Medigap policy, discontinues that policy to enroll in a Medicare Choice plan or a Medicare Select plan and then decides—before the end of their first 12 months of their first enrollment—to return to the traditional Medicare program;

(b) an individual enrolls in a Medicare Choice plan upon turning 65 and then decides—before the end of their first 12 months—to disenroll and enroll in the traditional Medicare program;

(c) an individual loses their employer sponsored retiree health benefits,

(d) an individual insured by a Medigap plan, a Medicare Choice plan, or a Medicare Select plan moves outside the state in which the insurer is licensed, moves outside the plan's or the insurer's service area, or the insurer or health plan goes out of business or withdraws from the market; or has its Medicare contract terminated.

(Note. In the case of a beneficiary who previously owned a Medigap policy, that individual would not be guaranteed issued a Medigap plan with benefits which are greater than those contained in the individual's previous policy.)

2. *Pre-existing Condition Exclusions.* Medigap insurers will no longer be allowed to impose pre-existing condition exclusions during guaranteed issue periods (i.e. during first 6 months of Medicare eligibility, and during the new guaranteed issue periods listed above under portability.)

3. *Guarantee issue for the Disabled.* Provides a one time open enrollment period for disabled Medicare beneficiaries during the six month period after they first become eligible for Medicare.

4. *New Medigap High Deductible Option.* The 10 standard Medigap policies will be amended to allow an optional high deductible feature. Under this provision, a State must choose one or more of the current 10 Medigap standard policies and authorize the sale of those policies with an optional high deductible feature. The new products will be authorized to have an annual $1,500 deductible before the policy begins paying benefits.

Effective Date

January 1, 1998.

CHAPTER 3: PACE PROGRAM

Present Law

OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. These projects, known as the Programs of All Inclusive Care for the Elderly, or PACE projects, were intended to determine whether an earlier demonstration program, ON LOK, could be replicated across the country. OBRA 90 expanded the number of organizations eligible for waivers to 15.

Committee Provision

The provision would repeal current ON LOK and PACE project demonstration waiver authority and establish in Medicare law PACE as a permanent benefit category eligible for coverage and reimbursement under the Medicare program. PACE providers would offer comprehensive health care services to eligible individuals in accordance with a PACE program agreement and regulations. In general, PACE providers would be public or private nonprofit entities, except for entities (up to 10) participating in a demonstration to test the operation of a PACE program by private, for-profit entities.

CHAPTER 4: DEMONSTRATIONS

MEDICARE MEDICAL SAVINGS ACCOUNT DEMONSTRATION

Present Law

Medical Savings Accounts are not currently an option for Medicare beneficiaries.

Reason for Change

The intention of this act is to give Medicare beneficiaries the same choices for health care delivery as the private sector currently has, including Medical Savings Accounts. In addition, Medical Savings Accounts coupled with high-deductible insurance policies discourage over-utilization of health care items and services and therefore help to slow the growth in health care spending.

Committee Provision

Medicare beneficiaries will be able to elect as a Medicare Choice option, a medical savings account high deductible insurance policy in combination with a medical savings account. The high deductible insurance policy must provide reimbursement for at least the items and services covered under Medicare Parts A and B—but only after the enrollee incurs countable expenses equal to the amount of an

annual deductible of not more than $2,250 and not less than $1,500 in 1999, updated annually by an inflation factor.

To the extent an individual chooses such a plan, the Secretary of Health and Human Services would pay the premium of the high deductible insurance policy and also make an annual contribution to the beneficiary's medical savings account equal to the difference between the premium of the insurance policy and the Medicare Choice capitation rate in the beneficiary's county. Only contributions by the Secretary of Health and Human Services could be made to a Medicare Choice MSA and such contributions would not be included in the taxable income of the Medicare Choice MSA holder.

Contributions to the enrollee's MSA can be used by the enrollee to pay for any medical care they choose. Withdrawals from Medicare Choice MSAs are excludable from taxable income if used for qualified medical expenses regardless of whether an account holder is enrolled in an MSA Plan at the time of the distribution. Withdrawals for purposes other than qualified medical expenses are includable in taxable income. An additional tax of 50% of the amount includible in taxable income applies to the extent total distributions for purposes other than qualified medical expenses in a taxable year exceed the amount by which the value of the MSA (as of December 31 of the preceding taxable year) exceeds 60 percent of the MSA plan's deductible.

Any MSA plan purchased by a Medicare beneficiary must include a cap on out-of-pocket costs of $3,000.

The demonstration will be limited to the first 100,000 Medicare beneficiaries who enroll and new enrollments will not be permitted after January 1, 2003.

An exception to the enrollment and date limits listed above will be made for individuals who already have tax-deductible MSAs upon turning 65. These individuals will be permitted to retain qualified MSAs under Medicare Choice without respect to this demonstration's limit on enrollment or sunset date.

Effective Date

January 1, 1998.

COMPETITIVE PRICING DEMONSTRATION FOR MEDICARE CHOICE

Present Law

Under section 402 of the Social Security Amendments of 1967 (P.L. 90–248, 42 U.S.C. 1395b–1), the Secretary is authorized to develop and engage in experiments and demonstration projects for specified purposes, including to determine whether, and if so, which changes in methods of payment or reimbursement for Medicare services, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of such health services.

Reason for Change

Under the authority described above, HCFA is currently seeking to demonstrate the application of competitive pricing as a method

for establishing payments for risk contract HMOs in the Denver area. HCFA's actions have been challenged in the courts.

Committee Provision

An Office of Competition would be established within the Department of Health of Human Services to negotiate with plans and administer the competitive pricing process.

Plans would submit a premium amount based on core benefit package which must include benefits currently provided under Medicare A & B plus prescription drugs. The Office of Competition would calculate the weighted average premium—90% would be paid by Medicare and 10% by the enrollee. Plans would be allowed to offer two standardized supplemental benefit packages to be included in the comparative information given to beneficiaries.

The Secretary must establish a technical advisory group in each demonstration site that includes plan representatives, beneficiaries, employers and providers. The Secretary must meet with the technical advisory group at least monthly beginning six months prior to the demonstration and regularly throughout the implementation period.

Standardized Medicare payment amount (government contribution)

Not later than June 1 of each year, the Office of Competition would solicit premium bids on a core package of standardized benefits.

The government contribution would be set at the weighted average of the premium bids. The Office of Competition would have the authority to negotiate with plans to adjust their premium bids to ensure that the standardized Medicare payment amount would never be greater than per capita fee- for-service spending in that area.

The Office of Competition would negotiate with plans to ensure that premiums are actuarially sound and fair and do not foster adverse selection.

The standardized Medicare payment amount would be adjusted upward or downward at the time the beneficiary enrolls in the plan according to their health status. The beneficiary's share of the premium would be based on the standardized Medicare payment amount regardless of the risk adjustment made to the amount the plan is paid.

Enrollees cost-sharing

Beneficiaries would be required to pay a minimum of 10% of the premium. If seniors choose a plan that costs less than the standardized Medicare payment amount, their premium will be lower. If seniors choose a plan that costs more than the federal payment, they will have to pay the difference.

Transition/Phase-in

Beginning on January 1, 1999, this competitive pricing model would be tested as a demonstration in 10 urban areas with less than 25% Medicare HMO penetration and 3 rural markets. By December 31, 2001, the Secretary will evaluate the demonstration project. The President will make a legislative recommendation to

Congress on whether the method of paying plans as tested in the demonstration project should be extended to the entire Medicare population.

Effective Date

Payment under the demonstration will begin on January 1, 1999. The demonstration will last no longer than December 31, 2002. The Office of Competition will be established upon enactment.

MEDICARE ENROLLMENT DEMONSTRATION

Present Law

HMOs with Medicare contracts may directly market to and enroll Medicare beneficiaries.

Reason for Change

There is some evidence that allowing plans to conduct their own enrollment operations may lead to greater risk selection (i.e. "cherry picking" healthier beneficiaries). One possible solution to this would be to require all beneficiaries to enroll through HCFA. However a preferred option would be to requiring plans to contract with a private third party enroller approved by the Secretary.

Committee Provision

The Secretary is authorized to conduct a demonstration for using a third-party contractor to conduct the Medicare Choice plan enrollment and disenrollment functions in an area. Such demonstration shall be conducted separately from the Medicare competitive pricing demonstrations. In conducting the demonstrations the Secretary must:

1. Consult with affected parties on the design of the demonstration, selection criteria for the third party contractor, and the establishment of performance standards
2. Establish performance standards relative to accuracy and timeliness. Should the third-party broker not comply with these standards, the enrollment and disenrollment functions would immediately revert to the Medicare Choice plans.
3. In the case of a dispute between the Secretary and the Medicare Choice plans in the demonstration regarding compliance with the standards, the plans shall conduct these functions.

EXTENSION AND EXPANSION OF SOCIAL HMO DEMONSTRATION

Present Law

The Deficit Reduction Act of 1984 required the Secretary to grant 3-year waivers for demonstrations of social health maintenance organizations (SHMOs) which provide integrated health and long-term care services on a prepaid capitation basis. The waivers have been extended on several occasions since then and a second generation of projects was authorized by OBRA 90.

Committee Provision

The provision would require the Secretary to extend waivers for SHMOs through December 31, 2000, and to submit a final report on the projects by March 31, 2001. The limit on the number of persons served per site would be expanded from 12,000 to 36,000. The Secretary also would be required to submit to Congress by January 1, 1999, a plan, including an appropriate transition, for the integration of health plans offered by first and second generation SHMOs and similar plans into the Medicare Choice program. The report on the plan would be required to include recommendations on appropriate payment levels for SHMO plans, including an analysis of the extent to which it is appropriate to apply the Medicare Choice risk adjustment factors to SHMO populations.

COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS

Present Law

OBRA 87 required the Secretary to conduct demonstration projects to test a prepaid capitated, nurse-managed system of care. Covered services include home health care, durable medical equipment, and certain ambulatory care services. Four sites (Mahomet, Illinois; Tucson, Arizona; New York, New York; and St. Paul, Minnesota) were awarded contracts in September, 1992, and represent a mix of urban and rural sites and different types of health provider, including a home health agency, a hospital-based system, and a large multi-specialty clinic. The community nursing organization (CNO) sites completed development activities and implemented the demonstration in January 1994, with service delivery beginning February 1994.

Committee Provision

The provision would extend the CNO demonstration for an additional period of 2 years, and the deadline for the report on the results of the demonstration would be not later than 6 months before the end of the extension.

MEDICARE COORDINATED CARE DEMONSTRATION

Present Law

No provision.

Reason for Change

A study sponsored by the Physician Payment Review Commission (PPRC) concluded that ''an effective case management program could help Medicare patients who are chronically ill or who are facing costly, complex treatment options. Based on experience of private payers, these Medicare patients would receive more appropriate medical care and Medicare would experience lower claims cost relative to the current program, which lacks a coordination of care function.''

Committee Provision

The Secretary would be required to establish a demonstration program to evaluate methods such as case management and other models of coordinated care that improve the quality of care and reduce Medicare expenditures for beneficiaries with chronic illnesses enrolled in traditional Medicare.

The Secretary would be required to examine best practices in the private sector for coordinating care for individuals with chronic illnesses for one year and, using the results of the evaluation, establish at least nine demonstration projects (6 urban and 3 rural) within 24 months of the date of enactment.

Not later than two years after implementation, the Secretary would be required to evaluate the demonstrations and submit a report to Congress. The evaluation would have to address, at a minimum, the cost-effectiveness of the demonstration projects, quality of care received by beneficiaries, beneficiary satisfaction, and provider satisfaction. If the evaluation showed the demonstration project to either reduce Medicare expenditures or to not increase Medicare expenditures while increasing the quality of care received by beneficiaries and increasing beneficiary satisfaction, the Secretary would continue the project in the demonstration sites, and could expand the number of demonstration sites to implement the program nationally. The Secretary would be required to submit a report to Congress every two years for as long as the demonstration project continued.

In carrying out the demonstration projects, the Secretary would be required to provide that the aggregate payments in Medicare be no greater than what such payments would have been if the demonstration projects had not been implemented. Such sums as necessary would be authorized to be appropriated for the purpose of evaluating and reporting on the demonstrations.

MEDICARE SUBVENTION DEMONSTRATION PROJECT

Present Law

Under current law, Medicare is prohibited from reimbursing for any services provided by a Federal health care provider, unless the provider is determined by the Secretary of Health and Human Services to be providing services to the public generally as a community institution or agency or is operated by the Indian Health Service. In addition, Medicare is prohibited from making payment to any Federal health care provider who is obligated by law or contract to render services at the public expense.

Reasons for Change

The Committee provision is intended to provide for greater access by Medicare-eligible military retirees to military treatment facilities (MTFs) operated by the Department of Defense, and greater access by veterans to medical centers operated by the Department of Veterans Affairs.

Committee Provision

The Committee provision would establish two, three-year demonstration projects under which Medicare would reimburse the Department of Defense and the Department of Veterans Affairs for medical care provided to Medicare-eligible military retirees and veterans, respectively. The Secretary of Health and Human Services would enter into agreements with the Secretary of Defense and the Secretary of Veterans Affairs on the specifications of each demonstration project; these agreements would be transmitted to Congress prior to operation of the demonstration projects. Both demonstration projects permit Medicare payment for services on a fee-for-service basis and as a capitated payment for services provided in managed care organizations operated by each department. The Medicare outlays for both demonstrations are capped, and both departments would be required to maintain current levels of efforts.

Effective Date

January 1, 1998.

CHAPTER 5: COMMISSIONS

ESTABLISHMENT OF THE NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE

Present Law

No provision.

Reasons for Change

In 1995, expenditures out of the Hospital Insurance (HI or Part A) Trust Fund exceeded all sources of revenues into the Trust Fund. The Medicare Trustees predict in their 1997 annual report that in 2001 Medicare will out-spend its revenues and spend down its current surplus, becoming insolvent with a $23.4 billion shortfall. This shortfall grows rapidly to over *one half trillion dollars* in 2007. And, this is before the baby-boomers begin to retire in 2010.

In the long-term, demographic trends will continue to increase financial pressure on the HI Trust Fund, challenging its ability to maintain our promise to beneficiaries. Today, there are less than 40 million Americans who qualify to receive Medicare. By the year 2010, the number will be approaching 50 million, and by 2020, it will be over 60 million. While these numbers are increasing, the number of workers supporting retirees will decrease. Today, there are almost four workers per retiree, but in 2030 there will be only about two per retiree.

The National Bipartisan Commission on the Future of Medicare will serve as an essential catalyst, and ultimately lead to a solution that will preserve and protect the Medicare program for current beneficiaries, their children, grandchildren, and great-grandchildren.

Committee Provision

The National Bipartisan Commission on the Future of Medicare will be established to:

1. review and analyze the long-term financial condition of both Medicare Trust Funds;
2. identify problems that threaten the financial integrity of both the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds;
3. analyze potential solutions that ensure the financial integrity and the provision of appropriate benefits including the extent to which current Medicare update indexes do not accurately reflect inflation;
4. make recommendations to restore solvency of the HI Trust Fund and the financial integrity of the SMI Trust Fund through the year 2030;
5. make recommendations for establishing the appropriate financial structure of the program as a whole;
6. make recommendations for establishing the appropriate balance of benefits covered and beneficiary contributions;
7. make recommendations for the time periods during which the Commission's recommendations should be implemented;
8. make recommendations regarding the financing of graduate medical education (GME), including consideration of alternative broad-based sources of funding for such education and funding for institutions not currently eligible for Medicare GME support that conduct approved graduate medical residencies, such as children's hospitals;
9. make recommendations on the feasibility of allowing individuals between the age of 62 and Medicare eligibility age to buy into the Medicare program; and
10. make recommendations on the impact of chronic disease and disability trends on future costs and quality of services under the current benefit, financing, and delivery system structure of the Medicare program.

The Commission will consist of 15 members, appointed in the following manner:

3 by the President;

6 by the House of Representatives (not more than 4 from the same political party);

6 by the Senate (not more than 4 from the same political party); and

the Chairman will be designated by the joint agreement of the Speaker of the House of Representatives and the Majority Leader of the Senate.

Members of the Commission may be appointed from both the public and private sector.

The Commission must submit a report to the President and Congress no later than 12 months from the date of enactment.

The Commission terminates 30 days after the report is submitted.

Funding is authorized to be appropriated from both Medicare Trust Funds.

Effective Date

Upon enactment.

THE MEDICARE PAYMENT REVIEW COMMISSION

Current Law

The Prospective Payment Assessment Commission was established by Congress through the Social Security Act Amendments of 1983 (P.L. 98–21). The Commission is charged with reporting each year its recommendation of an update factor for PPS payment rates and for other changes in reimbursement policy. It is also required each year to submit a report to Congress which provides background information on trends in health care delivery and financing. The Physician Payment Review Commission was established by the Congress through the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99–272). It was charged with advising and making recommendations to the Congress on methods to reform payment to physicians under the Medicare program. In subsequent laws, Congress mandated additional responsibilities relating to the Medicare and Medicaid programs as well as the health care system more generally.

The law specified that both Commissions were to be appointed by the Director of the Office of Technology Assessment and funded through appropriations from the Medicare trust funds. In 1995, the Office of Technology Assessment was abolished. In May 1997, P.L.105–13 was enacted; this legislation extended the terms of those Commission members whose terms were slated to expire in 1997 to May 1, 1998.

Reason for Change

Both the ProPAC, which is responsible for hospital and health facilities payment policy, and the PPRC, which is responsible for physician payment policy and other Part B issues, have assumed critically important roles in assisting Congress with oversight and policy making for the Medicare program. However, with fee-for-service payment policy becoming relatively mature after years of refinement, Congress will require guidance in the future primarily in the Medicare Choice area. This area will require evaluation and oversight best suited for a single commission which can view the Medicare program in terms of an integrated totality between Parts A and B.

Committee Provision

The Medicare Payment Review Commission will be formed to replace the Physician Payment Review Commission and the Prospective Payment Assessment Commission. The new Medicare Payment Review Commission (MPRC) will submit an annual report to Congress containing an examination of issues affecting the Medicare program.

The Commission will review, and make recommendations to Congress concerning, payment policies under both the Medicare Choice program and the Medicare fee-for-service program.

Membership

The Commission will be composed of 15 members appointed by the Comptroller General. The members will include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of services, and other related fields. The membership will also include representatives of consumers and the elderly.

TAX TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS

Present Law

To qualify as a charitable tax-exempt organization described in Internal Revenue Code (the "Code") section 501(c)(3), and organization must be organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster international sports competition, or for the prevention of cruelty to children or animals. Although section 501(c)(3) does not specifically mention furnishing medical care and operating a nonprofit hospital, such activities have long been considered to further charitable purposes, provided that the organization benefits the community as a whole.

No part of the net earnings of a 501(c)(3) organization may inure to the benefit of any private shareholder or individual. No substantial part of the activities of a 501(c)(3) organization may consist of carrying on propaganda, or otherwise attempting to influence legislation, and such organization may not participate in, or intervene in, any political campaign on behalf of (or in opposition to) any candidate for public office. In addition, under section 501(m), an organization described in section 501(c)(3) or 501(c)(4) is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance.

A tax-exempt organization may, subject to certain limitations, enter into a joint venture or partnership with a for-profit organization without affecting its tax-exempt status. Under current ruling practice, the IRS examines the facts and circumstances of each arrangement to determine (1) whether the venture itself and the participation of the tax-exempt organization therein furthers a charitable purpose, and (2) whether the sharing of profits and losses or other aspects of the arrangement entail improper private inurement or more than incidental private benefit.

Committee Provision. The proposal would provide that an organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of Code section 501(c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization ("PSO") (as defined in section 1845(a)(1) of the Social Security Act), whether or not such PSO is exempt from tax. Thus, participation by a hospital in a PSO (whether taxable or tax-exempt) would be deemed to satisfy the first part of the inquiry under current IRS ruling practice.

The proposal would not change present-law restrictions on private inurement and private benefit. However, the proposal would provide that any person with a material financial interest in such a PSO shall be treated as a private shareholder or individual with respect to the hospital for purposes of applying the private inurement prohibition in Code section 501(c)(3). Accordingly, the facts and circumstances of each PSO arrangement would be evaluated to determine whether the arrangement entails impermissible private inurement or more than incidental private benefit (e.g., where there is a disproportionate allocation of profits and losses to the non-exempt partners, the tax-exempt partner provides property or services to the joint venture at less than fair market value, or a non-exempt partner receives more than reasonable compensation for the sale of property or services to the joint venture).

The proposal would not change present-law restrictions on lobbying and political activities. In addition, restrictions of Code section 501(m) on the provision of commercial-type insurance would continue to apply.

Subtitle B—Prevention Initiatives

ENHANCED COVERAGE FOR MAMMOGRAPHY SERVICES

Present Law

Under current law, Medicare provides coverage for screening mammograms. The frequency of coverage depends on the age and risk factors of the woman. For women ages 35–39, one test is authorized. For women ages 40–49, one mammogram is covered every 24 months, except an annual test is authorized for women at high risk for breast cancer. Annual mammograms are covered for women ages 50–64. For women aged 65 and over, Medicare covers one mammogram every 24 months. Medicare's Part B deductible and Part B coinsurance apply for these services.

Reasons for Change

The Committee provision would expand Medicare's coverage rules for mammograms.

Committee Provision

The Committee provision would authorize annual mammograms for all women ages 40 and over, and waive co-insurance payments for beneficiaries.

Effective Date

January 1, 1998.

NEW COVERAGE FOR COLORECTAL SCREENING

Present Law

Medicare does not cover colorectal cancer screening procedures. Such services are only covered as diagnostic services.

Reasons for Change

The Committee proposal would establish a new screening benefit for Medicare beneficiaries.

Committee Provision

The Committee provision would authorize coverage of colorectal cancer screening tests, and provide the Secretary, after consultation with appropriate organizations, to determine which screening procedures shall be reimbursed, payment amounts or limits for each procedure, and the frequency of each procedure, with consideration for risk factors. The Committee provision would direct the Secretary to promulgate the regulation three months following date of enactment. The Committee notes the Administration's Medicare reform proposal contained a provision to provide coverage of preventive colorectal screening. The Committee expects that this provision will be implemented expeditiously.

Effective Date

January 1, 1998.

DIABETES SELF-MANAGEMENT BENEFIT

Present Law

Medicare covers home blood glucose monitors and associated testing strips for certain diabetes patients. Home blood glucose monitors enable diabetics to measure their blood glucose levels and then alter their diets or insulin dosages to ensure that they are maintaining an adequate blood glucose level. Home glucose monitors and testing strips are covered under Medicare's durable medical equipment benefit. Coverage of home blood glucose monitors is currently limited to certain diabetics, formerly referred to as Type I diabetics, where: (1) the patient is an insulin-treated diabetic; (2) the patient is capable of being trained to use the monitor in an appropriate manner, or, in some cases, another responsible person is capable of being trained to use the equipment and monitor the patient to assure that the intended effect is achieved; and (3) the device is designed for home rather than clinical use.

Reasons for Change

The Committee provision provides for improved diabetes management benefits.

Committee Provision

The Committee provision would include among Medicare's covered benefits diabetes outpatient self-management training services. These services would include educational and training services furnished to an individual with diabetes by or under arrangements with a certified provider in an outpatient setting meeting certain quality standards. These services would be covered only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care to provide the individual with necessary skills and knowledge (in-

cluding skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

Certified providers for these purposes would be defined as physicians or other individuals or entities that, in addition to providing diabetes outpatient self-management training services, provide other items or services reimbursed by Medicare. Providers would have to meet quality standards established by the Secretary. They would be deemed to have met the Secretary's standards if they meet standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards of the Board, or if they are recognized by an organization representing persons with diabetes as meeting standards for furnishing such services.

In establishing payment amounts for diabetes outpatient self-management training provided by physicians and determining the relative value for these services, the Secretary would be required to consult with appropriate organizations, including organizations representing persons or Medicare beneficiaries with diabetes.

In addition, the provision would extend Medicare coverage of blood glucose monitors and testing strips to Type II diabetics and without regard to a person's use of insulin (as determined under standards established by the Secretary in consultation with appropriate organizations). The provision would also reduce the national payment limit for testing strips by 10 percent beginning in 1998.

The Secretary, in consultation with appropriate organizations, would be required to establish outcome measures for purposes of evaluating the improvement of the health status of Medicare beneficiaries with diabetes. The Secretary would also be required to submit recommendations to Congress from time to time on modifications to coverage of services for these beneficiaries.

Effective Date

January 1, 1998.

COVERAGE OF BONE MASS MEASUREMENTS

Present Law

Medicare does not have a uniform national policy for coverage of bone mass measurement.

Reason for Change

Many Medicare coverage decisions are made locally by individual carriers, that is, contractors to the Medicare program who process claims for payment for Part B items and services. There is no consistent national policy regarding payment for bone mass measurement. Early detection of bone mass loss is important for women at high risk of developing osteoporosis.

Committee Provision

The Committee provision would authorize coverage of bone mass measurement for the following high-risk individuals: an estrogen-deficient woman at clinical risk for osteoporosis; an individual with vertebral abnormalities; an individual receiving long-term

glucocorticoid steroid therapy, an individual with primary hyperparathyroidism, and an individual being monitored to assess osteoporosis drug therapy.

Effective Date

January 1, 1998.

Subtitle C—Rural Initiatives

Present Law

The Medicare program includes a number of provisions to help rural seniors receive health services and for Medicare to pay fairly in rural areas.

Athough the standardized amount under the Medicare Prospective Payment System (PPS) paid to hospitals is the same whether they are rural or urban, there are adjustments to that base payment that are lower for rural areas reflecting the lower cost of health care in rural America. The wage index, for example, in a rural area is often significantly lower than in an urban area.

Certain rural hospitals do receive improved payments over other rural hospitals, or, they can also have greater flexibility than urban hospitals in their delivery of care. The following are some of the special rural hospital designations:

1. Sole Community Hospitals (SCH): geographically isolated hospitals that represent the only readily available source of inpatient care in an area. SCHs are paid the highest of three amounts: (1) payment based on hospital-specific costs in 1982, updated to the current year; (2) payment based on hospital-specific costs in 1987, updated to the current year; or (3) the PPS payment for the hospital. About 60% of SCHs currently receive payment based on their hospital-specific base year costs (about 728 hospitals are SCHs).

2. (Expired provision) Small rural Medicare Dependent hospitals (MDHs): the designation of Medicare dependent, small rural hospitals expired on September 30, 1994. These hospitals were reimbursed on the same basis as sole community hospitals. MDHs were hospitals with 100 beds or less located in a rural area and that had more that 60% of its inpatient days attributable to Medicare (in FY 1994, about 390 hospitals were MDHs). Since the provision expired, these hospitals have been receiving PPS payments.

3. Rural Referral Centers (RRCs): relatively large rural hospitals with at least 275 beds or that meet specific criteria indicating that they receive a high referral from other hospitals. (about 130 hospitals are designated RRCs).

4. Limited-Service Hospitals: under current law, there are several demonstration projects that are in place allowing hospitals in rural communities greater flexibility in delivering care. There is also a grant program to help states coordinate the type of care delivered among limited service hospitals.

a. Rural Health Care Transition Act: up to $50,000 per year available to nonprofit acute care hospitals in rural areas with less than 100 beds. The grants can be used for improvement

of outpatient or emergency services, recruitment of health professionals, or development of alternative delivery systems (the program is extended through FY 1997. In FY 1995, grants were made to 129 facilities in 44 states).

b. Medical Assistance Facility (MAF) Demonstration: only in the State of Montana, a category of facilities in remote rural areas that do not qualify as full-service hospitals but provide emergency services and short-term inpatient care. Funding is through July 1, 2000.

c. Essential Access Community Hospitals Demonstration Projects (EACH/RPCH): Provides $25 million per year in grants to establish rural networks for EACH/RPCHs. RPCHs are facilities in rural areas that do not qualify as full-service hospitals but provide temporary inpatient care to patients requiring stabilization prior to discharge or transfer to another hospital. EACHs provide emergency and medical backup services to RPCHs participating in the network (7 states: WV, CA, CO, KS, NY, NC, and SD are participating in the demonstration program).

5. Rural Health Clinics (RHCs). The RHC program provides Medicare and Medicaid reimbursement to health clinics in underserved rural communities. Medicare reimburses RHCs on the basis of their actual costs for providing care. Once certified as an RHC, a clinic remains eligible for cost reimbursement indefinitely, even if the area it serves no longer qualifies as rural or underserved.

6. Telemedicine. Under a Health Care Financing Administration (HCFA) demonstration, Medicare began reimbursing telemedicine services in 1996 at five sites in four states—North Carolina, West Virginia, Iowa and Georgia. HCFA is analyzing the demonstration to determine which telemedicine services should be covered and how. Outside of the demonstration project, Medicare reimburses only for certain physician services. HCFA does not have the authority to reimburse all physician consultations made with the use of telemedicine. Medicare requires a face-to-face encounter in order to cover consultation services, unless standard medical practice does not require face-to-face contact as in the case of radiology.

Reasons for Change

Rural providers are often financially dependent on Medicare payments. The provisions assist rural areas to continue to provide high quality, cost effective access to health services.

Since the Medicare physician fee schedules were established in 1989, the number of clinics participating in the RHC program has grown by over 30 percent a year to nearly 3,000. According to a November, 1996 Government Accounting Office (GAO) report, contrary to its original purpose, the RHC program is generally not focused on serving Medicare and Medicaid populations having difficulty obtaining primary care in isolated rural areas. Rather, the payments are being provided to RHCs that are financially viable clinics in suburban areas. Most RHCs are conversions of existing physician practices that generally do not need the RHC program payments to expand care to underserved portions of the area's pop-

ulation. According to GAO, at many of the RHCs, their providers receive extraordinarily high reimbursement for patient visits, as much as $214 for each patient visit at one clinic compared with an average of $37 received by providers on the Medicare fee schedule.

Committee Provision

The following rural provisions are included in the Chairman's Mark:

1. A fourth reimbursement option is made available to Sole Community Providers; it allows SCHs to choose an alternative target amount based on costs in FY 1994 or FY 1995.

2. The Medicare Dependent Hospital (MDH) program will be reinstated effective for cost reporting periods on or after October 1, 1997. The same program with the expired provisions setting out the criteria of rural hospitals with 100 or less beds and 60 percent of discharges or patient days will be used to identify eligible hospitals. MDHs will receive Medicare payment based on the expired provisions payment arrangement.

3. A new Medicare rural hospital flexibility program will be available to all states. (a) $25 million per year in FY 1998–2002 is authorized for grants available to states seeking to establish a network of access to health care services in rural communities. (b) The provision also creates a new single designation for small rural limited-service hospitals known as Critical Access Hospitals (CAHs). These hospitals must be state certified, more than 35 miles from another hospital, make available 24 hour emergency care services, and can have up to 15 acute care inpatient beds (swing beds are permitted) for providing care not to exceed 96 hours (unless inclement weather or other emergency conditions).

Payment for inpatient and outpatient services provided at CAHs will be made on the basis of reasonable costs of providing such services. Such payment will also continue for designated EACH, RPCH hospitals in effect on September 30, 1997, as well as for the MAF demonstration program.

4. Rural Referral Centers (RRCs) can apply to the Medicare Geographic Classification Review Board to be reclassified for purposes of a wage index adjustment. RRCs could apply without having to meet the wage threshold requiring that the hospital's average hourly wage (AHW) is at least 108% of the statewide rural AHW. The Secretary shall make the adjustment required to allow the change in wage indexes to occur in a budget neutral manner. In addition, any hospital designated as a RRC since fiscal year 1991 is permanently grandfathered.

5. Rural Health Clinics (RHCs). (a) Extends per-visit payment limits applicable to independent rural health clinics to provider-based clinic (with the exception of clinics based in small rural hospitals with less than 50 beds). (b) Requires clinics have a quality assurance and performance program as specified by the Secretary. (c) Limits the nurse practitioner/physician assistant (NP/PA) waiver to clinics already certified as RHCs. Clinics seeking initial certification will be required to meet the NP/PA staffing requirement. (d) Requires triennial recertification of RHCs: (i) the Secretary must certify that

there are insufficient numbers of needed health care practitioners in the clinic's area; (ii) clinics that no longer meet the shortage area requirement will be permitted to retain their designation only if the Secretary determines that they are essential to the delivery of primary care services that would otherwise be unavailable in the area; and (iii) rural health clinics currently owned and operated by PA's will be grandfathered through 2002.

6. Medicare reimbursement for telehealth services in underserved rural areas.

a. The provision requires HCFA to reimburse for telehealth services in underserved rural areas, using the health professional shortage area (HPSA) designation. Reimbursement methodology would (i) provide a bundled payment to be shared between the referring and consulting health care provider that would be no greater than the standard amount paid to the consulting health care provider according to HCFA's current fee schedule for face-to-face encounters, and (ii) prohibit any reimbursement for line charges or other facility fees. The Secretary would also be required to study the possibility for reimbursement for homebound or nursing home-bound seniors.

b. The provision also authorizes $27 million for a 5-year telemedicine demonstration project for high-capacity computing and advanced networks.

The Committee is concerned that HCFA is not fully utilizing existing HCFA telemedicine demonstration projects. The Committee intends that HCFA provide full Medicare payments to all sites and providers affiliated with existing HCFA demonstration projects, regardless of whether the telemedicine equipment at those sites was purchased with HCFA funds or from other federal, state, or private funds.

The Committee is also concerned that the current Medicare telemedicine demonstration does not include rural sites in the Western United States. Therefore, the Committee strongly recommends HCFA extend the demonstration to at least three additional sites located in rural regions of the Western United States. HCFA should use all sites and providers affiliated with the demonstration as well as other willing telemedicine providers within all participating states. To get a cross-sampling of rural Western sites, the following criteria should be met:

The first site—(1) is recognized by its state government as the primary telemedicine project of the state; (2) consists of a consortium of both public and private academic institutions, military establishments, health care providers, telecommunication carriers and Native organizations; (3) is in existence for at least three years; (4) attempts to unite health care facilities throughout the state; (5) exists in a state with communities and Native villages not accessible by roads due to extremes in geography and climate; and (6) exists in a state containing significant Native population.

The second site—(1) is located in a frontier state with an at least two existing telehealth networks that emphasizes mental health care specialty services; (2) has prior experience working with other

third-party payers both public and not-for-profit; and (3) has an existing state-wide network of telehealth sites.

The third site—(1) is located in a Northern Plains state serving a predominantly rural population; (2) offers a full range of specialty health care services; (3) includes at least one network with an emphasis on geriatric and long-term care; and (4) works with at least one mid-level practitioner to provide emergency care services.

Effective Date

All provisions are effective in fiscal year 1998. The MDH program expires on September 30, 2002.

Subtitle D—Anti-Fraud and Abuse Provisions and Improvements in Protecting Program Integrity

CHAPTER 1—REVISIONS TO SANCTIONS FOR FRAUD AND ABUSE

AUTHORITY TO REFUSE TO ENTER INTO MEDICARE AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES

Present Law

Section 1866 of the Social Security Act sets forth certain conditions under which providers may become qualified to participate in the Medicare program. The Secretary may refuse to enter into an agreement with a provider, or may refuse to renew or may terminate such an agreement, if the Secretary determines that the provider has failed to comply with provisions of the agreement, other applicable Medicare requirements and regulations, or if the provider has been excluded from participation in a health care program under section 1128 or 1128A of the Social Security Act. Section 1842 of the Social Security Act permits physicians and suppliers to enter into agreements with the Secretary under which they become "participating" physicians or suppliers under the Medicare program.

Reasons for Change

This provision would help protect against fraud and abuse in the Medicare program.

Committee Provision

The provision would add a new section giving the Secretary authority to refuse to enter into an agreement, or refuse to renew or terminate an agreement, with a provider if the provider has been convicted of a felony under federal or state law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries. This authority would extend to the Secretary's agreements with physicians or suppliers who become "participating" physicians or suppliers under the Medicare program. Similar provisions would apply to the Medicaid program.

Effective Date

On enactment.

EXCLUSION OF ENTITY CONTROLLED BY FAMILY MEMBER OF A SANCTIONED INDIVIDUAL

Present Law

Section 1128 of the Social Security Act authorizes the Secretary of HHS to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program and programs receiving funds under the Title V Maternal and Child Health Services Block Grant, or the Title XX Social Services Block Grant. The Secretary may exclude any entity which the Secretary determines has a person with a direct or indirect ownership or control interest of 5 percent or more in the entity or who is an officer, director, agent, or managing employee of the entity, where that person has been convicted of a specified criminal offense, or against whom a civil monetary penalty has been assessed, or who has been excluded from participation under Medicare or a state health care program. The Committee expects the Secretary to examine the facts and circumstances of each case carefully before applying this penalty.

Reasons for Change

This provision would help protect against fraud and abuse in the Federal programs.

Committee Provision

The provision would specify that if a person transfers an ownership or control interest in an entity to an immediate family member or to a member of the household of the person in anticipation of, or following, a conviction, assessment or exclusion against the person, that the entity may be excluded from participation in Federal health care programs on the basis of that transfer. The terms "immediate family member" and "member of the household" are defined in this section.

ADDITIONAL AUTHORITY TO IMPOSE CIVIL MONEY PENALTIES

Present Law

Section 1128A of the Social Security Act sets forth a list of fraudulent activities relating to claims submitted for payments for items of services under a Federal health care program. Civil money penalties of up to $10,000 for each item or service may be assessed. In addition, the Secretary of HHS (or head of the department or agency for the Federal health care program involved) may also exclude the person involved in the fraudulent activity from participation in a Federal health care program, defined as any program providing health benefits, whether directly or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program). Violations of the anti-kickback statute (sec. 1128B of the Social Security Act) are punishable only as criminal matters.

Reason for Change

The provisions providing for a civil monetary penalty for either contracting with an excluded individual or furnishing items or services ordered by an excluded individual are intended to close loopholes in current law identified by the Inspector General of the Department of Health and Human Services by which individuals excluded from Federal health care programs continue to participate. The anti-kickback civil monetary penalty would provide an intermediate sanction, where such violations under current law may only be prosecuted as criminal offenses.

Committee Provision

The provision would add a new civil money penalty for cases in which a person contracts with an excluded provider for the provision of health care items or services, where the person knows or should know that the provider has been excluded from participation in a Federal health care program. A civil money penalty is also added for cases in which a person provides a service ordered or prescribed by an excluded provider, where that person knows or should know that the provider has been excluded from participation in a Federal health care program. Lastly, a civil monetary penalty is provided for violations of the anti-kickback statute.

The Committee notes that the two new civil monetary penalties for arranging or contracting with an excluded individual, or for providing items or services ordered or prescribed by an excluded individual, do not place an affirmative responsibility on a provider or supplier to determine the excluded status of any individual. Rather, only if a provider or supplier knows or should know of an individual's excluded status, that is, information has come to the attention of a provider or supplier regarding the excluded status of an individual and the provider or supplier acts with deliberate ignorance or reckless disregard of the individual's excluded status, the provider or supplier may be liable for a civil monetary penalty.

Effective Date

On enactment.

CHAPTER 2—IMPROVEMENTS IN PROTECTING PROGRAM INTERGRITY

DISCLOSURE OF INFORMATION, SURETY BONDS, AND ACCREDITATION

Present Law

Section 1834(a) of the Social Security Act establishes requirements for payments under Medicare for covered items defined as durable medical equipment. Home health agencies are required, under Section 1861(o) of the Social Security Act, to meet specified conditions in order to provide health care services under Medicare, including requirements, set by the Secretary, relating to bonding or establishing of escrow accounts, as the Secretary finds necessary for the effective and efficient operation of the Medicare program.

Reasons for Change

This provision would help protect against fraud and abuse in the Medicare program.

Committee Provision

The provision would require that suppliers of durable medical equipment provide the Secretary with full and complete information as to persons with an ownership or control interest in the supplier, or in any subcontractor in which the supplier has a direct or indirect 5 percent or more ownership interest, other information concerning such ownership or control, and a surety bond for at least $50,000. Home health agencies, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies would also be required to provide a surety bond for at least $50,000. The Secretary may impose the surety bond requirement which applies to durable medical equipment suppliers to home health agencies, suppliers of ambulance services, and certain clinics that furnish medical and other health services (other than physicians'' services).

The amendments with respect to suppliers of durable medical equipment would apply to equipment furnished on or after January 1, 1998. The amendments with respect to home health agencies would apply to services furnished on or after such date, and the Secretary of Health and Human Services (HHS) is directed to modify participation agreements with home health agencies to provide for implementation of these amendments on a timely basis. The amendments with respect to ambulance services, certain clinics, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies would take effect on the date of enactment of this Act.

The Committee provision would also authorize the Secretary to require durable medical equipment suppliers to be accredited or to meet equivalent standards.

Effective Date

Various dates.

PROVISION OF CERTAIN IDENTIFICATION NUMBERS

Present Law

Section 1124 of the Social Security Act requires that entities participating in Medicare, Medicaid and the Maternal and Child Health Block Grant programs (including providers, clinical laboratories, renal disease facilities, health maintenance organizations, carriers and fiscal intermediaries), provide certain information regarding the identity of each person with an ownership or control interest in the entity, or in any subcontractor in which the entity has a direct or indirect 5 percent or more ownership interest. Section 1124A of the Social Security Act requires that providers under Part B of Medicare also provide information regarding persons with ownership or control interest in a provider, or in any subcontractor in which the provider has a direct or indirect 5 percent or more ownership interest.

Reasons for Change

This provision would help protect against fraud and abuse in the Medicare program.

Committee Provision

The provision would require that all Medicare providers supply the Secretary with both the employer identification number and social security account number of each disclosing entity, each person with an ownership or control interest, and any subcontractor in which the entity has a direct or indirect 5 percent or more ownership interest. The Secretary of Health and Human Services (HHS) is directed to transmit to the Commissioner of Social Security information concerning each social security account number and to the Secretary of the Treasury information concerning each employer identification number supplied to the Secretary for verification of such information. The Secretary would reimburse the Commissioner and the Secretary of the Treasury for costs incurred in performing the verification services required by this provision. The Secretary of HHS would report to Congress on the steps taken to assure confidentiality of social security numbers to be provided to the Secretary under this section. This section's reporting requirements would then become effective 90 days after submission of the Secretary's report to Congress on confidentiality of social security numbers.

Effective Date

Generally on enactment.

IMPROVEMENT OF EXCLUSION AUTHORITY AND NON–DISCHARGEABILITY OF CERTAIN DEBTS

Present Law

Under the Bankruptcy Code, a provider can assert that any civil monetary penalty due to the Medicare program is discharged and does not survive the bankruptcy proceeding. Current law provides for various causes of exclusion from the Medicare program. However, several bankruptcy courts have held that a provider may not be excluded from Medicare during the pendency of a bankruptcy proceeding because of the court's automatic stay.

Reasons for Change

Current law supports and sustains Medicare fraud and abuse by permitting providers to escape sanctions through the Bankruptcy Code.

Committee Provision

The Committee provision would amend the Social Security Act to specify that any overpayment determined to have occurred due to fraud and civil monetary penalty amounts are not dischargeable under the Bankruptcy Code and that a bankruptcy court cannot bar exclusions from the Medicare program.

Effective Date

On enactment.

IMPROVEMENTS IN PAYMENT METHODOLOGY

Present Law

Under Part B, Medicare continues to pay for certain items or services on basis of reasonable charges. Such items or services include parenteral and enteral nutrition, dialysis equipment, certain medical supplies, and therapeutic shoes. The Secretary has a limited "inherent reasonableness" authority under Part B to adjust the amounts Medicare pays for any item or service that are either grossly excessive or deficient.

Reasons for Change

Replacing reasonable charge methodologies with fee schedules would provide less variability and more appropriate payment for those items or services paid according to reasonable charges, and give providers more predictability of payment and promote greater efficiency in providing items and services. Improved flexibility in the application of the Secretary's inherent reasonableness authority would help ensure that Medicare pays an appropriate amount for medical items and services.

Committee Provision

The Committee provision would permit the Secretary to replace reasonable charge methodologies by fee schedules. The Committee provision would also provide the Secretary with greater flexibility to determine the appropriateness of payment amounts under Part B (excluding physician services) and adjust payment amounts accordingly.

Effective Date

On enactment.

REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION

Present Law

Diagnostic test and durable medical equipment providers may be required by the Secretary to provide certain diagnostic information with submission of a claim for payment. However, that information may be available only to the ordering physician or other health care practitioner.

Reason for Change

Diagnostic test and durable medical equipment providers often do not have diagnostic information readily to them, thereby delaying submission of claims for payments or, in the absence of such information, resulting in a rejection of a claim for payment. Lack of diagnostic information can also impede certain program integrity activities.

Committee Provision

The Committee provision would require physician and other health care practitioners to provide diagnostic information when ordering an item or service from a diagnostic test or durable medical equipment supplier.

Effective Date

January 1, 1998.

REPORT BY GENERAL ACCOUNTING OFFICE ON OPERATION OF FRAUD AND ABUSE CONTROL PROGRAM

Present Law

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) required a report by the General Accounting Office (GAO) not later than January 1, 2000, 2002, and 2004, on the operation of a new Medicare fraud and abuse control program designed to improve investigation and prosecution of fraud against the Medicare program.

Reason for Change

An earlier GAO report would be useful in providing an independent assessment of progress in combating fraud and abuse in the Medicare program.

Committee Provision

The Committee provision would require the first GAO report no later than June 1, 1998.

Effective Date

On enactment.

COMPETITIVE BIDDING AUTHORITY FOR PART B SERVICES

Present Law

Medicare does not use competitive bidding for the selection of providers authorized to provide covered services to beneficiaries.

Reasons for Change

Medicare has the potential of achieving greater value in both price and quality for covered Part B medical items and services with the additional flexibility provided by competitive bidding. Both the General Accounting Office (GAO) and the Inspector General of the Department of Health and Human Services report that private payers using competitive acquisition strategies pay significantly less than Medicare for certain items. Competitive bidding may also increase quality because Medicare currently does not evaluate medical items and services for quality, but quality would be one factor the Secretary would be required to consider in a competitive acquisition process.

Committee Provision

The Committee provision would provide the Secretary with the authority to acquire Part B covered medical items and services (except physician services) through a competitive bidding process.

The Secretary would establish competitive acquisition areas for contract awards for specific items and services. The Secretary may limit the number of contractors in a competitive acquisition to the number needed to meet projected demand for items and services covered under the contracts. Additionally, the Secretary may not award a contract unless the Secretary finds the entity meets quality standards specified by the Secretary.

Generally, the Secretary would be limited in the amount of payment for an item or services to the amount otherwise payable under an applicable fee schedule, unless the Secretary determines an additional amount is warranted by reason of technological innovation, quality improvement, or similar reasons specified by the Secretary.

In using this broad, new authority, the Committee encourages the Secretary to carefully consider any effects on beneficiary choice and on rural areas.

Effective Date

January 1, 1998.

CHAPTER 3—CLARIFICATIONS AND TECHNICAL CHANGES

OTHER FRAUD AND ABUSE RELATED PROVISIONS

Present Law

Section 1128A of the Social Security Act provides for civil monetary penalties for offering inducements to any individual enrolled in a Federal health plan to order or receive any service from a particular provider. Section 1128D provides for safe harbors, advisory opinions, and fraud alerts as guidance regarding application of health care fraud and abuse sanctions. Section 1128E of the Social Security Act directs the Secretary of HHS to establish a national health care fraud and abuse data collection program for the reporting of final adverse actions against health care providers, suppliers, or practitioners.

Reasons for Change

The Committee provision provides for certain technical corrections and improvements to the anti-fraud and abuse provisions enacted as part of the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”).

Committee Provision

The Committee provision would make certain technical changes in provisions added by the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”). In addition, the Committee provision would clarify that Medicare SELECT insurance contracts do not violate section 1128A, as amended by HIPPA, and clarify the

application of waivers provided under 1128B(b)(3) to section 1128A(i)(6).

The Committee provision would also provide that mandatory and permissive exclusions under section 1128 apply to any Federal health care program, defined as any program providing health benefits, whether directly or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program).

The Committee provision would provide for a civil money penalty of up to $25,000 to be imposed against a health plan that fails to report information on an adverse action required to be reported under the health care fraud and abuse data collection program established under HIPPA. The Committee provision would require the Secretary to publicize those government agencies which fail to report information on adverse actions as required.

The application of exclusion authority under section 1128 of the Social Security Act to federal programs would be effective on the date of enactment of this Act. The sanction provision for failure to report adverse action information as required under Section 1128E of the Social Security Act would apply to failures occurring on or after the date of the enactment of this Act. The other amendments made by this section would be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

Effective Date

Generally on enactment.

Subtitle E—Prospective Payment Systems

CHAPTER 1—PROVISIONS RELATING TO PART A

LONG-TERM CARE AND REHABILITATION HOSPITALS (AND UNITS)

Present Law

Rehabilitation and long-term care hospitals are two of the categories of hospitals not paid by the Medicare Prospective Payment System (PPS). These hospitals receive Medicare cost-based payments with special rules. For a complete explanation of these payments, please refer to the section titled "PPS-Exempt Hospital Payments" in Subtitle F—Provisions Relating to Part A.

Reasons for Change

TEFRA payments are not suited, nor were they intended, to be applied over the long run. The Prospective Payment Assessment Commission (ProPAC) recommends replacing current TEFRA payments with a case-mix adjusted prospective payment system that would provide incentives for controlling costs.

Committee Provision

(a) For rehabilitation hospitals and distinct-part units, the Secretary shall establish a case-mix adjusted Prospective Payment System (PPS), effective Fiscal Year 2001. Data will be collected

from all facilities necessary for administering and evaluating such a system. The case-mix adjuster may reflect a patient classification system which assigns patients to groups primarily on the basis of functional status, modified by age and diagnosis.

(b) For long-term care hospitals, the Secretary shall collect data in order to eventually establish a case-mix adjusted PPS. The Secretary shall develop a proposal for an adequate patient classification system which reflects the differences in patient resource use and costs among long-term care hospitals. The Secretary shall collect relevant data necessary for developing, administering, and evaluating such a system. The Secretary shall submit recommendations to the Congress no later than October 1, 1999.

CHAPTER 2—PROVISIONS RELATING TO PART B

Subchapter A—Payment for Hospital Outpatient Department Services

ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS (FDO) FOR CERTAIN OUTPATIENT HOSPITAL SERVICES

Present Law

Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a fee schedule portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs or charges, net of beneficiary cost sharing, and the fee schedule portion is based, in part, on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance. For cost reporting periods beginning on or after January 1, 1991, the hospital cost portion and the ASC cost portion are 42 percent and 58 percent, respectively.

A hospital may bill a beneficiary for the coinsurance amount owed for the outpatient service provided. The beneficiary coinsurance is based on 20 percent of the hospital's submitted charges for the outpatient service, whereas Medicare usually pays based on the blend of the hospital's costs and the amount paid in other settings for the same service. This results in an anomaly whereby the amount a beneficiary pays in coinsurance does not equal 20 percent of the program's payment and does not result in a dollar-for-dollar decrease in Medicare program payments.

Reasons for Change

There is a flaw in the payment formula for certain hospital outpatient department services. As a result, Medicare overpays for such services because a beneficiary's coinsurance payments are not properly credited to reduce Medicare's allowed payment amounts.

Committee Provision

The provision would require that beneficiary coinsurance amounts be deducted after the reimbursement calculation for hos-

pital outpatient services, so that Medicare payments would reflect the full amount of the beneficiary coinsurance. Medicare's payment for hospital outpatient services would equal the blended amount less any amount the hospital may charge the beneficiary as coinsurance for services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

Effective Date

October 1, 1997.

EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES

Present Law

a. Reduction in Payments for Capital-Related Costs.—Hospitals receive payments for Medicare's share of capital costs associated with outpatient departments. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) extended a 10-percent reduction in payments for the capital costs of outpatient departments through FY 1998.

b. Reduction in Payments for Non-Capital-Related Costs.—Certain hospital outpatient services are paid on the basis of reasonable costs. OBRA 93 extended a 5.8-percent reduction for those services paid on a cost-related basis through FY 1998.

Reasons for Change

The Committee provision would establish more appropriate growth in payments.

Committee Provision

a. Reduction in Payments for Capital-Related Costs.—The provision would extend the 10-percent reduction in payments for outpatient capital through FY 1999 and during FY 2000 before January 1, 2000.

b. Reduction in Payments for Non-Capital-Related Costs.—The 5.8-percent reduction for outpatient services paid on a cost basis would be extended through FY 1999 and during FY 2000 before January 1, 2000.

Effective Date

On enactment.

PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Present Law

Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a fee schedule portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the

lower of the hospital's costs or charges, net of beneficiary cost sharing, and the fee schedule portion is based, in part, on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance. For cost reporting periods beginning on or after January 1, 1991, the hospital cost portion and the ASC cost portion are 42 percent and 58 percent, respectively.

Reasons for Change

The current payment methodology for hospital outpatient department services is complicated and confusing, and a prospective payment system would simplify determination of payment amounts. Moreover, the current payment methodology results in beneficiaries bearing an increasing percentage of the cost of many hospital outpatient department services.

Committee Provision

The Committee provision would require the Secretary of Health and Human Services (HHS) to establish a prospective payment system for covered hospital outpatient department (OPD) services beginning in 1999. The Secretary would be required to develop a classification system for covered OPD services, such that services classified within each group would be comparable clinically and with respect to the use of resources. The Secretary would be required to establish relative payment rates for covered OPD services using 1997 hospital claims and cost report data, and determine projections of the frequency of utilization of each such service or group of services in 1999. The Secretary would be required to determine a wage adjustment factor to adjust the portions of payment attributable to labor-related costs for relative geographic differences in labor and labor-related costs that would be applied in a budget neutral manner. The Secretary would be required to establish other adjustments as necessary to ensure equitable payments under the system. The Secretary would also be required to develop a method for controlling unnecessary increases in the volume of covered OPD services.

For 1999, the Secretary would be required to establish a conversion factor for determining the Medicare OPD fee payment amounts for each covered OPD service (or group of services) furnished in 1999 so that the sum of the products of the Medicare OPD fee payment amounts and the frequencies for each service or group would be required to equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999. In subsequent years, the Secretary would be required to establish a conversion factor for covered OPD services furnished in an amount equal to the conversion factor established for 1999 and applicable to services furnished in the previous year increased by the OPD payment increase factor. The increase factor would be equal to the hospital market basket (MB) percentage increase plus 3.5 percentage points.

Hospitals OPD copayments would be limited to 20 percent of the national median of the charges for the service (or services within the group) furnished in 1997 updated to 1999 using the Secretary's

estimate of charge growth during this period. The Secretary would be required to establish rules for the establishment of a copayment amount for a covered OPD service not furnished during 1997, based on its classification within a group of such services.

The Secretary would be required to establish a procedure under which a hospital, before the beginning of a year (starting with 1999), could elect to reduce the copayment amount for some or all covered OPD services to an amount that is not less than 25 percent of the Medicare OPD fee schedule amount for the service involved, adjusted for relative differences in labor costs and other factors. A reduced copayment amount could not be further reduced or increased during the year involved, and hospitals could disseminate information on the reduction of copayment amount.

The Secretary would be authorized periodically to review and revise the groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, medical technology, the addition of new services new cost data, and other relevant information. Any adjustments made by the Secretary would be made in a budget neutral manner. If the Secretary determined that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary would be authorized to adjust the update to the conversion factor otherwise applicable in a subsequent year.

The Committee provision would provide that the copayment for covered OPD services would be determined by the provisions of this bill instead of the standard 20-percent coinsurance other Part B services. The Committee provision would prohibit administrative or judicial review of the prospective payment system. The Committee provision would also provide for conforming amendments regarding approved ambulatory surgical center procedures performed in hospital OPDs, for radiology and other diagnostic procedures, and for other hospital outpatient services.

The Committee provision would become effective for hospitals described in section 1886(d)(l)(B)(v) of the Social Security Act, beginning on January 1, 2000, and the Secretary would have the authority to establish a separate conversion factor for such hospitals.

Effective Date

Generally January 1, 1999.

Subchapter B—Ambulance Services

PAYMENTS FOR AMBULANCE SERVICES

Present Law

Payment for ambulance services provided by freestanding suppliers is based on reasonable charge screens developed by individual carriers based on local billings. Hospital or other provider-based ambulance services are paid on a reasonable cost basis; payment cannot exceed what would be paid to a freestanding supplier. Annual updates in payments for ambulances services are provided in regulation.

Reasons for Change

The Committee provision would establish an improved payment methodology for ambulance services.

Committee Provision

The Committee provision would specify payment rules for ambulance services for FY 1998 through FY 2002. For ambulance services paid on a reasonable cost basis, the annual increase in the costs recognized as reasonable would be limited to the percentage increase in the consumer price index reduced for FY 1998 by 1 percent. Similarly, for ambulance services furnished on a reasonable charge basis, the annual increase in the charges recognized as reasonable would be limited to the percentage increase in the consumer price index reduced for FY 1998 by 1 percent.

The Committee provision would require the Secretary to establish a fee schedule for ambulance services through a negotiated rule-making process no later than January 1, 1999. In establishing the fee schedule, the Secretary would be required to: (1) establish mechanisms to control Medicare expenditure increases; (2) establish definitions for services; (3) consider appropriate regional and operational differences; (4) consider adjustments to payment rates to account for inflation and other relevant factors; and (5) phase-in the application of the payment rates in an efficient and fair manner. The Secretary would be required to assure that payments in FY 1999 under the fee schedule did not exceed the aggregate amount of payments which would have been made in the absence of the fee schedule. The annual increase in the payment amounts in each subsequent year would be limited to the increase in the consumer price index minus 1 percentage point. Medicare payments would equal 80 percent of the lesser of the fee schedule amount or the actual charge.

The Committee provision would authorize payment for advanced life support (ALS) services provided by paramedic intercept service providers in rural areas. The ALS services would be provided as part of a two-tiered system in conjunction with one or more volunteer ambulance services. The volunteer ambulance service involved must be certified as qualified to provide the service, have a contractual agreement with the volunteer ambulance service providing the additional ALS intercept service, provide only basic life support services at the time of the intercept, and be prohibited by state law from billing for services. The ALS service provider must be certified to provide the services and bill all recipients (not just Medicare beneficiaries) for ALS intercept services.

Effective Date

On enactment.

CHAPTER 3—PROVISIONS RELATING TO PARTS A AND B

Subchapter A—Payments to Skilled Nursing Facilities

PAYMENTS TO NURSING HOMES

Present Law

Medicare pays skilled nursing facilities (SNFs) on a per day basis for reasonable costs, subject to per day cost limits. The limits are applied to the per day routine service costs only (nursing, room and board, administrative, and other overhead) of a facility. Routine cost limits are updated annually by the skilled nursing home market basket. OBRA 93 eliminated the annual market basket update for SNF limits for cost reporting periods beginning in FY 1994 and FY 1995.

Non-routine costs, such as therapy services (e.g., physical therapy, occupational therapy, and speech therapy services) are paid according to reasonable costs. There are no cost limits for non-routine costs. Medicare pays, under Part A and Part B, a variety of providers (i.e., nursing homes for facility-based therapists, independent therapists, therapy companies) for non-routine services.

Freestanding SNF routine cost limits are set at 112 percent of the mean per day routine costs. Hospital-based SNF routine cost limits are set at the limit for freestanding SNFs, plus 50 percent of the difference between the freestanding limit and 112 percent of the mean per day routine service costs of hospital-based SNFs.

Payments for ancillary service and capital costs are unlimited, since both are paid on the basis of reasonable costs and neither are subject to limits.

New providers are exempt from Medicare's routine cost limits for about their first three years of operation. During this period they receive full cost reimbursement for all routine services, as well as ancillary and capital costs.

Under certain circumstances, Medicare permits exceptions payments for facilities that exceed their cost limits.

Low volume SNFs (less than 1500 SNF days per year) may choose to be paid on a prospective payment basis at 105 percent of the mean. Low volume SNFs did not receive inflation updates for 1994 and 1995 prospective rates.

There are no requirements for SNFs to monitor or bill for any Part B service delivered to a beneficiary when a Medicare beneficiary is residing at a SNF outside of the 100 days covered by Medicare.

To research and develop a prospective payment system for SNF care, HCFA since 1984 has been sponsoring research on a patient classification system for Medicare SNF patients. Specifically, HCFA has sought to adapt to Medicare patients a classification system known as the Resource Utilization Groups (RUGs), which was developed originally for a Medicaid nursing home population and which used primarily functional disability scores for classifying patients. The version of RUGs that HCFA is currently testing for application to Medicare is known as RUGs–III is being tested in six states (Kansas, Maine, Mississippi, New York, South Dakota, and

Texas). HCFA anticipates that 1,000 SNFs will be participating in the demonstration by the time enrollment closes in 1997.

Reasons for Change

Medicare payments for skilled nursing facilities (SNF) grew over 28 percent for 1994–1995 according to CBO. Spending growth of nursing home care is unsustainable in the Medicare program. Providers are paid based on costs subject to certain limits for routine services, with no limits for non- routine services. Providers have no incentives to keep the cost growth of non-routine services low.

Committee Provision

The proposal extends the FY 1997 routine cost limits until a new Prospective Payment System (PPS) is established on July 1, 1998:

(a) The Secretary shall determine the standard federal payment rates for the SNF PPS based on cost reports beginning in fiscal year 1995, excluding cost reports from new SNFs exempted from cost limits, and excluding exceptions payments made to SNFs. The Secretary shall trend the rate forward by the market basket index of minus one percentage point for fiscal years 1996, 1997, and 1998.

The standard federal payment rates shall be based on the average cost of SNF services and determined on a per diem basis with regional variation. The labor portion of the standard federal payment will be adjusted by an appropriate wage index.

The standard federal payment rates will be adjusted to account for case-mix based on a resident classification system which reflects the relative resource needs of caring for different types of patients. The Secretary shall collect resident assessment data and other data in order to develop the case-mix adjuster.

The standard federal payment rates will be updated annually by the market basket after fiscal year 1998.

During the four year transition to a fully prospective system, a SNF's payment shall be based on a blend of the federal payment rate and the facility's specific rate. The facility specific rate will include all costs of skilled nursing services (including routine costs, ancillary costs, capital related costs, and all Part B services which will be covered under the new PPS) and will be based on the most recent settled cost report available, updated annually. For SNFs participating in the RUGS–III demonstration project, their base year facility specific rate will be equal to their 1997 RUG rate.

The Secretary will have the authority to develop normative standards based on program data which reflects the overall practices of SNFs for comparable cases. The Secretary may adjust payments when a variation from the standards cannot be justified.

As was the case for the development of the Medicare hospital PPS and physician payment reform, certain administrative or judicial review will not be permitted for the establishment of the SNF PPS. Administrative or judicial review will not be permitted for the determination of the federal per diem rates, including the computation of the standardized per diem rates and adjustments for case-mix; and for the transition for low-volume SNFs and rural hospitals providing SNF care with inpatient beds.

(b) SNFs will be required to consolidate all bills to Medicare for all Part B services used by Medicare patients (with the exception of physician services). Payments for Part B services would have to be made to the facility. The Secretary is required to use applicable Part B payment methodologies in developing fee schedules for items and services subject to consolidated billing. The Secretary shall rely on new salary equivalency guidelines for physical therapy, occupational therapy, respiratory therapy, and speech language pathology in determining reasonable costs for such services.

(c) New provider exemptions are eliminated for cost reporting periods beginning on or after July 1, 1998.

(d) The Secretary shall conform payments to low volume nursing homes with the policies in these provisions.

Effective Date

The new payment system will be effective July 1, 1998.

Subchapter B—Home Health Services and Benefits

PAYMENT FOR HOME HEALTH SERVICES

Present Law

Home health care services are primarily nursing services (e.g., cleaning and dressing a wound) or therapies (e.g., physical therapy) provided by a nurse or other health care worker in the home.

There are no cost sharing requirements for beneficiaries for home health services.

Medicare pays home health agencies the lower of their costs or a limit; there are no exemptions for new entrants. The limits are based on 112 percent of the average cost per visit for free-standing agencies for each of the six types of visits.

Medicare's home health policies do not specify the duration of a visit.

While the limits are computed at the service level, they are applied to aggregate agency costs. That is, an aggregate cost limit is set for each agency that equals the limit for each type of service multiplied by the number of visits of each type provided by that agency. There is an adjustment made to payments to reflect the regional variation of wages which is the same as the local hospital wage index.

In OBRA 93, the per visit cost limits for home care were frozen for two years. The freeze meant that the cost limits set in 1993 could not be adjusted in 1994 and 1995 for inflation or wage cost increases. Cost limits were then recalculated for cost reporting periods beginning on or after July 1, 1996.

Home health agencies can have their cost reimbursement payments paid to them from Medicare through periodic interim payments (PIPs). These lump sum payments are made several times a year based on anticipated costs incurred in order to help agencies with their cash flow. PIP payments are reconciled at the end of the cost reporting year between the Health Care Financing Administration and the agency.

Reasons for Change

Medicare home health service utilization and costs are growing at an unsustainable rate for the Medicare program. ProPAC reports that from 1980-1994, persons using the home care benefit grew from 26 to 88 persons per 1,000 Medicare enrollees and from an average of 23 visits to an average of 65 visits per person using the home care benefit. From 1988 to 1996, Medicare's payments for home health services increased 37% on average every year.

Medicare's current cost-based payment system for home care provides no incentive for providers or patients to be cost conscious.

Committee Provision

The provision requires the Secretary to establish a prospective payment system (PPS) for home health services and implement the system in FY 2000. Until the new PPS is in effect, an interim payment system will be in place.

1. Interim payment for home health services for FY 1998–1999. Reduces per visit cost limits to 105% of the national median of labor-related and nonlabor costs for freestanding home health agencies beginning in FY 1998. Home health agencies will be paid the lesser of: (a) their actual costs; (b) the per visit limits; or (c) a new agency-specific per beneficiary annual limit calculated from 1994 reasonable costs, updated by the home health market basket.

The Secretary is required to expand research on a PPS for home health that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of variance in cost.

2. To establish the PPS, the Secretary will compute a standard prospective payment amount that will initially be based on the most current audited cost report data available to the Secretary. For FY 2000, payment amounts under the prospective system will be computed in such a way that total payments equal amounts that would have been paid had the system not been in effect, but would also reflect a 15% reduction in cost limits and per beneficiary limits in effect September 30, 1999. Payment amounts will be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner. The new payment system will take into account regional differences or differences based on whether or not services are provided in an area. Beginning FY 2001, standard prospective payment amounts will be updated by the home health market basket index.

3. With the implementation of the home health PPS, as was the case for the development of the Medicare hospital PPS and physician payment reform, certain administrative or judicial review will not be permitted. Administrative or judicial review will not be permitted for the establishment of the computation of the initial standard payment amounts and case-mix adjustments; the transition period (if any) for the prospective system; and the amount or types of exceptions to the prospective payment amounts.

4. Beginning in FY 1998, payment for home health services will be based on the location of where home health services are furnished.

5. Periodic interim payments are eliminated October 1, 1999 with the implementation of the home health care PPS.

HOME HEALTH BENEFITS

Present Law

Payment for home health care is made from the Part A trust fund for all home health services except for those provided to individuals enrolled under Part B, but not entitled to receive benefits under Part A. Only about 1% of home health services are reimbursed under Part B.

Eligibility and reimbursement policies are identical for home health services under Parts A and B. Although the original 1965 home health care benefit required coinsurance, there currently is no coinsurance requirement and home health services are not counted towards the Part B deductible. The Part B deductible applies to all Medicare Part B benefits excluding home health care. All part B benefits, including current Part B home health care are included in the calculation of the Part B premium.

Once beneficiaries qualify for the home health benefit, the program covers part-time or intermittent nursing care provided by or under the supervision of a registered nurse and part-time or intermittent home health aide services, among other services. Coverage guidelines issued by HCFA have defined part-time and intermittent.

In order to be eligible for home health care, a Medicare beneficiary must be confined to his or her home. The law specifies that this "homebound" requirement is met when the beneficiary has a condition that restricts the ability of the individual to leave home, except with the assistance of another individual or with the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. The law further specifies that while an individual does not have to be bedridden to be considered confined to home, the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

A Medicare beneficiary who is "homebound" is entitled to an unlimited number of home-based part-time nursing visits provided by or under the supervision of a nurse.

Reasons for Change

The Medicare Hospital Insurance (HI or Part A) Trust Fund will be insolvent in 2001. The rapid and unsustainable level of growth in home health care has contributed significantly to the Trust Fund's impending fiscal straights. Redefining the home health benefit to a predominantly Medicare Supplemental Medical Insurance (SMI or Part B) Trust Fund benefit will help clarify and rationalize the current unlimited, and undefined aspects of the home health benefit.

Committee Provision

(a) Beginning in 1998, the home health benefit will be redefined. The Part A benefit will be limited to 100 visits that follow a 3 day hospital stay, and the Part B benefit will include all other home health visits.

(b) Beginning in 1998, the new Part B home health benefit will be paid partly from the Part A Trust Fund for a seven year phase-in period. For example, the newly defined Part B home health benefit will be paid 14% (1/7) from Part B and 86% (6/7) from Part A in FY 1998. The next year, payment will be 28% (2/7) from Part B and 72% (5/7)from Part A, etc. The amount paid from Part B will be included in the Part B premium calculation each year, as is all other Part B spending.

(c) Consistent with other Part B services, cost-sharing is established for Part B home health services at $5 per visit, billable on a monthly basis, capped at an annual amount equal to the annual hospital deductible.

(d) Effective for services furnished on or after October 1, 1997, the provision defines part-time and intermittent skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of qualifying for Medicare's home health benefit because of a need for intermittent skilled nursing care, ''intermittent'' would mean skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day of skilled nursing and home health aide services combined for periods of 21 days or less (with extensions for exceptional circumstances when the need for additional care is finite and predictable).

(e) The Secretary shall conduct a study on the criteria that should be applied with regards to the determination of whether an individual is considered homebound for purposes of receiving the home health benefit. The Secretary shall report to Congress with specific recommendations no later than October 1, 1998.

(f) The Medicare Explanation of Benefits notice will include home health care benefits provided and billed for.

(g) Seamless administration of the home health benefit is assured by (i) allowing beneficiaries the same appeals rights either under Part A or Part B ($100 in benefits must be in dispute), and (ii) requiring fiscal intermediaries to administer claims for all home health benefits.

Subtitle F—Provisions Relating to Part A

PPS HOSPITAL PAYMENT UPDATE

Present Law

Since 1983, Medicare has paid hospitals for most inpatient services with a fixed, predetermined amount according to patient diagnosis. The payment system is called the Medicare Prospective Payment System (PPS).

Medicare's PPS payments are updated each year for inflation. The inflation update is based on the projected increase in "market basket index" (MB), which estimates the prices of the goods and services hospitals buy to provide care.

Since fiscal year (FY) 1986, Congress has repeatedly set the update factor at a level below the MB. In OBRA 1993, the update was set at:

1. FY 1994—Rural hospitals: MB minus .55 percentage points. Urban hospitals: MB minus 2.5 percentage points.
2. FY 1995—Rural hospitals: inflation update necessary to eliminate the rural/urban differential. Urban hospitals: MB minus 2.5 percentage points.
3. FY 1996—MB minus 2 percentage points.
4. FY 1997—MB minus 0.5 percentage points.
5. FY 1998 and later years—Equal to the MB with no reductions.

Reasons for Change

In recent years, hospitals' cost growth has slowed while operating margins have improved to record levels. According to the Prospective Payment Assessment Commission (ProPAC), in FY 1995 the average hospital Medicare PPS margin was 10%, and is anticipated to be about 12% in FY 1996, 14% in FY 1997, and 17% in FY 1998. The healthy operating margins reflect the difference between Medicare payments and the increasing efficiency attributed to the amount and timing of services furnished during inpatient stays. While margins have continued to improve, estimates of the proportion of hospitals with negative Medicare PPS margins has continued to decline. According to ProPAC, in FY 1995 34% of all hospitals had a negative Medicare PPS margin, the decline is anticipated to continue through next year to 19% of all hospitals.

ProPAC recommends a zero update for the FY 1998 PPS update in order to adjust for increasing efficiencies reflected in hospitals' declining costs. ProPAC believes a zero update would allow hospitals to continue furnishing quality care to Medicare beneficiaries while simultaneously fulfilling Medicare's responsibility to act as a prudent purchaser.

Hospital payments should be placed on a calendar year cycle because of the interaction with Regulatory Reform which will continue to delay the timely implementation of the hospital updates. Regulatory Reform requires that "major" rules have a 60 day waiting period from the date the final rule is issued to the date of implementation. The Office of Management and Budget (OMB) determined that the September 1996 interim final rule for Prospective Payment System (PPS) regulations including all Medicare hospital payments constituted a "major rule." As a "major rule", the fiscal year 1997 PPS regulations could not be implemented for 60 days which would have caused a 30 day delay beyond the October 1st date Medicare usually provides hospitals with their annual payment inflation update. The Regulatory Reform bill was signed into law in March of 1996, and the Administration had ample time to notify agencies regarding compliance. The delay in payments could have been avoided had HCFA issued final regulations 60 days in advance of the October 1st date.

Although Congress intervened to permit the regulations to go into effect in a timely manner, it appears that the Health Care Financing Administration has not altered the timing of the development of the PPS regulations which will again lead to a delay in implementation of the regulations beyond the October 1st implementation date. In order to avert a perennial delay in the implementation of the PPS regulations, the implementation date should be moved to a calendar year cycle, which will correspond to the same timing for annual updates for physicians and most other Medicare Part B services.

Committee Provision

Establishes a calendar year cycle for all hospital PPS payments. Hospital payments for fiscal year 1997 are continued until January 1, 1998, the first calendar year update. The annual market basket update for hospitals will equal MB minus 2.5 percentage points in CY 1998, and MB minus 1 percentage point for each calendar year, 1999-2002.

Effective Date

For discharges on or after October 1, 1997.

CAPITAL PAYMENTS FOR PPS HOSPITALS

Present Law

Hospital capital expenses (the costs of building or acquiring facilities and major equipment) are paid for under the Prospective Payment System (PPS).

Until fiscal year 1992, Medicare payments for capital costs were based on each hospital's actual expenses, subject to statutory percentage reductions. A 10-year transition to fully prospective payments began in FY 1992, during which capital payments are paid prospectively based on average capital costs per case in FY 1989, updated for inflation and other cost changes.

From FY 1992 through FY 1995, the Health Care Financing Administration (HCFA) updated base payment rates using a moving average of capital cost increases in previous years. During this period, Congress required HCFA to adjust the payment rates in each year in a budget neutral manner so that anticipated aggregate capital payments would equal 90 percent of anticipated aggregate costs. This provision expired on September 30, 1995, resulting in a 22.6 percent increase in the Federal capital payment rate for FY 1996.

The Secretary implements the capital provisions by regulation. Currently, there is no separate payment for property tax related capital costs. Medicare provides for a special exceptions process for certain major capital projects.

Reasons for Change

Hospital inpatient capital payments grew 22.6 percent per discharge in FY 1996 due to expiring statutory provisions. According to HCFA, overall payments per discharge in FY 1997 are expected to increase to 27.7% above what they would have been had the

budget neutrality provision not expired in FY 1996. In addition, ProPAC has stated that data indicate that the original base calculation for capital payments was overstated.

Under current law, payments for transitional capital were reduced from 85% to 70% as an attempt to contain Medicare costs. Several hospitals across the country began construction or renovation projects and raised capital under the old rules for Medicare capital costs, but under current law are required to pay off their debts under the new (lower) Medicare capital reimbursement rates.

Committee Provision

For discharges occurring on or after October 1, 1998 the Committee provision reinstates the original OBRA 1990 budget neutrality requirement (extended in OBRA 1993 for fiscal years 1994 and 1995) through fiscal years 1998-2002 so that aggregate capital payments each year equal 90 percent of what payments would be under reasonable cost payments.

The provision amends the exceptions process provided in federal regulation to include as eligible for an exception hospitals located in an urban area, with over 300 beds, and without regard to whether a hospital qualifies for additional disproportionate share hospital (DSH) payment amounts. The provision amends the project size requirement to require that a hospital's project costs must be at least 150% of its operating costs during the first 12-month cost reporting period beginning on or after October 1, 1991. The provision requires the minimum payment level for qualifying hospitals be equal to 85%. The provision requires that a hospital be considered to meet the requirement that the capital project involved be completed no later than the end of the hospital's last cost reporting period beginning before October 1, 2001, if: (1) the hospital had obtained a certificate of need for the project approved by the state or local planning authority by September 1, 1995, and (2) by September 1, 1995, the hospital has expended on the project at least $750,000 or 10% of the estimated cost of the project. The provision also requires that the additional payment that would otherwise be payable for the cost reporting period will be reduced by the amount (if any) by which the hospital's current year Medicare capital payments (excluding the hospital's capital-related DSH payments) exceeds the hospital's capital costs for such year.

The provision requires the Secretary to implement the provision in a budget neutral manner not to exceed $50 million per year to ensure that the provision will not result in an increase in the total amount that would have otherwise been paid. The provision requires the Secretary to publish annually (beginning in 1999) in the Federal Register a description of the distributional impact of the application of this capital exception on hospitals which receive and do not receive a capital exception payment. The provision also provides a conforming amendment that requires the provision of capital exception payments.

Effective Date

Discharges occurring on or after October 1, 1997.

PPS-EXEMPT HOSPITAL PAYMENTS

Present Law

Not all hospitals paid by Medicare are paid by the Prospective Payment System (PPS). There are a number of special categories of hospitals that Medicare pays based on the hospitals' costs. These five types of hospitals are:

1. Rehabilitation hospitals/rehabilitation units of hospitals treat patients with injuries or conditions who require extensive hospital-based therapy and who can withstand at least 3 hours of therapy per day (i.e., a patient in need of therapy must be healthy enough to tolerate the minimum therapy required);
2. Psychiatric hospitals/psychiatric units of hospitals (e.g., patients with severe mental illnesses that require hospital stays);
3. Long-term care hospitals treat patients who on average, require, 25 days or more of hospital care;
4. Cancer hospitals limited by law in OBRA 1989 as determined at that time by the National Cancer Institute as research-based cancer hospitals; and
5. Pediatric hospitals.

Medicare will reimburse for only two of these types of facilities as distinct-part units within an acute care hospital. A PPS hospital can establish psychiatric or rehabilitation "distinct units" or wings, and the host hospital receives a separate reimbursement for patients undergoing treatment in those wings. A hospital may not create a PPS-exempt long-term care unit, it must completely separate the two forms of care so that the long-term care hospital is a "hospital within a hospital."

These types of hospitals are excluded by law from Medicare's PPS payments (PPS-exempt) and are paid on the basis of reasonable costs, subject to limits in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rate of increase limits. The rate of increase limits are called "TEFRA limits".

TEFRA payments for inpatient operating costs are based on each provider's current Medicare allowable costs per discharge or a target amount. A hospital's target amount is based on its inpatient operating costs per discharge in a base year, trended to the current year by an annual update factor. While payments must be for covered services, a new facility seeking to establish its TEFRA base-year ceiling is exempted from any limit.

A facility with Medicare-allowable inpatient operating costs less than its ceiling (its target amount times the number of discharges) receives its costs plus an additional amount, known as the "bonus" payment, that is equal to half the difference between its ceiling and costs or 5 percent of its ceiling, whichever is less.

A facility with Medicare-allowable inpatient operating costs above its ceiling receives a "relief" payment equal to its ceiling plus either 50 percent of the difference between its costs and ceiling or 10 percent of its ceiling, whichever is less.

There are additional payments made for exceptions.

OBRA 93 provided for an update factor to the TEFRA limits that range from zero to market basket minus 1.0 percentage point for fiscal years 1994-1997. A hospital with operating costs in FY 1990

that exceeded its TEFRA target amount by 10 percent or more receives a full MB update, with partial reductions applied to hospitals near the threshold.

PPS-exempt hospitals are paid for the reasonable costs of capital.

Reasons for Change

TEFRA payments rely on historical costs to set target amounts that systematically reward certain facilities and penalize others.

Newly certified facilities have no incentives under Medicare to restrain their costs. In fact, they have an incentive to come into TEFRA with high base year costs per case, thereby establishing a high target amount. These newly certified facilities are then essentially guaranteed cost reimbursement for their high costs, as long as they stay below their target amounts. According to ProPAC, in 1995, target amounts for Rehabilitation hospitals and units varied from a target amount of $8,585 representing the 10th percentile, to $95,930 maximum target amount paid to a hospital or unit for essentially the same discharge. For long-term care hospitals, in 1995, $4,612 represented the 10th percentile target amount, $84,995 the maximum target amount. The very wide divergence in payments per discharge can not be justified for either of these types of hospitals, other than the incentives rooted in a cost-based reimbursement system.

Fueled by the TEFRA payment incentives, the number of PPS-exempt providers has grown rapidly since 1990, especially rehabilitation facilities and long-term care hospitals. Although the total number of facilities remains small, few other provider groups can match the growth seen in rehabilitation facilities and long-term care hospitals.

The number of rehabilitation hospitals and units combined increased 26% from 1990 to 1995. The number of long-term care hospitals grew by 105% over that same period.

Committee Provision

(a) The update will vary for hospitals above and below their target amounts for fiscal years 1998-2002. For hospitals (1) with costs that exceed their target amounts in fiscal year 1995 by 10 percent or more, the update will equal the market basket; (2) that exceed their target, but by less than 10%, the update factor is the market basket minus .25 percentage points for each percentage point by which costs are less than 10% over the target, but it shall not be less than zero; (3) that are either at their target, or below (but not below 2/3 of the target amount for the hospital) the update factor would be the market basket minus 1.5 percentage points, but in no case less than zero; or (4) that do not exceed 2/3 of their target amount, the update factor would be 0.

(b) Hospital capital payments for PPS-exempt hospitals are reduced by 15 percent for FY 1998–2002 (cancer and children's hospitals are exempted).

(c) Bonus payments are reduced to the lesser of:

(1) 10% of (the TARGET amount minus COSTS), or

(2) 1% of COSTS.

(d) Relief payments are altered so that they apply only to those facilities in greatest need (with costs that are at least 10% above their target).

(e) Target amounts are adjusted for existing rehabilitation hospitals, long-term care hospitals, and psychiatric hospitals. Hospitals with low target amounts will be adjusted so that they will not be less than 50 percent of the national average, and the maximum amount reimbursed will be limited to the 90th percentile of each category of hospitals' target amounts.

Establishes new payment criteria for start-up facilities, so that target amounts do not exceed 130 percent of the national average. The Secretary shall calculate new provider base target amounts for each facility type using data from all providers within each category modified by geographic location, size, and patient characteristics that are related to resource use.

(f) Permanently grandfathers long-term care hospitals that were established within a hospital prior to September 30, 1995.

(g) Establishes a new category of PPS-exempt hospitals. Non-research cancer hospitals that were qualified as long-term care hospitals between 1991 and 1995 may qualify under the new designation. At least 50% of their discharges must be cancer related.

(h) Makes technical correction for a National Cancer Institute designated comprehensive cancer center.

Effective Date

Cost reports beginning on or after October 1, 1998.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Present Law

Under Medicare's Prospective Payment System (PPS), an extra payment is made for certain hospitals that serve a disproportionate share of low-income patients.

The amount of the extra DSH payment for each hospital is based on a formula that considers certain hospital and patient factors. The factors considered in determining whether a hospital qualifies for a DSH payment adjustment include the number of beds, the disproportionate patient percentage, and the hospital's location. A hospital's disproportionate patient percentage is the sum of (1) the total number of inpatient days attributable to Federal Supplemental Security Income (SSI) beneficiaries divided by the total number of Medicare patient days, and (2) the number of Medicaid patient days divided by total patient days, expressed as a percentage. A hospital is classified as a DSH under any of the following circumstances:

(1) If its disproportionate patient percentage equals or exceeds:

(a) 15 percent for an urban hospital with 100 or more beds, or a rural hospital with 500 or more beds (the latter is set by regulation);

(b) 30 percent for a rural hospital with more than 100 beds and fewer than 500 beds or is classified as a sole community hospital;

(c) 40 percent for an urban hospital with fewer than 100 beds; or

(d) 45 percent for a rural hospital with 100 or fewer beds, or

(2) if it is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent payments. (This provision is intended to help hospitals in States that fund care for low-income patients through direct grants rather than expanded Medicaid programs.)

For a hospital qualifying on the basis of (1)(a) above, if its disproportionate patient percentage is greater than 20.2 percent, the applicable PPS payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage. If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is equal to: 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage. If the hospital qualifies as a DSH on the basis of (1)(b), the payment adjustment factor is determined as follows:

(a) if the hospital is classified as a rural referral center, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent;

(b) if the hospital is a sole community hospital (SCH) the adjustment factor is 10 percent;

(c) if the hospital is classified as both a rural referral center and a SCH, the adjustment factor is the greater of 10 percent or 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent; and

(d) if the hospital is not classified as either a SCH or a rural referral center, the payment adjustment factor is 4 percent.

If the hospital qualifies on the basis of (1)(c), the adjustment factor is equal to 5 percent. If the hospital qualifies on the basis of (1)(d), the adjustment factor is 4 percent. If the hospital qualifies on the basis of (2) above, the payment adjustment factor is 35 percent.

Reasons for Change

It is more difficult for rural hospitals to qualify for Medicare DSH payments because the threshold is much higher for rural than urban hospitals, even if they treat the same number of low-income individuals. The Prospective Payment Assessment Commission (ProPAC) supports applying a uniform threshold to all hospitals.

ProPAC also recommends that Medicare DSH payments should reflect the additional costs of services provided to low-income groups in both inpatient and outpatient settings, and uninsured and underinsured patients as reflected by uncompensated and charity care.

According to ProPAC, DSH payments have grown rapidly since fiscal year 1989, increasing almost fourfold from $1.1 billion to $4.3

billion in 1996. This acceleration is largely due to legislative changes that raised the DSH payment rate for some hospitals.

Committee Provision

From October 1, 1997 to January 1, 1999, apply current formula with a 4% reduction in the DSH adjustment. This will reduce DSH payments to hospitals by 4%.

For Calendar Years 1999–2002, the Secretary will continue to apply an additional 4% reduction in the DSH payment adjustment.

On January 1, 1999, the Secretary must establish a new formula that takes into account Medicaid, Medicare SSI, and uncompensated/charity care. This new formula will have one threshold for all hospitals. In each year, the Secretary must implement the new formula in a budget neutral manner in order to achieve the same savings that would have been achieved with the old formula under the provisions above.

Effective Date

Cost reporting periods beginning on or after October 1, 1997.

CAPITAL ASSETS SALE EQUAL TO BOOK VALUE

Present Law

Medicare provides for establishing an appropriate allowance for depreciation and for interest on capital indebtedness and a return on equity capital when a hospital or skilled nursing facility has undergone a change of ownership. The valuation of the asset is the lesser of the allowable acquisition costs of the asset to the owner of record, or the acquisition cost of such asset to the new owner.

Reasons for Change

There is increasing evidence that intangible losses that do not have any true value associated to them are being included in the sale of facilities because Medicare will currently reimburse for these "paper" losses.

Committee Provision

Establishes the value of a capital asset at the time of change of ownership at the book value of the asset. The Committee provision also applies this valuation to providers of services other than hospitals and skilled nursing facilities, and eliminates return on equity.

Effective Date

After the third month beginning after the date of enactment of this Act.

GRADUATE MEDICAL EDUCATION PAYMENTS

Present Law

Since the inception of the Medicare program in 1965, Medicare has reimbursed teaching hospitals for certain costs associated with

approved graduate medical education (GME) programs. GME is a period of clinical education of physicians after graduation from medical school. Physicians-in-training are called "interns" or "residents." Since enactment of the hospital prospective payment system (PPS) in the early 1980's, Medicare has made two specific GME payments to teaching hospitals: direct and indirect medical education payments.

(a) Direct Medical Education (DME) Payments.—DME payments reimburse a teaching hospital for the costs of a resident's salary, benefits, and certain overhead associated with operating a teaching program. The DME payment is calculated as the product of three factors: (1) The adjusted number of full-time residents; (2) the Medicare patient load of the hospital (the fraction of the hospital's total number of inpatient days the Medicare beneficiaries represent); and an amount per resident (which reflects each teaching hospital's allowed DME costs per resident in 1984 adjusted for inflation).

(b) Indirect Medical Education (IME) Payments.—IME payments reimburse teaching hospitals for certain other costs associated with physician training, such as the additional tests or procedures that may be ordered by a resident. For IME, Medicare pays teaching hospitals an additional percentage of each Medicare beneficiary's hospital bill by increasing the diagnosis-related group (DRG) payment by approximately 7.7 percent for each 10 percent increment in a hospital's ratio of interns and residents to hospital beds.

(c) Direct and Indirect Medical Education Payments for Managed Care Organizations.—Teaching hospitals do not receive a direct payment from Medicare for either DME and IME payments for beneficiaries enrolled in HMOs. Instead, such payments are included in the monthly amount Medicare pays to HMOs.

Reason for Change

(a) Direct Medical Education (DME) Payments.—The number of U.S. medical school graduates filling residency positions in teaching hospitals has remained relatively constant, while the total number of resident positions have grown sharply in recent years. Expert testimony has suggested that Medicare's unlimited reimbursement of additional resident positions has substantially fueled this growth, and contributed to a generally acknowledged surplus in the physician workforce. However, it is also believed rural areas have physician shortages, in part because residency programs are rarely located in rural areas which would create ties and attachments to rural communities.

(b) Indirect Medical Education (IME) Payments.—The Prospective Payment Assessment Commission (ProPAC) has advised Congress that Medicare is paying more than Medicare's share of hospitals' costs for IME, and that this amount should be reduced. In addition, current law limits ME payments to hospital departments, which provides a disincentive to train residents in ambulatory care settings where medical care is increasingly provided.

(c) Direct and Indirect Medical Education Payments for Managed Care Organizations.—At present, there is no assurance that the portion of the monthly Medicare payment to HMOs attributed to direct and indirect medical education is actually paid to teaching hospitals. Moreover, payment of graduate medical education sub-

sidies by Medicare directly to teaching hospitals for HMO enrollees would permit teaching hospitals to be more competitive in negotiating rates with HMOs and other managed care organizations.

Committee Provision

(a) Direct Medical Education (DME) Payments.—The Committee provision would provide that the number of allopathic and osteopathic interns and residents reimbursed by Medicare could not exceed the number of interns and residents reported on a hospital's cost report for the period ending December 31, 1996. Subject to this limit, for cost reporting periods beginning on or after October 1, 1997, the Committee provision provides for calculating the number of FTEs as the average of the cost period and the preceding cost period; for each subsequent year, the cost period and the two preceding cost periods. The Committee provision also would permit DME payments to Federally qualified health centers (FQHCs) and rural health clinics (RHCs) with approved medical residency training programs.

(b) Indirect Medical Education (IME) Payments.—The Committee provision would reduce the additional payment adjustment for IME from 7.7 percent for each 10 percent increment in the ratio of interns and residents to beds to:

1. Fiscal year 1998: 7.0 percent, and
2. Fiscal year 1999: 6.5 percent,
3. Fiscal year 2000: 6.0 percent,
4. Fiscal year 2001: 5.5 percent and after, for each 10 percent increment in the ratio of interns/residents to beds.

For purposes of computing the intern-and-resident to bed ratio, the Committee would limit the number of interns and residents to the total number of residents and interns in a hospital or non-hospital setting reported on the hospital's cost report for the period ending December 31, 1996. This provision would be effective for discharges occurring after October 1, 1997. Subject to this limit, for hospital's first cost-reporting period beginning on or after October 1, 1997, the number of FTE residents and interns for payment purposes would equal the average of the actual FTE resident and intern count for the cost reporting period and the preceding year's cost reporting period. For the cost reporting period beginning October 1, 1998, and each subsequent cost reporting period, subject to certain limits, the total number of FTE residents and interns for payment purposes would equal the average of the actual FTE resident count for the cost reporting period and the preceding two year's cost reporting periods.

The Committee provision would permit that time spent by an intern or resident in patient care activities under an approved medical residency training program at a non-hospital setting shall be counted towards FTEs if the hospitals incurs all or substantially all the costs for training in that setting.

(c) Direct and Indirect Medical Education Payments for Medicare Choice Organizations.—The Committee provision would provide that care provided by teaching hospitals to Medicare beneficiaries enrolled in managed care organizations would be recognized in the formulas for direct and indirect graduate medical education pay-

ments in proportion to the annual carve out of such amounts from payments to Medicare Choice organizations.

(d) Other Provisions.—The Committee provision would authorize the Secretary to approve DME and IME payments to facilities which had not previously had a Medicare approved graduate medical education program and to annually increase such payments for a period of no more than 5 years, and to increase such payments to facilities with programs less than 5 years old for a period of 5 years following establishment of the program. The Secretary would be limited by the difference in number of positions reimbursed or counted in the current calendar year and the previous calendar year. The Secretary shall give special consideration to facilities that meet rural underserved needs.

The Committee provision would also authorize the Secretary to establish consortia demonstration projects which demonstrate innovative graduate medical education and payment methods. The purposes of the consortia demonstration projects are varied, such as encouraging the participation of payers, public and private, to further supplement Medicare's funding for the extra costs associated with graduate medical education. The Committee encourages the Secretary to give special consideration to applications for consortia demonstration projects that emphasize rural primary care with training experience in community-based settings; geriatrics; participation by other payers that supplements Medicare funding for graduate medical education, and the use of telehealth and computer technologies to supervise and support residents in community-based training settings.

Effective Date

Cost reporting periods beginning on or after October 1, 1997.

ELIMINATE ADD-ONS FOR OUTLIERS (DSH AND GME)

Present Law

Medicare provides outlier payments to hospitals that are intended to protect them from the risk of large financial losses associated with cases having exceptionally high costs or unusually long hospital stays.

Outlier payments are meant to be self-funded as a percentage of all hospital payments. Every year, the Secretary of Health and Human Services establishes an outlier payment funding pool of 5% to 6% of all the anticipated hospital payments for that year.

Beginning in FY 1998, the length of stay outlier policy will terminate, and hospitals will receive outlier payments only for very high cost cases. For each diagnosis related group (DRG), a specific dollar loss threshold is set, and outlier payments are calculated based on the amount by which a hospital's costs exceed this loss threshold. For teaching and disproportionate share hospitals, however, their estimated cost for each case is reduced by the amount of the hospital's IME and DSH payment adjustments. The amount by which the estimated cost exceeds the outlier threshold thus is less for a case treated at a teaching or disproportionate share hospital, resulting in lower outlier payments. The lower outlier payment amount is then increased by the hospital's IME and DSH adjust-

ments, but this generally is not enough to offset the loss in outlier payments resulting from the reduced cost estimate for the case.

Reasons for Change

Teaching and DSH adjustments are now made on top of the DRG plus the outlier payment which means the Medicare program is spending more on IME and DSH for outlier cases than is warranted.

Committee Provision

Changes the ways that IME and DSH payments are calculated for cost outlier cases. The IME and DSH adjustments will be made to the base payment amount, not to the outlier portion of a hospital's payment. The provision would result in teaching and disproportionate share hospitals being treated like all other hospitals in the calculation of outlier payment amounts. Their estimated costs per case would not be reduced by their IME and DSH payments, and an additional IME or DSH adjustment would not be added to these payments.

Effective Date

The provision would apply to discharges occurring after September 30, 1997.

TREATMENT OF TRANSFER CASES

Present Law

Medicare adjusts its payment to a hospital which has transferred a patient to another hospital. In these cases, the diagnosis related group (DRG) payment to the hospital "sending" a patient to a second hospital is reduced because the "sending" hospital did not complete the term of care for the patient.

In a transfer situation, full payment is made for a patient's stay to the second hospital which completes the patient's hospital care and then discharges the patient. The "sending" hospital is paid a per diem rate for each day of the stay; total per diem payments are not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

This transfer policy is only applicable when an acute care hospital transfers a patient to another acute care hospital.

Reasons for Change

Present law does not apply to patients discharged from a hospital to a skilled nursing facility, home health agency or to a Prospective Payment System-exempted (PPS-exempt) hospital or distinct unit. The Committee provision will curb the current "double dipping" trend of hospitals moving Medicare patients early on in their course of treatment to an alternative health care setting (often a separate wing or floor of the same facility) while still receiving the full hospital DRG payment.

Committee Provision

Discharges from an acute care hospital to a PPS-exempt hospital or unit, a skilled nursing facility, (after April, 1998, discharges to home health care), will be considered "transfers" for payment purposes.

BAD-DEBT

Present Law

Certain hospital and other provider bad debts are reimbursed by Medicare on an allowable cost basis. To be qualified for reimbursement, the debt must be related to covered services and derived from deductible and coinsurance amounts left unpaid by Medicare beneficiaries. The provider must be able to establish that reasonable collection efforts were made and that sound business judgement established that there was no likelihood of recovery at any time in the future.

Reasons for Change

The payment of hospitals' Medicare-related bad debt is a legacy of hospital cost-based reimbursement. Under the current prospective payment system, bad debts should be considered a cost of doing business. Providers under Part B of the Medicare program are not reimbursed for bad debt.

Committee Provision

Reduces bad debt payments to providers by 25 percent for cost reporting periods beginning during FY 1998; 40 percent for cost reporting periods beginning in FY 1999; and 50 percent for subsequent cost reporting periods.

FLOOR ON AREA WAGE INDEX

Present Law

As part of the methodology for determining payments to hospitals under the Medicare prospective payment system (PPS), the Secretary is required to adjust a portion of the standardized amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average wage level.

Reason for Change

Insures that the wage index in urban areas is at least equal to that of rural areas in a state.

Committee Provision

For discharges occurring on or after October 1, 1997, the area wage index applicable for any hospital which is located in an urban area can not be less than the average of the area wage indices applicable to hospitals located in rural areas in the state in which the hospital is located. The Secretary is required to make any adjustments in the wage index in a budget neutral manner.

INCREASE BASE PAYMENT RATE TO PUERTO RICO

Present Law

Hospitals in Puerto Rico are paid in a similar manner to hospitals paid on the United States mainland, however, they are paid a much lower amount. The lower payments are largely attributed to the dramatically lower prevailing wage in Puerto Rico. For hospital capital payments, Puerto Rico receives a special payment for capital which is lower than what most hospitals on the US mainland receive.

Puerto Rico hospital payments are based on a different standardized amount. The Puerto Rican standardized amount is a blend of 75% of the local average cost of treating a patient in Puerto Rico and 25% of a national amount (this is not the same as the national standardized amount).

Reasons for Change

In 1995, Puerto Rico's urban hospitals had an average inpatient PPS margin of −4%, while mainland United States hospitals had an average 10.7% margin.

Committee Provision

Increases payments to Puerto Rico's hospitals by altering the blended formula for the standardized amount from the 75% local rate, 25% Federal rate to a 50%/50% blend.

PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH

Present Law

Medicare made additional payments for the costs of administering blood clotting factor to Medicare beneficiaries with hemophilia admitted for hospital stays where the clotting factor was furnished between June 19, 1990 and September 30, 1994.

Reasons for Change

Due to increases in the cost of clotting factor resulting from the increase in AIDs prevalence in the blood supply, in 1989, Congress changed the way Medicare paid for inpatient costs of clotting factor by providing an add-on to the PPS payment rates. This change was initially limited to 18 months and then subsequently extended through FY 1994.

Committee Provision

Permanently reinstates Medicare's additional payments for the costs of administering blood clotting factor to Medicare beneficiaries with hemophilia admitted for hospital stays where the clotting factor was furnished. Reaches back to September 30, 1994, and makes the provision permanent.

PAYMENTS FOR HOSPICE SERVICES

Present Law

Medicare covers hospice care for terminally ill beneficiaries with a life expectancy of 6 months or less. Persons electing Medicare's hospice benefit are covered for four benefit periods: two 90-day periods, a subsequent 30-day period, and a final period of unlimited duration.

At the beginning of the first 90-day period when a Medicare beneficiary elects hospice, both the individual's attending physician and the hospice physician must certify in writing that the beneficiary is terminally ill not later than 2 days after hospice is initiated (or, verbally not later than 2 days after care is initiated and in writing not later than 8 days after care has begun).

Medicare covers hospice care, in lieu of most other Medicare benefits. Payment for hospice care is based on one of four prospectively determined rates, which correspond to four different levels of care, each day a beneficiary is under the care of the hospice. The four categories are routine home care, continuous home care, inpatient respite care, and general inpatient care. The prospective payment rates are updated annually by the hospital market basket index (MB).

Hospice services are defined in Medicare statute to include nursing care; physical and occupational therapy and speech language pathology services; medical social services; home health aide services; medical supplies (including drugs and biologicals) and medical appliances; physician services; short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management); and counseling. Beneficiaries electing hospice waive coverage to most Medicare services when the services they need are not related to the terminal illness.

Medicare law requires that hospices routinely provide directly substantially all of certain specified services, often referred to as core services. Physician services are among these core services. HCFA has defined "directly" to require that services be provided by hospice employees.

Hospices generally bill Medicare on the basis of location of the home office, rather than where service is actually delivered.

Medicare law provides financial relief to beneficiaries and providers for certain services for which Medicare payment would otherwise be denied. Medicare payment under this "limitation of liability" provision is dependent on a finding that the beneficiary did not know and could not reasonably have been expected to know that services would not be covered on one of several bases (but not on the determination that an individual is not terminally ill).

Reasons for Change

The hospice benefit should be altered to better reflect the needs of the terminally ill. The current benefit should be changed to provide hospices greater flexibility to deliver services, as well as clearer guidelines for patient certification. Patients who enroll in hospice care, yet who are not deemed to be terminally ill should not be penalized.

Committee Provision

(a) Hospice benefit periods will be restructured to include two 90 day periods, followed by an unlimited number of 60 day periods. The medical director of the hospice will have to recertify at the beginning of the 60 day periods that the beneficiary is terminally ill. The provision will also allow greater flexibility in items and services provided in hospice care as long as they are part of the patient's plan of care. Hospices will be allowed to contract with physicians. Certain staffing requirements will be waived for rural hospices. Eliminates the specific time frame physicians must complete certification forms in order to admit a patient to hospice care.

(b) Requires payment for hospice care furnished in an individual's home be based on the geographic location of the home.

(c) Places limitations on hospice care liability for individuals who are not in fact terminally ill. Provides that Medicare beneficiaries do not have to pay for hospice care based on an incorrect diagnosis of terminal illness if the beneficiary did not know, and could not reasonable have been expected to know, that the diagnosis was in error. As is the case under current practice for other situations involving waiver of liability, a beneficiary has a favorable presumption of ignorance, while a provider of services does not.

Effective Date

Cost reporting periods beginning on or after October 1, 1997.

RELIGIOUS, NON-MEDICAL SERVICES

Present Law

Since Medicare was first enacted, the program has covered the services furnished by Christian Science sanatoria under Part A of the program. In order to be a covered provider, the institution must be listed and certified by the First Church of Christ Scientist, of Boston, Massachusetts. A certified sanatorium qualifies as both a hospital and as a skilled nursing facility. Under Medicare, two separate types of benefits are payable: services received in an inpatient Christian Science sanatorium and extended care services in a sanatorium. Section 1861(e)(9) of the Social Security Act includes a Christian Science sanatorium in the definition of a hospital; 1861(y) defines extended care in a Christian Science skilled nursing facility. Under the Medicaid program, states have the option of covering services provided by Christian Scientist sanatoria and extended care facilities.

Reasons for Change

The need for clarification of how the statute treats religious, nonmedical institutions became evident after the current statutory provisions were successfully challenged in a Minnesota District Court which held that they violate the Establishment Clause of the Constitution as an impermissible sectarian preference. The Court's decision enjoined the Secretary from further implementation of the law, but the injunction was stayed until August.

Committee Provision

This provision replaces existing law and provides for reimbursement of nursing services to individuals who decline to accept medical care due to sincerely held religious beliefs. The provision requires the Health Care Financing Administration (HCFA) to develop conditions of participation for religious, nonmedical institutions and to require that such conditions are met. The provision requires that HCFA develop the conditions of participation in a manner that will not exceed $20 million per year.

Subtitle G—Provisions Relating to Part B Only

CHAPTER 1—PAYMENTS FOR PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

PAYMENTS FOR PHYSICIAN'S SERVICES

Present Law

(a) Physician Fee Schedule.—Medicare pays for over 7,000 physician services according to a fee schedule. The Medicare physician fee schedule uses two formulas: (1) one to calculate the fee for each service; and (2) another to annually revise or ''update'' the fees.

Under the fee schedule, each physician service is assigned relative value units (RVUs) that reflect three factors: physician work, practice expenses (i.e., office costs), and malpractice insurance costs. The RVUs for each service are adjusted for geographic variations in the costs of practicing medicine.

To determine the Medicare fee payment for a physician service, the adjusted RVUs for that service are multiplied by a dollar amount called a ''conversion factor.'' There are currently three conversion factors, for (1) surgical services; (2) primary care services; and (3) other nonsurgical services. In 1997, the conversion factors were: $40.96 for surgical services; $35.77 for primary care services; and $33.85 for other nonsurgical services.

Each year, unless Congress otherwise provides, a default formula is used to update each conversion factor. The default update is the sum of the Medicare Economic Index (MEI) (a measure of inflation) and a volume performance adjustment. If the volume performance adjustment is less than MEI, the update is positive; if less than MEI, the update is negative.

The volume performance adjustment is intended to reward restraint in increases in the quantity of physician services provided to beneficiaries (so-called volume and intensity of services), and is a comparison of actual physician spending in a base period with an expenditure goal known as the Medicare Volume Performance Standard (MVPS). MVPS is calculated from changes in volume and intensity of services and certain other factors, based on data from the second-preceding fiscal year (e.g., 1995 data would be used to determine the 1997 update). The MVPS derived from this calculation is subject to a reduction known as the ''performance standard factor.'' The MVPS has a lower limit of MEI minus five percentage points.

Anesthesia services are reimbursed according to a separate fee schedule, although that fee schedule also uses RVUs and a conver-

sion factor. The anesthesia services conversion factor was $16.68 in 1997.

(b) Resource-Based Methodology for Practice Expenses.—Currently, practice expenses (i.e., the costs of running a doctor's office) are based on charges to the Medicare program before the enactment of the physician fee schedule in 1989, not the resources actually used in providing each physician service. However, a resource-based methodology for practice expenses was intended by the Omnibus Reconciliation Act of 1989 (OBRA 1989), which established the physician fee schedule. In the Social Security Act Amendments of 1994, Congress instructed the Secretary of Health and Human Services to implement a resource- based methodology for practice expenses, to be implemented in 1998.

Reasons for Change

(a) Physician Fee Schedule.—The Committee provision provides for a single conversion factor. A single conversion factor restores the integrity of the fee schedule. When the fee schedule was established, it was intended that each RVU should be worth the same amount across all physicians' services, and not by the category of physician service (i.e., surgical services, primary care services, and other non-surgical services). However, under current law, physician services assigned the same number of RVUs may be paid differing amounts. The Committee provision corrects this distortion of the physician fee schedule. A single conversion factor has been recommended by the Physician Payment Review Commission.

(b) Resource-Based Methodology for Practice Expenses.—The resource-based practice expense methodology is expected to result in enhanced reimbursement for physician services provided in an office setting with undervalued office costs, and reduced reimbursement for services provided in a hospital or other health care facility (such as surgical procedures) with overvalued costs. To allow this redistribution to proceed in an orderly fashion, the Committee provision would provide for an extended transition period for implementation of the resource-based methodology for practice expenses.

Committee Provision

(a) Physician Fee Schedule.—The Committee bill would provide for the establishment of a single conversion factor, rather than three conversion factors, effective January 1, 1998. The provision would set the single conversion factor for 1998 at the 1997 primary care conversion factor, updated to 1998 by the Secretary's estimate of the weighted average of the three separate updates that would occur in the absence of the legislation.

The Committee bill would modify the default update formula, effective for calendar year 1997. The update would equal the product of MEI and the update adjustment factor. The update adjustment factor would match spending on physician services to a cumulative sustainable growth rate. By November of each year, the Secretary will calculate the update adjustment factor for the succeeding year on the basis of a comparison between cumulative target spending (cumulated from annual sustainable growth rate calculations) and cumulative actual spending from a base year of July 1996 to June

1997. The annual sustainable growth rate would be calculated with the same factors as the current Medicare Volume Performance Standard (MVPS), except the factor of growth in historical volume and intensity of physician services is replaced with projected annual growth in real Gross Domestic Product (GDP) and the performance standard factor is eliminated.

The update would be subject to upper and lower bounds. The update could be no greater than approximately MEI plus three percentage points, or less than MEI minus seven percentage points.

The Committee provision specify that the conversion factor for anesthesia services would equal 46 percent of the conversion factor established for other services for 1998.

(b) Resource-Based Methodology for Practice Expenses.—The Committee provision would provide a one-year delay in the implementation of the proposed rule for a resource-based methodology for practice expenses by the Health Care Financing Administration (HCFA) and a subsequent phase in of a rule over a subsequent three-year period, from January 1, 1999 through January 1, 2001. For 1998, the Committee bill would establish a special rule by which approximately 10 percent of the amount of money expected to be redistributed under practice expense reform would be subtracted from the practice expenses of physician services where practice RVUs exceed work RVUs by 110 percent and added to the practice expenses of primary care services provided in a physician's office which have been determined to have been historically underpaid. Full implementation of practice expense reform would occur no later than 2001, with implementation in equal yearly proportions over this period.

The Committee is aware and concerned that many issues have been raised about the resource-based practice expense methodology proposed by HCFA. To provide for an independent and objective review of these issues, the Committee provision would provide for a study within 6 months by the General Accounting Office. The GAO study is intended to be a thorough examination of the proposed rule on practice expenses. As part of this examination, the Committee expects that GAO will consult with organizations representing physicians and to address the issue of beneficiary access to medical services. The Committee provision would also direct the Secretary to solicit the individual views of physicians in the practice of surgical and non-surgical specialties, physicians in academic practice, and other appropriate experts. The Committee provision would direct the Secretary to report to the appropriate committees of jurisdiction the results of these consultations.

The Committee expects the Secretary to carefully review both the GAO report and the information provided by the individual physicians and other experts. The Committee intends to review these reports carefully as well. If the Secretary determines that insufficient data exists to support the proposed rule, or finds other serious problems with the proposed rule, the Committee expects the Secretary to collect new data or take such other actions needed to correct any deficiencies, including a new study, before proceeding to a final rulemaking. In general, any new data collection or other action to correct deficiencies shall include the following: (1) direct and indirect cost accounting according to standard accounting prin-

ciples; (2) physician associated costs of non-physician staff, personnel, equipment and supplies used by a physician in the delivery of patient related service, regardless of site; and (3) inclusion of appropriate physician practices relevant to the provision of services to Medicare beneficiaries.

Effective Date

Generally January 1, 1998.

INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, AND PHYSICIAN ASSISTANTS

Present Law

(a) Payments for Nurse Practitioners and Clinical Nurse Specialists.—Separate payments are made for nurse practitioner (NP) services provided in collaboration with a physician, which are furnished in a nursing facility. Such payments equal 85 percent of the physician fee schedule amount. Nurse practitioners and clinical nurse specialists (CNSs) are paid directly for services provided in collaboration with a physician in a rural area. Payment equals 75 percent of the physician fee schedule amount for services furnished in a hospital and 85 percent of the fee schedule amount for other services.

(b) Payments for Physician Assistants.—Separate payments are made for physician assistant (PA) services when provided under the supervision of a physician: (1) in a hospital, skilled nursing or nursing facility, (2) as an assistant at surgery, or (3) in a rural area designated as a health professional shortage area.

Reasons for Change

Expanded reimbursement of nurse practitioners, clinical nurse specialists, and physician assistants would enhance the availability of care in rural areas and of primary care services to Medicare beneficiaries generally.

Committee Provision

(a) Payments for Nurse Practitioners and Clinical Nurse Specialists.—The provision would remove the restriction on settings. It would also provide that payment for NP and CNS services could only be made if no facility or other provider charges are paid in connection with the service. Payment would equal 80 percent of the lesser of either the actual charge or 85 percent of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment would equal 80 percent of the lesser of either the actual charge or 85 percent of the amount that would be recognized for a physician serving as an assistant at surgery. The provision would authorize direct payment for NP and CNS services.

The provision would clarify that a clinical nurse specialist is a registered nurse licensed to practice in the state and who holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

(b) Payments for Physician Assistants.—The Committee provision would remove the restriction on settings. The Committee provision would also provide that payment for PA services could only be made if no facility or other provider charges are paid in connection with the service. Payment would equal 80 percent of the lesser of either the actual charge or 85 percent of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment would equal 80 percent of the lesser of either the actual charge or 85 percent of the amount that would be recognized for a physician serving as an assistant at surgery. The provision would further provide that the PA could be in an independent contractor relationship with the physician. Employer status would be determined in accordance with state law.

Effective Date

January 1, 1998.

CHIROPRACTIC SERVICES DEMONSTRATION PROJECT

Present Law

Medicare covers chiropractic services involving manual manipulation of the spine to correct a subluxation demonstrated to exist by X-ray. Medicare regulations prohibit payment for the X-ray either if performed by a chiropractor or ordered by a chiropractor.

Reason for Change

Current policy on coverage of services provided by chiropractors was enacted 20 years ago and does not reflect current subsequent developments in recognition of the value of chiropractic services. This demonstration will provide additional information on the cost effectiveness of services provided by chiropractors.

Committee Provision

The Committee provision would direct the Secretary to establish a two-year demonstration project, beginning not later than one year after enactment, to examine methods under which access to chiropractic services by Medicare beneficiaries might be expanded on a cost-effective basis.

The Secretary would conduct a demonstration with at least the following elements: (1) the effect of allowing doctors of chiropractic to order and be reimbursed for x-rays; (2) the effect of removing the x-ray requirement; (3) the effect of allowing chiropractors, within the scope of their licensure, to provide physicians services to beneficiaries; and (4) the cost effectiveness of allowing beneficiaries who are enrolled with a risk-based HMO to have direct access to chiropractors. Direct access would be defined as the ability of a beneficiary to go directly to a chiropractor without prior approval from a physician or other gatekeeper.

The Committee provision would require that each of the demonstration elements to be examined in three or more rural areas, in three or more urban areas, and in three or more areas having a shortage of primary medical care professionals. The Secretary, in designing and conducting the demonstration, would be required to

consult, on an ongoing basis, with chiropractors, organizations representing chiropractors, and representatives of Medicare beneficiary groups. The provision would require the Secretary to examine the direct access element described above with at least 10 Medicare HMOs that have voluntarily elected to participate in the demonstration; these HMOs would be eligible to receive a small incentive payment.

The Secretary would be required to evaluate whether beneficiaries who use chiropractic services use fewer Medicare services overall, the overall costs effects of increased access to chiropractors, and beneficiary satisfaction with chiropractic services. The Secretary would be required to submit a preliminary report to Congress within two years of enactment and a final report by January 1, 2001 together with recommendations on each of the four elements noted above. The Secretary would be required to include specific legislative proposals for those items that the Secretary has found to be cost effective.

As soon as possible after submission of the final report, the Secretary would begin payment for elements of the demonstration project proven cost effective for the Medicare program.

Effective Date

January 1, 1998.

CHAPTER 2—OTHER PAYMENT PROVISIONS

PAYMENTS FOR CLINICAL LABORATORY DIAGNOSTIC SERVICES

Present Law

Since 1984, Medicare payments for clinical laboratory services have been made on the basis of local fee schedules established in areas designated by the Secretary. Beginning in 1986, the fee for each laboratory service has been limited by a national cap amount, which is based on the median of all local fees established for that laboratory test during a base year. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) mandated a reduction in the national cap amounts in 1996 to 76 percent of the median fee amount paid for each service in a base year.

Current law provides that fee schedule amounts for laboratory services are updated each January 1 by the decrease or increase in the consumer price index for urban consumers (CPI–U). OBRA 93 eliminated this update for 1994 and 1995.

Reasons for Change

The Committee provision would establish more appropriate growth in payments.

Committee Provision

The Committee provision would reduce the inflation updates by two percentage points each year from January 1, 1998, through December 31, 2002. It would also lower the cap from 76 percent of the median to 74 percent of the median beginning in 1998.

The Committee provision directs the Secretary of Health and Human Services to request the Institute of Medicine to conduct a study on Medicare Part B payments for clinical laboratory services, including the relationship between Medicare payments for laboratory services and access by beneficiaries to high quality services and new test procedures.

Effective Date

January 1, 1998.

IMPROVING PROGRAM INTEGRITY AND CONSISTENCY IN THE CLINICAL LABORATORY DIAGNOSTIC SERVICES BENEFIT

Present Law

Claims for payment for clinical laboratory diagnostic services, as other claims for payment under Medicare Part B, are processed by carriers, which are by statute health insurance companies under contract to the Health Care Financing Administration to conduct claims processing and certain program integrity activities. Carriers have a limited authority to establish coverage and payment rules.

Reasons for Change

The Committee provision would provide for improved program integrity in the administration of the laboratory services benefit

Committee Provision

The Committee provision would require the Secretary to divide the country into no more than 5 regions and designate a single carrier for each region to process laboratory claims no later than January 1, 1999. One of the carriers would be selected as a central statistical resource. The assignment of claims to a particular carrier would be based on whether the carrier serves the geographic area where the specimen was collected or other method selected by the Secretary.

The Committee provision would require the Secretary, by July 1, 1998, to adopt uniform coverage, administration, and payment policies for lab tests using a negotiated rule-making process. The policies would be designed to promote uniformity and program integrity and reduce administrative burdens with respect to clinical diagnostic laboratory tests.

The Committee provision would provide that during the period prior to the implementation of uniform policies, carriers could implement new local requirements under certain circumstances.

The provision would permit the use of interim regional policies where a uniform national policy had not been established. The Secretary would establish a process under which designated carriers could collectively develop and implement interim national standards for up to 2 years.

The Secretary would be required to conduct a review, at least every 2 years, of uniform national standards. The review would consider whether to incorporate or supersede interim regional or national policies.

With regard to the implementation of new requirements in the period prior to the adoption of uniform policies, and the development of interim regional and interim national standards, carriers must provide advance notice to interested parties and allow a 45 day period for parties to submit comments on proposed modifications.

The Committee provision would require the inclusion of a laboratory representative on carrier advisory committees. The Secretary would be required to consider nominations submitted by national and local organizations representing independent clinical labs.

This Committee provision would exempt independent physician offices until the Secretary could provide that such offices would not be unduly burdened by billing responsibilities with more than one carrier.

Effective Date

Generally on enactment.

DURABLE MEDICAL EQUIPMENT

Present Law

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) established six categories of durable medical equipment for purposes of determining fee schedules and making payments. Among these categories are home oxygen equipment, which is reimbursed on a regionally adjusted monthly payment amount. Fee schedule amounts for durable medical equipment are updated annually for inflation.

Reasons for Change

Although the Committee bill would reduce the growth in expenditures on durable medical equipment, spending in this area is expected to remain among the fastest growing areas in the Medicare program. In the category of home oxygen equipment, the General Accounting Office has reported that a Medicare substantially overpays for home oxygen equipment compared to the Veteran's Administration, even when differences between the two programs are considered.

Committee Provision

The Committee provision would reduce the update by two percentage points for all categories of DME, including orthotics and prosthetics and parenteral and enteral nutrients, supplies, and equipment, each year from January 1, 1998, through January 1, 2002.

The Committee provision would provide for the monthly payment amount for home oxygen services to be reduced 25 percent in 1998 and an additional 12.5 percent in 1999. The Committee provision would authorize the Secretary to create classes of oxygen equipment with differing payments, so long as there is no net increase in payments for home oxygen equipment. The Committee provision would also direct the Secretary to establish service standards and accreditation requirements for home oxygen providers. The Com-

mittee provision would direct the General Accounting Office to report within six months of enactment of this Act on access to home oxygen equipment, and direct the Secretary to arrange with peer review organizations established under section 1154 of the Social Security Act to evaluate access and quality of home oxygen equipment following enactment of this act. In addition, the Committee provision would require the Secretary to conduct a demonstration project of competitive bidding for home oxygen equipment.

The Committee provision would permit beneficiaries to purchase upgraded or enhanced durable medical equipment (DME) in a simpler fashion. A DME supplier would be permitted to bill the Medicare program for the basic DME item, and receive an additional payment from the beneficiary for the amount of the difference between the Medicare payment and the cost of the enhanced item. The Committee provision provides for the promulgation by the Secretary of consumer protection regulations, at which time this provision becomes effective.

Effective Date

Generally January 1, 1998.

UPDATES FOR AMBULATORY SURGICAL SERVICES

Present Law

Under current law, payments to ambulatory surgical centers are made on the basis of prospectively determined rates, determined by the Secretary for each covered procedure. Payments are updated annually for inflation.

Committee Provision

The Committee bill would reduce updates for payments to ambulatory surgical centers by two percentage points each year for 1998 through 2002.

Effective Date

January 1, 1998.

PAYMENTS FOR OUTPATIENT PRESCRIPTION DRUGS

Present Law

Under current law, Medicare provides a very limited outpatient prescription drug benefit (however, Medicare generally pays for drugs provided to a beneficiary while in a hospital). With some exceptions, Medicare pays only for outpatient drugs that cannot be "self-administered"—for example, drugs that must be administered directly by a physician in his office, such as intravenous drugs for cancer therapy; or require specialized equipment in the home, such as infusion therapy.

Reasons for Change

Medicare pays "reasonable charges" for outpatient drugs, which in practice is the manufacturers' recommended price. The Inspector

General of the Department of Health and Human Services has found that Medicare pays substantially more than most other payers for prescription drugs.

Committee Provision

The Committee provision would specify that in any case where payment is not made on a cost or prospective payment basis, the payment could not exceed 95 percent of the average wholesale price, as specified by the Secretary. In any case, the amount payable for any drug or biological shall not exceed the amount paid on May 1, 1997, increased annually by consumer price index.

The Secretary would be required to conduct such studies or surveys to determine the average wholesale price or other appropriate price of outpatient prescription drugs and report to Congress within six months following the date of enactment. If the Secretary further adjusts the payment amounts for outpatient prescription drugs, the Secretary is authorized to pay a dispensing fee to pharmacies.

Effective Date

On enactment.

CHAPTER 3—PART B PREMIUM AND RELATED PROVISIONS

PART B PREMIUM

Present Law

Part B of Medicare is a voluntary program for which beneficiaries pay a monthly premium. When Medicare was established in 1965, the Part B monthly premium was set at an amount to cover one-half of the Part B program costs, with the remainder of funding from general revenues.

Under current law, Part B monthly premiums are required to cover 25 percent of Part B program costs. However, this provision expires effective for calendar year 1999. For subsequent years, increases in the Part B premium are limited to the cost-of-living adjustment for Social Security beneficiaries.

Reasons for Change

The Committee provision would establish the policy that Part B premiums permanently cover 25 percent of Part B spending.

Committee Provision

The Committee provision would establish permanently Part B monthly premiums in law at 25 percent of Part B program costs.

Effective Date

January 1, 1998.

INCOME-RELATED PART B DEDUCTIBLE

Present Law

Part B of Medicare is a voluntary program. Beneficiaries enrolled in Part B must pay the first $100 each year of the costs of Part B covered services. This deductible amount is the same for all beneficiaries regardless of income. The deductible amount has been increased only three times since the inception of the Medicare program: from 1966 to 1972 the deductible was $50; from 1973 to 1981, $60; and from 1982 to 1990, $75.

Reasons for Change

There are many beneficiaries who can afford to pay more of Part B program costs, and taxpayers should not be asked to subsidize these beneficiaries. Moreover, a higher deductible would make beneficiaries more conscious of the costs of medical care, and encourage more prudent purchasing by beneficiaries of medical services. Savings from this provision would be applied to improving the financial status of the Part A (Hospital Insurance) Trust Fund.

Committee Provision

The Committee provision would provide for an income-related Part B deductible for individuals with incomes over $50,000 and couples with incomes over $75,000. The Committee provision would increase the amount of the deductible over the current law amount of $100 by an amount equal to the amount Part B premiums would be increased if there were a straight line phase out of the Federal subsidy (currently 75 percent) for the Part B premium. For individuals, this phase out would occur over the income range of $50,000 to $100,000; for couples, $75,000 to $125,000.

The Committee provision would require the Secretary to make an initial determination of the amount of an individual's adjusted gross income (AGI) by September 1 for the forthcoming year, and notify each beneficiary subject to an increased deductible. The beneficiary would have a 30-day period to provide information on the beneficiary's anticipated AGI and the Secretary would adjust the deductible amount. If it is subsequently determined that a beneficiary's deductible amount was too high and the beneficiary paid too much for medical services, the Secretary would provide for repayment of the difference. If the deductible amount was too low, and the beneficiary paid too little for medical services, the Secretary would seek recovery from the beneficiary.

For beneficiaries enrolled in Medicare Choice organizations, the Secretary would reduce the monthly payment by an amount the Secretary determines (on the basis of actuarial value) to be the equivalent amount of the increase in the deductible for a beneficiary. The Committee provision would allow Medicare Choice organizations to recoup the amount of any payment reduction from a beneficiary.

The Committee provision would require the Secretary to transfer amounts equal to the reduction in payments under this provision to the Part A (Hospital Insurance) Trust Fund.

Effective Date

January 1, 1998.

Subtitle H—Provisions Relating to Parts A and B

CHAPTER 1—SECONDARY PAYOR PROVISIONS

SECONDARY PAYOR PROVISIONS

Present Law

(a) Secondary Payer Extensions.—Generally, Medicare is the "primary payer," that is, Medicare pays medical claims first, with an individual's private or other public insurance only responsible for claims not covered by Medicare. For certain Medicare beneficiaries, however, the beneficiary's employer's health insurance plan pays medical bills first (so-called "primary payer"), with Medicare paying for any gaps in coverage within Medicare's coverage limits (Medicare is the "secondary payer"). Medicare is the secondary payer to certain employer group health plans for: (1) aged beneficiaries (age 65 and over); (2) disabled beneficiaries, and (3) beneficiaries with end-stage renal disease (ESRD) during the first 18 months of a beneficiary's entitlement to Medicare on the basis of ESRD.

The Medicare secondary payer provision regarding aged beneficiaries is permanent law. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) extended the law making Medicare the secondary payer for disabled and ESRD beneficiaries through October 1, 1998.

(b) Data Match Program.—The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) authorized a "data match" program to identify potential secondary payer situations. Medicare beneficiaries are matched against data collected by Internal Revenue Service and the Social Security Administration to identify cases in which a working beneficiary (or working spouse) may have employer-based health insurance coverage. Cases of incorrect Medicare payments are identified and recoveries of payments are sought. The authority for this program expires on September 30, 1998.

(c) Recovery of Payments.—In many cases where Medicare secondary payer recoveries are sought, claims have never been filed with the primary payer. Identification of potential recoveries under the data match process typically takes several years—considerably in excess of the period many health plans allow for claims filing. A 1994 appeals court decision held that HCFA could not recover overpayments without regard to an insurance plan's filing requirements. A 1994 appeals court decision held that HCFA could not recover from third party administrators of self-insured plans.

Reasons for Change

The Committee provision would provide for improved operation of the secondary payer program.

Committee Provision

The Committee provision would:

(a) Make permanent law that Medicare is the secondary payer for disabled beneficiaries who have employer-provided health insurance; and make permanent law and extend to 30 months the period of time employer health insurance is the primary payer for ESRD beneficiaries;

(b) Make the data match program authority permanent law; and

(c) Specify that the U.S. could seek to recover payments if the request for payments was submitted to the entity required or responsible to pay within three years from the date the item or service was furnished. This provision would apply notwithstanding any other claims filing time limits that may apply under an employer group health plan. The provision would apply to items and services furnished after 1990. The provision should not be construed as permitting any waiver of the 3-year requirement in the case of items and services furnished more than 3 years before enactment.

The provision would permit recovery from third party administrators of primary plans. However, recovery would not be permitted where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

The provision would clarify that the beneficiary is not liable in Medicare secondary payer recovery cases unless the benefits were paid directly to the beneficiary.

Effective Date

Generally on enactment.

CHAPTER 2—OTHER PROVISIONS

CONFORMING AGE FOR ELIGIBILITY UNDER MEDICARE TO RETIREMENT AGE FOR SOCIAL SECURITY BENEFITS

Present Law

In 1983, Congress raised the eligibility age for Social Security old-age cash benefits from age 65 to age 67, to be phased in over a transition period from 2003 to 2027. However, under current law, the age of entitlement for Medicare remains unchanged at age 65.

Reasons for Change

The Committee provision will establish a consistent national policy on eligibility for both Social Security old-age pension benefits and Medicare. Although this provision will not produce any savings that apply to the Committee's reconciliation instructions, this provision will improve the long-term solvency of the Hospital Insurance (Part A) Trust Fund.

Committee Provision

The Committee provision amends the relevant sections of the Social Security Act to raise the age of eligibility for Medicare benefits from age 65 to age 67 over the years 2003 to 2027 in the same in-

crements as for Social Security old-age pensions as detailed in section 216(l)(1)) of the Social Security Act.

INCREASE CERTIFICATION PERIOD FOR ORGAN PROCUREMENT ORGANIZATIONS

Present Law

Section 1138(b) of the Social Security Act requires that the Secretary can make Medicare and Medicaid payments for organ procurement costs to organ procurement organizations (OPOs) operating under Section 371 of the Public Health Service Act, or having been certified or recertified by the Secretary within the previous 2 years as meeting certain requirements.

Reasons for Change

OPOs compete during recertification periods for service areas. This competition involves massive data gathering and contracting for legal services in order to justify service areas.

Committee Provision

The provision would amend current law to provide OPOs three years between certifications or recertifications if the Secretary deems the organizations as having a good record in meeting standards to be a qualified OPO.

DIVISION 2—MEDICAID AND CHILDREN'S HEALTH INSURANCE INITIATIVES

Subtitle I—Medicaid

CHAPTER 1—MEDICAID SAVINGS

MANAGED CARE REFORMS

Present Law

To control costs and improve the quality of care, states are increasingly delivering services to their Medicaid populations through Health Maintenance Organizations (HMOs) and other managed care arrangements. Medicaid programs use three main types of managed care arrangements. These vary according to the comprehensiveness of the services they provide and the degree to which they accept risk, and include Primary Care Case Management (PCCM), fully capitated Health Maintenance Organizations (HMOs) and Health Insuring Organizations (HIOs), and partially capitated Pre-Paid Health Plans (PHPs). Under PCCM a Medicaid beneficiary selects, or is assigned to a single primary care provider, which provides or arranges for all covered services and is reimbursed on a fee-for-service basis in addition to receiving a small monthly "management" fee. Fully capitated plans contract on a risk basis to provide beneficiaries with a comprehensive set of covered services in return for a monthly capitation payment. Partially capitated plans provide a less than comprehensive set of services on a risk basis; services not included in the contract are reimbursed on a fee-for-service basis. Under fully and partially capitated managed care arrangements, beneficiaries have a regular source of coordinated care and states have predictable, controlled spending per beneficiary. This is in contrast to the traditional fee-for-service arrangements used by Medicaid beneficiaries where Medicaid pays for each service used.

The Medicaid statute contains several provisions that limit a state's ability to use managed care, including the freedom of choice, statewideness, and comparability requirements. These require that beneficiaries be free to receive services from the provider of their choice and that all covered benefits in a state plan be available throughout the state. States can bypass these requirements by establishing voluntary fully- or partially-capitated managed care plans. States are not, however, authorized to establish voluntary primary care case management (PCCM) programs. Voluntary managed care plans must meet other requirements that govern how Medicaid managed care plans operate. These include rules about solvency, enrollment practices, procedures for protecting beneficiaries' rights, and contracting arrangements of managed care plans.

As a proxy for quality, current law requires that plans limit their enrollment of Medicaid and Medicare beneficiaries to no more than 75% of total enrollment (known as the ''75/25 rule'). Publicly owned contracting plan, plans with more than 25,000 enrollees that serve a designated ''medically underserved'' area and that previously participated in an approved demonstration project, or plans that have had a Medicaid contract for less than three years may obtain a waiver of this requirement if they are making continuous and reasonable efforts to comply with the 75% limit. In addition, for some HMOs, the 75/25 rule has been bypassed through state demonstration waivers or through specific federal legislation. Beneficiaries must be permitted to disenroll from a managed care plan without cause during the first month of enrollment and may disenroll at any time for cause. Enrollees may be locked into the same plan for up to six months if the plan is a federally qualified (HMO). States may also guarantee eligibility for up to six months for persons enrolled in federally qualified HMOs. States may not restrict access to family planning services under managed care.

To mandate that a beneficiary enroll in a managed care entity, to operate a PCCM program, or to limit managed care services to a specific population or geographic area, a state must first obtain a waiver of the freedom-of-choice provision of Medicaid law. These renewable waivers, as authorized under section 1915(b) of Medicaid law, are initially good for two years. Most states have received waivers of federal law to implement managed care programs.

Reasons for Change

The Committee provision permits states to mandate enrollment of individuals in managed care plans without the need for waivers.

Committee Provision

The provision would give states the option of providing benefits through a managed care entity, including a PCCM program, without requiring a 1915(b) waiver of the statewideness, comparability, and freedom of choice requirements. States would be allowed to require that individuals eligible for medical assistance under the state plan enroll in a capitated managed care plan or with a primary care case manager. The provision would also eliminate the 75/25 rule effective June 20, 1997. Individuals who are ''dually eligible'' for Medicare and Medicaid and ''special needs'' children cannot be required to enroll in managed care, but may do so on a voluntary basis.

Present Law

All state contracts with a managed care organization must receive prior approval from the Secretary if expenditures are expected to be over $100,000.

Committee Provision

The provision would raise the threshold for federal review of managed care contracts from $100,000 to $1,000,000.

Present Law

In order to operate a PCCM system, states must obtain a waiver of the freedom-of-choice provision of Medicaid law. The waiver allows states to restrict the provider from whom a beneficiary can obtain services. Except in the case of an emergency, the beneficiary may obtain other services, such as specialty physician and hospital care, only with the authorization of the primary care provider. The aim of the program is to reduce the use of unnecessary services and provide better overall coordination of beneficiaries' care.

Reasons for Change

The Committee provision would establish rules for using primary care case management.

Committee Provision

The provision establishes a definition of PCCM, sets contractual requirements for PCCM arrangements, adds PCCM services to the list of Medicaid covered services, and repeals waiver authorization for PCCM.

Primary Care Case Manager means a provider that has entered into a primary case management contract with the state agency and that is a physician, a physician group practice, or an entity employing or having other arrangements with physicians who provide case management services or, at state option, a nurse practitioner, a certified nurse-midwife, or a physician assistant.

States would be permitted to mandate enrollment in PCCM or other managed care arrangements if a Medicaid beneficiary had a choice of at least two entities or managers and other conditions were met. States would be permitted to require beneficiaries to remain in a managed care arrangement for up to six months; states would also be permitted to guarantee six months of eligibility for enrollees. Prior to establishing a mandatory managed care requirement, a state would be required to provide for public notice and comment.

The payment limit and actuarial soundness standards would be modified to require that capitated payment amounts be set at rates that have been determined, by an actuary meeting the standards of qualification and practice established by the Actuarial Standards Board, to be sufficient and not excessive with respect to the estimated costs of services provided.

Present Law

The Medicaid statute includes a number of provisions intended to improve quality of care in prepaid programs and to protect beneficiaries. States are required to obtain an independent assessment of the quality of services furnished by contracting HMOs and prepaid health plans (those offering a non-comprehensive set of services under partial capitation), using either a utilization and quality control peer review organization (PRO) under contract to the Secretary or another independent accrediting body. In addition, states are prohibited from contracting with an organization which is managed or controlled by, or has a significant subcontractual relation-

ship with, individuals or entities potentially excludable from participating in Medicaid or Medicare. States are required to collect sufficient data on HMO enrollees'' encounters with physicians to identify the physicians furnishing services to Medicaid beneficiaries. As a proxy for quality, federal law requires that less than 75% of a managed care organization's enrollment must be Medicaid and Medicare beneficiaries. For some HMOs, the 75/25 rule has been bypassed through state demonstration waivers or through specific federal legislation. Some HMOs are federally qualified—determined by the Secretary to meet standards set forth in title XIII of the Public Health Service Act that includes quality standards.

Reasons for Change

The Committee provision establishes quality standards including consumer protections.

Committee Provision

The provision would require the state agency to develop and implement a quality assessment and improvement strategy consistent with standards that the Secretary shall monitor. These shall include standards for access to care so that covered services are available within reasonable time frames and in a manner that ensures continuity of care and adequate primary care and specialized services capacity. Procedures for monitoring and evaluating the quality and appropriateness of care and services to beneficiaries shall include requirements for provision of quality assurance data to the state using the data and information that the Secretary shall specify with respect to entities contracting under section 1876 or alternative data requirements approved by the Secretary; regular and periodic examination of the scope and content of the quality improvement strategy; and other aspects of care and service directly related to the improvement of quality of care including grievance procedures and marketing and information standards. Each year the Secretary shall conduct validation surveys of managed care organizations serving Medicaid beneficiaries to assure the quality and completeness of data reporting.

Entities entering into such agreements shall be required to submit to the state agency information that demonstrates improvement in the care delivered to members; to maintain an internal quality assurance program consistent with standards the Secretary shall establish in regulations; to provide effective procedures for hearing and resolving grievances between the entity and its members; and that adequate provision is made with respect to the solvency, financial reporting, and avoidance of waste, fraud, and abuse by those entities.

The PCCM contract shall provide for reasonable and adequate hours of operation including 24-hour availability of information, referral, and treatment with respect to medical emergencies; restriction of enrollment to individuals residing sufficiently near a service delivery site of the entity to be able to reach that site within a reasonable time using available and affordable modes of transportation; employment of, or contracts or other arrangements with sufficient numbers of physicians and other appropriate health care

professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care; prohibition on discrimination on the basis of health status or requirements for health services in enrollment, disenrollment, and reenrollment; and the right to terminate enrollment at any time for cause. In assuring beneficiaries' access to emergency care, the "prudent layperson" standard shall apply.

Managed care plans would be required to pay affiliated providers in a timely manner for items and services provided to Medicaid beneficiaries. Payments to federally qualified health centers and rural health centers must be made on a cost basis comparable to what other providers are paid.

If a state uses an enrollment broker, the broker must be independent of any MCO or PCCM that provides coverage to Medicaid beneficiaries in that state.

Subchapter B—Management Flexibility Reforms

ELIMINATION OF BOREN AMENDMENT REQUIREMENTS FOR PROVIDER PAYMENT RATES

Present Law

The Boren amendments require states to pay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICFs/MR) rates that are "reasonable and adequate" to cover the costs which must be incurred by "efficiently and economically operated facilities." In several states, providers and provider organizations challenged state policies in federal courts alleging that the state's procedures for reimbursement violated requirements of the Boren amendments. Following a Supreme Court decision that the amendments created enforceable rights for providers, a number of courts found that state systems failed to meet the test of "reasonableness" and some states had to increase payments to these providers.

Reasons for Change

The Committee provision would repeal the "Boren Amendment" provisions.

Committee Provision

The provision would repeal the present law provisions for payments for hospital services, nursing facilities services, services of intermediate care facilities for the mentally retarded and home and community-based services. States would provide for a public notice process for reimbursement methodology and proposed payment rates for these institutional providers. Providers, beneficiaries, and their representatives, and other concerned individuals are to be given an opportunity to review proposed payment rates and the methodologies underlying the establishment of such rates. Such notice shall describe how the rate-setting methods used by the states will affect access to services, quality of services and safety of beneficiaries. Final payment rates, the methodologies underlying the establishments of such rates, and justifications for such rates that

may take into account public comments received by the state (if any) shall be published in 1 or more daily newspapers of general circulation in the state or in any publication used by the state to publish state statutes or rules.

Not later than four years after enactment of this act, the Secretary shall study the effect on access to services, the quality of services, and the safety of beneficiaries and submit a report to Congress with conclusions from the study, together with any recommendations.

MEDICAID PAYMENT RATES FOR QUALIFIED MEDICARE BENEFICIARIES

Present Law

State Medicaid programs are required to pay Medicare cost-sharing charges for individuals who are beneficiaries under both Medicaid and Medicare (dual eligibles) and for qualified Medicare beneficiaries (QMBs). QMBs are individuals who have incomes not over 100% of the poverty level and who meet specified resources standards. The amount of required payment has been the subject of some controversy.

State Medicaid programs frequently have lower payment rates for services than the rates that would be paid under Medicare. Program guidelines permit states to either (1) pay the full Medicare deductible and coinsurance amounts or (2) pay cost-sharing charges only to the extent that the Medicare provider has not received the full Medicaid rate for an item or service. Some courts have forced state Medicaid programs to reimburse Medicare providers to the full Medicare allowable rates for services provided to QMBs and dually eligible individuals.

Reasons for Change

The Committee provision would clarify that state Medicaid programs could limit Medicare cost-sharing to amounts that do not exceed Medicaid payment rates.

Committee Provision

A state is not required to provide any payment for any expenses incurred relating to payment for a coinsurance or copayment for Medicare cost-sharing if the amount of the payment under title XVIII for the service exceeds the payment amount that otherwise would be made under the state plan. The amount of payment made under title XVIII plus the amount of payment (if any) under the state plan shall be considered to be payment in full for the service, the beneficiary shall not have any legal liability to make payment to the provider for the service, and any lawful sanction that may be imposed upon a provider for excess charges under this title or title XVIII shall apply to the imposition of any charge on the individual in such case. This shall not be construed as preventing payment of any Medicare cost-sharing by a Medicare supplemental policy on behalf of an individual.

NO WAIVER REQUIRED FOR PROVIDER SELECTIVITY

Present Law

Generally, Medicaid beneficiaries have freedom of choice of providers; they may obtain services from any person, institution, or organization that undertakes to provide the services and is qualified to perform the service. States may, under specified conditions, purchase laboratory services or medical devices through special arrangements such as a competitive bidding process. Otherwise, to restrict the providers from which a beneficiary may obtain services, a state must obtain a waiver of the freedom of choice requirement.

Committee Provision

States would be permitted to enter into exclusive contracts with selected providers at negotiated rates without the need for a waiver.

Subchapter C—Reduction of Disproportionate Share Hospital Payments

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

Present Law

States are required to make adjustments to the payment rates of certain hospitals that treat large numbers of low income and Medicaid patients. The law sets minimum standards by which a hospital may qualify as a disproportionate share (DSH) hospital, and minimum payments to be made to those hospitals. States are generally free to exceed federal minimums in both designation and payments up to certain ceilings. Each year states are designated as either "high" DSH states or "low" DSH states based on the percentage of total medical assistance payments for DSH adjustments in the prior year. States making DSH payments in excess of 12% of medical assistance are designated "high" DSH and those paying less than 12% of medical assistance for DSH are designated as low DSH. Total disproportionate share payments to each state are limited to a published allotment amount that can be no more than 12% of medical assistance payments in states designated as "low" DSH states, and in states designated as "high" DSH states the amount of payments in 1992. Payments to individual hospitals may be no more than the cost of care provided to Medicaid recipients and individuals who have no health insurance or other third-party coverage for services during the year (net of non-disproportionate share Medicaid payments and other payments by uninsured individuals). A hospital may not be designated as a DSH hospital by a state unless it serves a minimum of 1% Medicaid clients among their caseload.

Reasons for Change

Although the history of the DSH program dates back to 1981 as part of the "Boren amendment" reforms, the cost of DSH payments did not become significant until 1990. Between 1990 and 1995, federal and state DSH payments grew from $960 million to $19 billion

or 1,879 percent. While DSH growth has moderated, both the HCFA actuaries and CBO analysts believe that DSH spending will again accelerate.

While other methods of leveraging federal dollars appear to have been somewhat abated, some states have dramatically increased federal funding by making claims for services in mental health facilities.

Committee Provision

This provision would lower the DSH allotments by imposing freezes, making graduated proportional reductions, and reducing payments by amounts claimed for mental health services.

States would be restricted in providing DSH payments to Institutes for Mental Diseases (IMDs).

DSH allotments for each state for years after 2002 would be equal to the allotment for the previous year multiplied by the percentage change in the consumer price index for medical services.

A state must develop and report to the Secretary a methodology for prioritizing payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and Medicaid patients served by such hospitals. The state shall provide an annual report to the Secretary describing the disproportionate share payments to high-volume disproportionate share hospitals.

CHAPTER 2—EXPANSION OF MEDICAID ELIGIBILITY

STATE OPTION TO PERMIT WORKERS WITH DISABILITIES TO BUY INTO MEDICAID

Present Law

States must continue Medicaid coverage for "qualified severely impaired individuals under the age of 65." These are disabled and blind individuals whose earnings reach or exceed the SSI benefit standard. (The current law threshold for earnings is $1,053 per month.) This special eligibility status applies as long as the individual (1) continues to be blind or have a disabling impairment; (2) except for earnings, continues to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing or obtaining employment if Medicaid eligibility were to end; and (4) has earnings that are not sufficient to provide a reasonable equivalent of benefits from SSI, state supplementary payments (if provided), Medicaid, and publicly funded attendant care that would have been available in the absence of those earnings. To implement the fourth criterion, the Social Security Administration compares the individual's gross earnings to a "threshold" amount that represents average expenditures for Medicaid benefits for disabled SSI cash recipients in the individual's state of residence.

Committee Provision

States would have the option of allowing disabled SSI beneficiaries with incomes up to 250% of poverty to "buy into" Medicaid

by paying a premium. Premium levels would be on a sliding scale, based on the individual's income as determined by the state.

12 MONTH CONTINUOUS ELIGIBILITY FOR CHILDREN

Committee Provision

At the option of the state, the state may provide that a child may be eligible for benefits for 12 months' continuous coverage.

CHAPTER 3—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

ESTABLISHMENT OF PACE PROGRAM AS MEDICAID STATE OPTION

Present Law

OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. These projects, known as the Programs of All Inclusive Care for the Elderly, or PACE projects, were intended to determine whether an earlier demonstration program, ON LOK, could be replicated across the country. OBRA 90 expanded the number of organizations eligible for waivers to 15.

Committee Provision

States would be permitted to offer PACE to Medicaid beneficiaries who were also eligible for Medicaid. The PACE provision is described in Medicare.

CHAPTER 4—MANAGEMENT AND PROGRAM REFORMS

ELIMINATION OF REQUIREMENT TO PAY FOR PRIVATE INSURANCE

Present Law

States are required to identify cases in which it would be cost-effective to enroll a Medicaid-eligible individual in a private insurance plan and, as a condition of eligibility, require the individual to enroll in the plan.

Committee Provision

Identification and enrollment requirements would be eliminated. States would continue to have the option of purchasing private insurance.

ELIMINATION OF OBSTETRICAL AND PEDIATRIC PAYMENT RATE REQUIREMENTS

Present Law

States are required to assure adequate payment levels for obstetrical and pediatric services. For this purpose, states must provide annual reports to the Secretary on their payment rates for these services.

Committee Provision

These reporting requirements would be eliminated.

PHYSICIAN QUALIFICATION REQUIREMENTS

Present Law

Medicaid law establishes special minimum qualifications for a physician who furnishes services to a child under age 21 or to a pregnant woman.

Committee Provision

The current law provision would be repealed.

EXPANDED COST-SHARING REQUIREMENTS

Present Law

States are permitted to impose nominal cost-sharing charges with certain exceptions. No charges may be imposed on services that are provided to children under age 18; related to pregnancy; provided to inpatients in hospitals, nursing facilities, ICFs/MR, or other medical institution if the patients are required to spend all their income for medical expenses except for the amount exempted for personal needs; or on services that are emergency, family planning, or hospice services. States may not impose cost-sharing charges on categorically needy enrollees in health maintenance organizations.

Reasons for Change

Personal responsibility when participating in any public benefit program is vital and should be encouraged. Cost-sharing is an important method used to encourage use of primary and preventive care and discourage unnecessary or less economical care. Cost-sharing may discourage inappropriate use of services through inappropriate health care settings.

As Medicaid coverage is extended to families which are not below the poverty level, cost-sharing can have a positive affect on participation. The Committee received testimony that cost-sharing helps overcome the stigma of Medicaid as a welfare program and increases the use of preventive services.

Committee Provision

States would be permitted to impose limited cost-sharing on services provided to individuals whom federal law does not require the state to cover. No additional cost-sharing would be allowed for individuals who are required to be covered under federal law except as allowed under current law or any waiver granted to any state. States would be permitted to impose nominal copayments on HMO enrollees as allowed in fee-for-service.

If any charges are imposed under the state plan for cost-sharing, such cost-sharing shall be pursuant to a public schedule and reflect economic factors, employment status, and family size. Total cost-sharing for a family with income less than 150 percent of the fed-

eral poverty level is subject to an annual limit of 3 percent of gross earnings less child care expenses. Total cost-sharing for a family with income greater than 150 percent but less than 200 percent of the poverty level is subject to an annual limit of 5 percent of gross earnings less child care expenses. Existing waivers, if any, which have been approved by the Secretary and may allow for greater cost-sharing are not subject to this limit.

Cost-sharing includes copayments, deductibles, coinsurance, enrollment fees, premiums, and other charges for the provision of health care goods and services.

Cost-sharing charges cannot be counted as state expenditures for purposes of matching requirements.

PENALTY FOR FRAUDULENT ELIGIBILITY

Present Law

A person who knowingly and willfully disposes of assets, including transfers to certain trusts, in order to obtain Medicaid eligibility for nursing home care is liable for a criminal fine and/or imprisonment, if the disposition of assets results in a period of ineligibility for such Medicaid benefits.

Committee Provision

The provision would provide that a person who for a fee assists an individual to dispose of assets in order to obtain Medicaid eligibility for nursing home care would be subject to criminal liability if the individual disposes of assets and a period of ineligibility is imposed against such individual.

ELIMINATION OF WASTE, FRAUD, AND ABUSE

Committee Provision

The Committee provides a number of reforms to eliminate waste, fraud, and abuse in the Medicaid program including a ban on spending for nonhealth related items not covered in the state plan. It requires disclosure of information and surety bond requirements for suppliers of durable medical equipment and home health agencies. The intent of the surety bond requirement is to prevent fraudulent providers and suppliers from entering the Medicaid program. Surety bonds should not be used to discriminate against minority providers and suppliers.

STUDY ON EPSDT BENEFITS

Present Law

States are required to provide early and periodic screening, diagnostic, and treatment services (EPSDT) to Medicaid beneficiaries under age 21. Such services include screening, vision, dental, hearing services. A state is required to provide other necessary health care services to correct or ameliorate defects and conditions discovered by the screening services, whether or not the services are covered under the state's Medicaid plan.

Committee Provision

Not later than one year after enactment, the Secretary, in consultation with governors, state Medicaid and maternal and child health director, the Institute of Medicine, beneficiaries and their representatives, and the American Academy of Pediatrics, would be required to provide for a study on EPSDT benefits.

CHAPTER 5—MISCELLANEOUS

INCREASED FMAPS

Present Law

Under Medicaid law, the District of Columbia is treated as a state. Each state is required to pay 40% of the non-federal share of Medicaid expenditures. Under this rule, a state can require local jurisdictions to share in Medicaid costs. Each state must, however, assure that the lack of adequate funds from local sources will not result in diminished services in the state.

The federal government shares in the cost of Medicaid items and services according to a statutory formula designed to pay a higher matching percentage to states with lower per capita incomes relative to the national average per capita income. The federal share of a state's expenditures for Medicaid items and services is called the federal medical assistance percentage (FMAP). The law establishes a minimum FMAP of 50% and a maximum of 83%. For the District and 11 states, the FMAP is 50%.

Reasons for Change

The Committee will temporarily increase the federal share of the District's Medicaid program.

Committee Provision

The FMAP for the District would be increased to 60% for each of the fiscal years 1998–2000.

Present Law

The federal government shares in the cost of Medicaid items and services according to a statutory formula designed to pay a higher matching percentage to states with lower per capita incomes relative to the national average per capita income. The federal share is called the federal medical assistance percentage (FMAP). The law establishes a minimum FMAP of 50% and a maximum of 83% though currently, the highest match rate is 79%. For Alaska, 10 other states, and the District of Columbia, the match rate is 50%.

Committee Provision

The FMAP for Alaska would be increased to 59.8% for each of fiscal years 1998–2000. This increase would be offset by a decrease in the proposed FMAP increase for the District of Columbia (to 60%).

Reasons for Change

Alaska has higher costs of living. The national average FMAP is 59.8%.

INCREASE IN PAYMENT CAPS FOR TERRITORIES

Present Law

For the commonwealths and territories, the federal matching rate is 50 percent. The total amount which may be made is capped at annual maximum fixed amounts beginning in FY 1994 as specified in section 1108 of the Social Security Act. The limits are increased annually by the percentage increase in the medical care component of the consumer price index.

Puerto Rico: $116,500,000 in FY 1994, rounded to the nearest $100,000. Virgin Islands: $3,837,000, rounded to the nearest $10,000.

Guam: $3,685,000, rounded to the nearest $10,000.

Northern Mariana Islands: $1,100,000, rounded to the nearest $10,000. American Samoa: $2,140,000, rounded to the nearest $10,000.

Reasons for Change

The Committee provision will raise the current Medicaid caps on the territories.

Committee Provision

For FY 1998 and each fiscal year thereafter, the caps are raised and indexed from the FY 1997 levels for the commonwealths and territories by the following amounts:

Puerto Rico: $30 million.

Virgin Islands: $750,000.

Guam: $750,000.

Northern Mariana Islands: $500,000.

American Samoa: $500,000.

The 50 percent match rate and indexing under current law are maintained.

COMMUNITY-BASED MENTAL HEALTH SERVICES

Committee Provision

The Committee provides a definition for outpatient and intensive community-based mental health services to include psychiatric rehabilitation, day treatment, intensive in-home services for children, assertive community treatment, therapeutic out-of-home placements (excluding room and board), clinic services, partial hospitalization, and targeted case management.

OPTIONAL MEDICAID COVERAGE OF CERTAIN CDC-SCREENED BREAST CANCER PATIENTS

Present Law

Medicaid covers medically necessary services for beneficiaries who meet the program's categorical and financial requirements.

The Centers for Disease Control and Prevention screens uninsured women for breast cancer.

Reasons for Change

Uninsured women diagnosed with cancer have difficulty obtaining appropriate and timely treatment.

Committee Provision

Medicaid eligibility standards would be expanded to include women who are under age 65, who have been diagnosed with breast cancer, and who have no health insurance coverage.

TREATMENT OF STATE TAXES IMPOSED ON CERTAIN HOSPITALS THAT PROVIDE FREE CARE

Present Law

States may not claim for federal matching payments state spending generated from provider-related donations or health care taxes that are not broad based. Health care provider-specific taxes are not considered broad-based and, thus, may not be used to claim federal matching payments for Medicaid spending.

Committee Provision

This provision would amend the definition of the term "broad-based health care related tax" to specify that taxes that exclude hospitals which are exempt from taxation under Section 501(c)(3) of the Internal Revenue code and do not accept Medicaid or Medicare reimbursement would qualify for federal matching payments if used as state Medicaid spending. The provision would also prohibit states from claiming federal matching payments for state spending generated form health care taxes applied to these facilities.

TREATMENT OF VETERANS' PENSIONS UNDER MEDICAID

Present Law

Generally, Medicaid beneficiaries in nursing homes contribute most of their incomes to the cost of care except for an allowance for a dependent in the community. Medicaid law requires that at least $30 per month be reserved from an institutionalized recipient's income as a personal allowance for items and services not included in the institution's charges. By law, Veterans" Administration pension payments to a Medicaid beneficiary who is in a nursing home are limited to $90 per month and the full amount of the payment (except for a dependent allowance) is protected for personal needs. This statutory provision expires Sept. 30, 1997.

Committee Provision

The amendment would allow State Veterans Homes to collect from Medicaid eligible veteran residents amounts in excess of $90.00 per month to defray the cost of care, but excluding amounts of income attributable to a dependent.

EFFECTIVE DATE

Committee Provision

Except as otherwise specifically provided, the provisions of and amendments by this subtitle shall apply on and after October 1, 1997. There is an extension for state law amendment for a state that has a two-year legislative session.

Subtitle J—Children's Health Insurance Initiatives

ESTABLISHMENT OF CHILDREN'S HEALTH INSURANCE INITIATIVES

Present Law

Medicaid, Title XIX of the Social Security Act, provides almost 21 million children with health coverage. States choosing to participate in the Medicaid program are required to cover children in families who would have qualified to receive AFDC under the program rules in effect on August 22, 1996; children under age 6 in families with income below 133% of the federal poverty level; and children under age 14 in families with income below 100% of the federal poverty level. Coverage for children between the ages of 14 and 18 and in families with income below 100% of the federal poverty level is being phased-in through 2002. States also have the option to cover other categories of low-income children under Medicaid and many have done so. The costs of providing Medicaid coverage are shared by the states and the federal government. The federal share is determined by a formula that takes into account the average per capita income in the state relative to the national average. States with lower per capita incomes have higher federal matching rates. These federal matching rates range from a floor of 50% to almost 80%. All 50 states currently participate in Medicaid.

The Maternal and Child Health Block Grant is authorized under Title V of the Social Security Act to improve the health of all mothers and children consistent with the goals established under the Public Health Service Act. The program makes block grants to states to enable them to coordinate programs, develop systems, and provide a broad range of direct health services. The major component of the MCH block grant requires states to contribute $3 for every $4 of federal block grant funds collected.

Committee Provision

The provision would establish a new title of the Social Security Act, Title XXI, Child Health Insurance Initiatives. The new title would provide an entitlement to states for funds for 1998 through 2007 to expand access to health insurance for eligible children. Participating states would be required to extend Medicaid coverage to children under age 19 in families with income below 100% of the federal poverty level and to assure that funds provided under this section cover low-income children before covering higher income children. Total funding authorized and appropriated under this provision would be $2.5 billion in 1998, $3.2 billion in 1999, $3.2 billion in 2000, $3.2 billion in 2001, $3.9 billion in 2002, and for each of the fiscal years 2003 through 2007, $4.58 billion and would

be available without fiscal year limitation. Participating states would choose whether to receive their allotted funds through Medicaid or another program meeting the requirement of Title XXI and would be required to use 1% of their allotted funds for Medicaid outreach and public awareness campaigns to encourage employers to provide health insurance for children.

States participating in Title XXI would be required to submit to the Secretary, no later than March 31 of any fiscal year (or, in the case of fiscal year 1998, October 1, 1997), an outline that identifies which option the State intends to use to provide coverage under this section (Medicaid or other qualified program), describes how such coverage shall be provided, and includes other information as the Secretary may require. The outline would also include: (a) the eligibility standards for the program, (b) the methodologies to be used to determine eligibility, (c) the procedures to be used to ensure only eligible children receive benefits and that the establishment of a program under this section does not reduce the number of children who currently have insurance coverage, and (d) a description of how the state would ensure that Indians are served by a program under this title.

The funds would be distributed in the following manner. States would receive 1% of their allotted funds prior to the beginning of the fiscal year for the purpose of conducting outreach activities. During the year, the states would receive quarterly payments in an amount equal to the Federal Medicaid medical assistance percentage of the cost of providing health insurance coverage for an eligible low-income child and any applicable bonuses based on estimates by the states. The Secretary could increase or reduce payments as necessary to adjust for any overpayment or underpayment for prior quarters.

The remaining child health allotment funds would be divided into two pools: a basic allotment pool and a new coverage incentive pool. In 1998, the basic allotment pool would be comprised of 85% of funds remaining after subtracting the costs of the Medicaid expansions for children under age 19, the Medicaid 12 months continuous eligibility option and the increase in enrollment as a result of the 1% outreach requirement from total authorized funds. The remaining funds would become the new coverage incentive pool. For years thereafter, the Secretary would make annual adjustments to the size of the two pools in order to provide sufficient basic allotments and new coverage incentives.

A set aside of .25% of the basic allotment pool would be established for the territories. The rest of the basic allotment pool would be allotted to each state based on the average percentage of all children in families with income below 200% of poverty that reside in the state during the three fiscal years beginning on October 1, 1992 (as reported in the Current Population Surveys of March 1994, 1995 and 1996). Amounts allotted to a state would be available the state for a period of three years beginning with the fiscal year for which the allotment made.

States would be eligible for bonus payments for the number of low income children covered under either Medicaid or other state-run health insurance programs who are not in a required Medicaid coverage group during 1996 in an amount equal to 5% of the cost

of providing health insurance coverage. This 5% bonus would come from the state's basic allotment pool. Performance bonus payments in an amount of 10% of the cost of providing health insurance coverage for newly covered children in excess of those covered in 1996 would also be available with funds coming from the new coverage incentive pool.

States extending coverage for previously uninsured children could purchase employer-sponsored health insurance on behalf of eligible children or provide for insurance through other plans. If a state chooses to provide health insurance under plans other than employer-sponsored plan, it must provide for health insurance coverage that is at least the actuarial equivalent of those provided under the Federal Employees Health Benefits Program plans as provided in that state and must be certified by the Secretary as meeting this standard.

Total amounts paid to a state under this title would not be allowed to exceed 85% of the total cost of a state program conducted under this title. Funds under the non-Medicaid option could be used to subsidize the payment of employee contributions for health insurance for a dependent child under an employer sponsored plan or to provide an FEHBP equivalent plan.

States would not be eligible to receive funds under this title unless, in fiscal year 1998, state spending on children's health care is no less than the amounts spent in 1996. For years thereafter, states spending on children's health care must be no less than such spending in 1996 increased by a Medicaid child population growth factor as determined by the Secretary.

Funds may not be used to cover the costs of abortions except in cases of rape or incest or when necessary to save the women's life. No more than 10% of funds under this title would be allowed for the administrative costs of the program.

Provisions of Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, prohibiting the receipt of public benefits for certain legal immigrants for a period of five years, would not be applied to benefits provided under this section.

Under this program the Secretary would not approve any amount in excess of a state's allotment and would make adjustments in the federal share of the costs to ensure the caps are not exceeded. The title would not establish an entitlement for individuals to any health insurance or assistance or services provided by a state program. A state would be allowed to adjust the applicable eligibility criteria or other program characteristics if the state determines that funds allotted are not sufficient to provide health insurance coverage for all low-income children.

The following sections of Title XI would apply to States' Child Health Assistance Insurance Programs as they do under Title XIX: Section 1116 relating to administrative and judicial review, Section 1124 relating to disclosure of ownership and related information, Section 1126 relating to disclosure of information about certain convicted individuals, Section 1128A relating to criminal penalties for certain additional charges, Section 1128B(d) relating to criminal penalties, and Section 1132 relating to periods within which claims must be filed, Section 1902(a)(4)(C) relating to conflict of interest standards, Section 1903(e) relating to limitations on payment, Sec-

tion 1903(w) relating to limitations on provider taxes and donations, Section 1905(a)(B) relating to exclusion of care or services for individuals under the age of 65 in IMDs from the definition of medical assistance, Section 1921 relating to state licensure, Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) relating to third party liability.

Participating states would be required to provide an annual assessment of the operation of the program funded under this title that includes a description of the progress made in providing health insurance coverage for low income children. The Secretary would be required to submit to Congress an annual report and evaluation of the State programs based on the annual assessment and would include any conclusions and recommendations the Secretary considers appropriate.

Effective Date

October 1, 1997.

DIVISION 3—INCOME SECURITY AND OTHER PROVISIONS

Subtitle K—Income Security, Welfare-To-Work Grant Program, and Other Provisions

CHAPTER 1—INCOME SECURITY

SSI ELIGIBILITY FOR ALIENS RECEIVING SSI ON AUGUST 22, 1996

Present Law

SSI. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) bars most "qualified aliens" from Supplemental Security Income (SSI) for the Aged, Blind, and Disabled (sec. 402(a)). Current recipients must be screened for continuing eligibility during a 1-year period after enactment of the welfare law (i.e., by August 22, 1997). The pending Fiscal Year 1997 supplemental appropriations bill would extend this date until September 30, 1997.

Medicaid. States may exclude "qualified aliens" who entered the United States before enactment of the welfare law (August 22, 1996) from Medicaid beginning January 1, 1997 (sec. 402(b)). Additionally, to the extent that legal immigrants" receipt of Medicaid is based only on their eligibility for SSI, some will lose Medicaid because of their ineligibility for SSI.

Definitions and exemptions. "Qualified aliens" are defined by P.L. 104–193 (as amended by P.L. 104–208) as aliens admitted for legal permanent residence (i.e., immigrants), refugees, aliens paroled into the United States for at least 1 year, aliens granted asylum or related relief, and certain abused spouses and children.

Certain "qualified aliens" are exempted from the SSI bar and the State option to deny Medicaid, as well as from certain other restrictions. These groups include: (1) refugees for 5 years after admission and asylees 5 years after obtaining asylum; (2) aliens who have worked, or may be credited with, 40 "qualifying quarters." As defined by P.L. 104–193, a "qualifying quarter" is a 3-month work period with sufficient income to qualify as a social security quarter and, with respect to periods beginning after 1996, during which the worker did not receive Federal means-based assistance (Sec. 435). The "qualifying quarter" test takes into account work performed by the alien, the alien's parent while the alien was under age 18, and the alien's spouse (provided the alien remains married to the spouse or the spouse is deceased); and (3) veterans, active duty members of the armed forces, and their spouses and unmarried dependent children.

Committee Provision

Legal noncitizens who were receiving SSI benefits on August 22, 1996 (the date of enactment of the welfare reform law) would remain eligible for SSI, despite underlying restrictions in the Personal Responsibility and Work Opportunity Act. This section also specifies that Cuban and Haitian entrants are to be considered qualified aliens, thereby continuing the SSI and Medicaid eligibility of those who were receiving SSI benefits on August 22, 1996.

Effective Date

August 22, 1996.

EXTENSION OF ELIGIBILITY PERIOD FOR REFUGEES AND CERTAIN OTHER QUALIFIED ALIENS FROM 5 TO 7 YEARS FOR SSI AND MEDICAID

Present Law

Current law provides a 5-year exemption from: (1) the bar against SSI and Food Stamps; and (2) the provision allowing States to deny "qualified aliens" access to Medicaid, TANF, and Social Services Block Grant for three groups of aliens admitted for humanitarian reasons. These groups are: (1) refugees, for 5 years after entry; (2) asylees, for 5 years after being granted asylum; and (3) aliens whose deportation is withheld on the grounds of likely persecution upon return, for 5 years after such withholding.

Reasons for Change

The Committee proposal would extend the 5 year exemption period to allow sufficient time to assimilate into the country.

Committee Provision

This change would lengthen the period during which welfare eligibility is guaranteed to refugees, asylees, and aliens whose deportation has been withheld from 5 years to 7 years. Cuban and Haitian entrants would also be covered by this provision.

Effective Date

August 22, 1996.

SSI ELIGIBILITY FOR PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE

Committee Provision

Restrictions on SSI eligibility under welfare reform do not apply to permanent resident aliens who are members of an Indian tribe.

SSI ELIGIBILITY FOR DISABLED LEGAL ALIENS IN THE UNITED STATES ON AUGUST 22, 1996

Committee Provision

Disabled legal aliens residing in the United States on August 22, 1996 will be eligible for SSI benefits if they apply for such benefits on or before September 30, 1997.

EXEMPTION FROM RESTRICTION ON SSI PROGRAM PARTICIPATION BY CERTAIN RECIPIENTS ELIGIBLE ON THE BASIS OF VERY OLD APPLICATIONS

Committee Provision

Restrictions on SSI benefits shall not apply to any individual who is receiving benefits under such program after July 1996 on the basis of an application filed before January 1, 1979 and with respect to whom the Commissioner of Social Security lacks clear and convincing evidence that such individual is an alien ineligible for such benefits.

REINSTATEMENT OF ELIGIBILITY FOR BENEFITS

Committee Provision

This provision reinstates the linkage between SSI benefits and Medicaid.

EXEMPTION FOR CHILDREN WHO ARE LEGAL ALIENS FROM 5-YEAR BAN ON MEDICAID ELIGIBILITY

Committee Provision

The limitation on Medicaid eligibility shall not apply to any alien lawfully residing in any state who has not attained the age of 19 but only with respect to such alien's eligibility for medical assistance under a state plan.

EFFECTIVE DATE

Committee Provision

The amendments made by this chapter shall take effect as if they were included in the enactment of title IV of the Personal Responsibility and Work Opportunity Act of 1996.

CHAPTER 2—WELFARE-TO-WORK GRANT PROGRAM

ESTABLISH "WELFARE TO WORK" GRANTS

Present Law

The law combines recent Federal funding levels for three repealed programs (AFDC, Emergency Assistance, and JOBS) into a single block grant ($16.5 billion annually through Fiscal Year 2002). Each State is entitled to the sum it received for these programs in a recent year, but no part of the TANF grant is earmarked for any program component, such as benefits or work programs. The law also provides an average of $2.3 billion annually in a child care block grant.

Reasons for Change

The Committee proposal will establish a new "Welfare to Work" grant program.

Committee Provision

After reserving 1 percent of each year's appropriation for Indian tribes and .5 percent for evaluation by the Secretary of HHS, the remainder of each year's appropriation is divided into two grant funds. The first fund is used for grants to states and is allocated by a formula based equally on each state's share of the national poor population, unemployed workers, and adults receiving assistance under the Temporary Assistance for Needy Families block grant. There will be a small state minimum of 0.5 percent. The second fund is used to support proposals submitted by political subdivisions of states that are determined by the Secretary of Health and Human Services to hold promise for helping long-term welfare recipients enter the workforce.

Formula grants from the first fund are to be provided to States for the purpose of initiating projects that aim to place long-term welfare recipients in the workforce. Governors must distribute at least 85 percent of the state allotment to local jurisdictions within the state in which poverty and unemployment rates are above the state average. These funds must be distributed in accord with a formula devised by the governor that bases at least 50 percent of its allocation weight on poverty and may also include two additional factors, welfare recipients who have received benefits for 30 or more months and unemployment. Any local jurisdiction that, under this formula, would be allotted less than $100,000 will not receive any funds; these funds will instead revert to the governor. Governors may use up to 15 percent of the state allocation, plus any amounts remitted from local jurisdictions that would be allotted less than $100,000, to fund projects designed to help long-term recipients enter the workforce.

Competitive grants are awarded in FY 1998 and FY 2000, although approved projects can receive funds from the Secretary every year and have 3 years to spend funds once obligated, on the basis of the likelihood that program applicants can successfully make long-term placements of welfare-dependent individuals into the workforce. The Secretary must select projects that show promise in: (1) expanding the base of knowledge about welfare-to-work programs for the least job ready; (2) moving the least job ready recipients into the labor force; and (3) moving the least job ready recipients into the labor force even in labor markets that have a shortage of low-skill jobs. Other factors the Secretary, at her discretion, may use to select projects include: history of success in moving individuals with multiple barriers into work; evidence of ability to leverage private, State, and local resources; use of State and local resources that exceed the required match; plans to coordinate with other organizations at the local and State level; and use of current or former welfare recipients as mentors, case managers, or service providers. Any political subdivision of a state may apply for funds. Not less than 30 percent shall be awarded to rural areas. The Secretary cannot award grants unless the TANF agency has approved the grant application. Further, the Secretary must terminate funds for a project upon a determination that the TANF agency is not adhering to the agreement. Awards to each project must be based on the Secretary's determination of the amount needed for

the project to be successful. Allowable activities include job creation, on-the-job training, contracts with public or private providers of employment services, job vouchers, and job support services. The Secretary must include several required outcome measures in the evaluation study and must report on program outcomes to Congress in 1999 and 2001.

Funds under both the competitive grants and the formula grants can be spent only for job creation through public or private sector employment wage subsidies, on-the-job training, contracts with public or private providers of readiness, placement, and post-employment services, job vouchers for placement, readiness, and post-employment services, and job support services (not including child care) if such services are not otherwise available. Any entity receiving funds under either grant must expend at least 90 percent of the money on recipients who have received benefits for at least 30 months, who suffer from multiple barriers to employment, or are within 12 months of a mandatory time limit on benefits. States must provide a 33 percent match of federal funds and must comply with the 75 percent maintenance of effort requirements in TANF.

The Secretary shall also reserve $100 million to add to the "High Performance Bonus" amount in FY 2003 for states which are most successful in increasing the earnings of long-term welfare recipients or of those who are at risk of long-term welfare dependency.

Funds available under this program are $.75 billion for fiscal year 1998, $1.15 billion for fiscal year 1999, and $1.0 billion for fiscal year 2000. The Secretary must include several specific measures, such as success in job placements, in her evaluation of the program. In addition, the Secretary must submit a progress report to Congress in 1999 and a final report in 2001.

Effective Date

Date of enactment (funds are available beginning in fiscal year 1998).

NONDISPLACEMENT IN WORKER ACTIVITIES

Present Law

A TANF recipient may fill a vacant employment position. However, no adult in a work activity that is funded in whole or in part by federal funds shall be employed or assigned when another person is on layoff from the same or any substantially equivalent job; or if the employer has ended the employment of any regular employee or otherwise caused an involuntary reduction of his workforce in order to fill the vacancy so created with a TANF recipient. These provisions shall not preempt or supersede any state or local law that provides greater protection against displacement.

Committee Provision

A participant in a work activity pursuant to this section shall not displace (including a partial displacement, such as a reduction in the hours of nonovertime work, wages, or employment benefits) any individual who, as of the date of the participation, is an employee.

A participant in a work activity shall not be employed in a job when any other individual is on layoff from the same or any substantially equivalent job; when the employer has terminated the employment of any regular employee or otherwise reduced the workforce of the employer with the intention of filling the vacancy so created with the participant; or which is created in a promotional line that will infringe in any way upon the promotional opportunities of employed individuals.

ENROLLMENT FLEXIBILITY

Present Law

The Secretary is provided with authority to waive provisions of law, with authority to approve a variety of demonstration projects, and with authority to enter into contracts with entities other than public entities.

Reasons for Change

The Committee provision would encourage innovation in enrolling individuals for a variety of federal, state, and local benefit programs for which they may be eligible.

Committee Provision

A state plan to consolidate and automate the administration of low-income benefit programs, including Medicaid and to competitively contract for the administration of such programs that was submitted to the Secretary of Health and Human Services prior to June 1, 1997 shall be deemed by the Secretary to be approved.

The state is required to take necessary steps to safeguard the privacy, confidentiality, and protections of individuals provided under law. The state is required to take necessary steps to provide that all protections for individuals seeking benefits including appeals and grievances as provided by law are ensured.

CLARIFICATION OF A STATE'S ABILITY TO SANCTION AN INDIVIDUAL RECEIVING ASSISTANCE UNDER TANF FOR NONCOMPLIANCE

Present Law

The Personal Responsibility and Work Opportunity Reconciliation Act provides that states may penalize welfare recipients by reduction of benefits. For example, the PRWO provides that states shall not be prohibited from sanctioning welfare recipients who test positive for use of controlled substances. Further, if a parent fails to cooperate in establishing paternity or in establishing, modifying, or enforcing a child support order, and the individual does not qualify for a good cause exception, the state must reduce the family's benefit by at least 25 percent and may reduce it to zero.

Reasons for Change

The Administration has interpreted the Fair Labor Standards Act as applying to workfare programs under the TANF law. This interpretation will require that workfare participants receive a benefit that at least equals the federal minimum wage rate multiplied

by their required hours of work. Reduction in the benefit of a workfare participant for noncompliance with program rules might violate the federal minimum wage.

Committee Provision

The amendment provides that, notwithstanding any minimum wage requirement, states will not be prohibited from sanctioning a workfare participant for noncompliance even if that sanction reduces the benefit below the minimum wage equivalent.

CHAPTER 3—UNEMPLOYMENT COMPENSATION

INCREASE IN FEDERAL UNEMPLOYMENT ACCOUNT CEILING AND SPECIAL DISTRIBUTION TO STATES FROM THE UNEMPLOYMENT TRUST FUND

Present Law

FUTA taxes are credited to Federal accounts in the Unemployment Trust Fund in proportions that are set by statute. Funds are held in reserve in these accounts to provide Federal spending authority for certain purposes. The Employment Security Administration Account (ESAA) funds Federal and State administration of the UI program. The Extended Unemployment Compensation Account (EUCA) finances the Federal share of extended UI benefits. The Federal Unemployment Account (FUA) provides authority for loans to States with insolvent UI benefit accounts. Each of these accounts has a statutory ceiling. ESAA's balance after the end of a fiscal year is reduced to 40% of the prior-year appropriation from ESAA. Excess funds are transferred to EUCA and/or FUA. The ceilings on EUCA and FUA are set as a percent of total wages in employment covered by UI. The current ceilings are 0.5% of wages for EUCA and 0.25% of wages for FUA. If all three accounts reach their ceilings, excess funds are distributed among the 53 State benefit accounts in the Unemployment Trust Fund, after repayment of any outstanding general revenue advances to FUA and EUCA. These transfers to the State accounts are termed "Reed Act transfers" after the name of the legislation that authorized this use of excess FUTA funds. The Department of Labor projects that Reed Act transfers will be triggered beginning in Fiscal Year 2000 under present law.

Reasons for Change

The Committee provision would increase the Federal Unemployment Account ceiling from 0.25 percent to 0.50 percent of covered wages.

Committee Provision

The provision would double the Federal Unemployment Account ceiling from 0.25 percent to 0.50 percent of covered wages, effective at the beginning of fiscal year 2002. In addition, for each of fiscal years 2000, 2001, and 2002, if Federal account ceilings are reached, an annual total of no more than $100 million in Reed Act transfers are to be made from Federal UI accounts to State accounts for use

by States in administering their UI programs. (Annual amounts in excess of $100 million are to accrue to the Federal Unemployment Account, notwithstanding the continued 0.25 percent ceiling). Funds are to be distributed among the States in the same manner as administrative funds from the Federal account are allocated.

Effective Date

The increase in the Federal Unemployment Account ceiling is to occur on October 1, 2001; special distributions are made beginning in fiscal year 2000, based on account balances at the end of the preceding fiscal year.

CLARIFYING PROVISION RELATING TO BASE PERIODS

Present Law

Federal law establishes broad guidelines for the operation of State unemployment insurance (UI) programs but leaves most of the details of eligibility and benefits to State determination. One of these general Federal guidelines calls for States to use administrative methods that ensure full payment of UI benefits "when due." All States meet this requirement with program rules that the U.S. Department of Labor has found to be in compliance. In complying with the "when due" clause, States must decide what "base period" to use in measuring a claimant's wage history for the purpose of determining individual eligibility and benefit entitlement. States have generally used a base period consisting of the first 4 of the last 5 completed calendar quarters. However, several States that use this base period also use an "alternative base period," usually the last 4 completed calendar quarters. This alternative base period is used for claimants who are found to be ineligible because their earnings were too low in the regular base period. Although current State base periods have Department of Labor approval, a Federal court in Illinois, in the case of *Pennington* v. *Doherty*, ruled that the State of Illinois is not in compliance with the "when due" clause because it could use a more recent base period, which would benefit a significant number of claimants. This case may be appealed further. If left standing, it will apply only to three States: Illinois, Indiana, and Wisconsin. However, similar suits have been filed in other States, and they could lead to a de facto national rules change based on judicial action.

Reasons for Change

The Committee provision clarifies that states have full discretion in setting their own unemployment insurance base periods for determining eligibility for unemployment insurance benefits.

Committee Provision

The provision reinforces current policy by affirming that States have complete authority to set their own base periods used in determining individuals' eligibility for unemployment insurance benefits. According to the Congressional Budget Office, failing to make this change could result in 41 States being required to adopt alternative base periods at a cost of $400 million annually in added UI

benefits plus increased administrative costs. CBO assumes that States would increase their revenue collections (by raising payroll taxes) to cover any increase in benefit outlays.

Effective Date

This section shall apply for purposes of any period beginning before, on, or after the date of enactment of this Act.

TREATMENT OF CERTAIN SERVICES PERFORMED BY INMATES

Present Law

Federal law requires UI coverage for most nongovernmental employment, and employers have to pay taxes under the Federal Unemployment Tax Act (FUTA) for their employees. Federal law also requires state UI programs to cover jobs in state and local government agencies. Each governmental employer reimburses the state UI program for the cost of any unemployment benefits paid to its workers.

Federal law does except certain employment from this mandatory coverage. One exception permits states to exclude from coverage services performed for a governmental agency by inmates of custodial or penal institutions. However, any work performed by inmates by private employers through work-release programs or other cooperative arrangements between prison authorities and private employers does not come under this exception. Further, there is no exception to FUTA coverage of private employers for jobs held by inmates of penal institutions. Thus, it is possible for a prison inmate on work-release to earn UI coverage that may be used to claim UI benefits, if the inmate, when released, is unemployed and available for work.

Reasons for Change

The Committee provision exempts services performed by inmates who participate in prison work programs from unemployment taxes and benefits.

Committee Provisions

The Committee provision will prevent the payment of unemployment compensation benefits to former prisoners who became "unemployed" when they were released and were no longer participating in a prison work program. Inmates who provide services directly to the prison are already exempt from unemployment taxes. This would extend the same treatment to inmates who participate in other work programs while in prison.

Subtitle M—Welfare Reform Technical Corrections

WELFARE REFORM TECHNICAL CORRECTIONS

Reasons for Change

The Committee provision makes approximately 200 technical and conforming amendments to the "Personal Responsibility and Work Opportunity Act of 1996," (P.L. 104-193).

Committee Provision

The Committee adopts H.R. 1048, the "Welfare Reform Technical Corrections Act of 1997," as amended by deleting all provisions relating to Title II of the Social Security Act. It is further amended by the following provision to remove teen parents attending school from the limit on vocational education.

REMOVE TEEN PARENTS ATTENDING SCHOOL FROM THE LIMIT ON VOCATIONAL EDUCATION

Present Law

The law restricts to 20 percent the proportion of persons in all families and in two-parent families who may be treated as engaged in work for a month by reason of participating in vocational educational training, or if single teenage household heads without a high school diploma, by reason of satisfactory attendance at secondary school or participation in education directly related to employment. The law also requires all unmarried parents under age 18 who did not complete high school to participate in education as a condition of eligibility for TANF.

Reason for Change

In some states the number of teen parents who must attend school in order to receive TANF is so large that the state's ability to use vocational education training is significantly reduced. Further, states want the additional flexibility to promote vocational education for adults as a means of promoting eventual self-sufficiency.

Committee Provision

Remove single heads of household under age 20 from the calculation of the limit on the number of persons that are permitted to meet the work requirement through vocational educational activity.

DIVISION 4—EARNED INCOME CREDIT AND OTHER PROVISIONS

Subtitle L—Earned Income and Other Provisions

CHAPTER 1—EARNED INCOME CREDIT

DESCRIPTION OF EARNED INCOME CREDIT PROVISIONS

Present Law

In general

Certain eligible low-income workers are entitled to claim a refundable earned income credit (EIC) (sec. 32 of the Internal Revenue Code of 1986 ("Code")). A refundable credit is a credit that not only reduces an individual's tax liability but allows refunds to the individual in excess of income tax liability. The amount of the credit an eligible individual may claim depends upon whether the individual has one, more than one, or no qualifying children, and is determined by multiplying the credit rate by the individual's earned income up to an earned income amount. (Note: In the case of a married individual who files a joint return with his or her spouse, the income for purposes of these tests is the combined income of the couple.)

The maximum amount of the credit is the product of the credit rate and the earned income amount. The credit is reduced by the amount of alternative minimum tax ("AMT") the taxpayer owes for the year. The EIC is phased out above certain income levels. For individuals with earned income or modified adjusted gross income ("modified AGI'), in excess of the beginning of the phaseout range, the maximum credit amount is reduced by the phaseout rate multiplied by the amount of earned income (or modified AGI, if greater) in excess of the beginning of the phaseout range.

For individuals with earned income (or modified AGI, if greater) in excess of the end of the phaseout range, no credit is allowed. Modified AGI means AGI, but for this purpose does not include the following amounts: (1) net capital losses (if greater than zero); (2) net losses from trusts and estates; (3) net losses from nonbusiness rents and royalties; and (4) 50 percent of the net losses from business, computed separately with respect to sole proprietorships (other than in farming), sole proprietorships in farming, and other businesses. Amounts attributable to a business that consists of the performance of services by the taxpayer as an employee are not taken into account for purposes of (4).

The parameters for the EIC for 1997 are given in the following table:

EARNED INCOME CREDIT PARAMETERS (1997)

	Two or more qualifying children	One qualifying child	No qualifying children
Credit rate (percent)	40.00	34.00	7.65
Earned income amount	$9,140	$6,500	$4,340
Maximum credit	$3,656	$2,210	$332
Phaseout begins	$11,930	$11,930	$5,430
Phaseout rate (percent)	21.06	15.98	7.65
Phaseout ends	$29,290	$25,760	$9,770

Under present law, an individual is not eligible for the earned income credit if the aggregate amount of "disqualified income" of the taxpayer for the taxable year exceeds $2,250. Disqualified income is the sum of: (1) interest (taxable and tax-exempt); (2) dividends; (3) net rent and royalty income (if greater than zero); (4) capital gain net income; and (5) net passive income (if greater than zero) that is not self-employment income. The $2,250 threshold is indexed for inflation.

The earned income amount and the phaseout amount are indexed for inflation.

Earned income

Under present law, earned income means the sum of (1) wages, salaries, tips, and other employee compensation, and (2) the amount of the taxpayer's net earnings from self employment for the taxable year, determined without regard to the deduction for one-half of the taxpayer's self-employment taxes (Code sec. 164(f)). For purposes of this definition, earned income is computed without regard to any community property laws, pension and annuity payments are not treated as earned income, certain amounts relating to nonresident aliens are disregarded, and no amount received by inmates for services in penal institutions is treated as earned income.

Eligible individual

Under present law, an individual is an eligible individual entitled to claim the EIC for a year if

(1) the individual has a qualifying child for the taxable year, or

(2) the individual does not have a qualifying child, but satisfies the following requirements:

(i) the individual's principal place of abode is in the United States for more than ½ of the year,

(ii) the individual (or, if the individual is married, either the individual or the individual's spouse) has attained age 25, but has not attained age 65 before the close of the year, and

(iii) the individual is not a dependent for whom a dependency exemption is allowed on another taxpayer's return for a taxable year beginning in the same calendar year as the taxable year of the individual.

An individual is not an eligible individual for the year if the individual (1) is a qualifying child of another taxpayer, (2) claims any exclusion from income under Code section 911 for citizens or resi-

dents living abroad, (3) is a nonresident alien individual for any portion of the year unless the individual is treated as a U.S. resident for the year under Code section 6013, or (4) does not include the individual's taxpayer identification number ("TIN") or the individual's spouse's TIN on the tax return.

Qualifying child

A qualifying child must meet a relationship test, an age test, an identification test, and a residence test. Under the relationship and age tests, an individual is eligible for the EIC with respect to another person only if that other person: (1) is a son, daughter, or adopted child (or a descendent of a son, daughter, or adopted child); a stepson or stepdaughter; or a foster child of the taxpayer (a foster child is defined as a person whom the individual cares for as the individual's child; it is not necessary to have a placement through a foster care agency); and (2) is under the age of 19 at the close of the taxable year (or is under the age of 24 at the end of the taxable year and was a full-time student during the taxable year), or is permanently and totally disabled. Also, if the qualifying child is married at the close of the year, the individual may claim the EIC for that child only if the individual may also claim that child as a dependent.

To satisfy the identification test, an individual must include on their tax return the name, age, and TIN of each qualifying child.

The residence test requires that a qualifying child must have the same principal place of abode as the taxpayer for more than one-half of the taxable year (for the entire taxable year in the case of a foster child), and that this principal place of abode must be located in the United States. For purposes of determining whether a qualifying child meets the residence test, the principal place of abode shall be treated as in the United States for any period during which a member of the Armed Forces is stationed outside the United States while serving on extended active duty.

Advance payment

An individual with qualifying children may elect to receive the credit on an advance basis by furnishing an advance payment certificate to his or her employer. For such an individual, the employer makes an advance payment of the credit at the time wages are paid. The amount of advance payment allowable in a taxable year is limited to 60 percent of the maximum credit available to an individual with one qualifying child.

TIN requirement

Under present law, for purposes of determining who is an eligible individual and who is a qualifying child, a TIN means a social security number issued to an individual by the Social Security Administration other than a social security number issued pursuant to clause (II) (or that portion of clause (III) that relates to clause (II)) of section 205(c)(2)(B)(i) of the Social Security Act relating to the issuance of a Social Security number to an individual applying for or receiving Federally funded benefits.

Mathematical or clerical errors

The IRS may summarily assess additional tax due as a result of a mathematical or clerical error without sending the taxpayer a notice of deficiency and giving the taxpayer an opportunity to petition the Tax Court. If an individual fails to provide a correct TIN, such omission is treated as a mathematical or clerical error. Also, if an individual who claims the EIC with respect to net earnings from self employment fails to pay the proper amount of self-employment tax on such net earnings, the failure is treated as a mathematical or clerical error for purposes of the amount of EIC claimed.

Where the IRS uses the summary assessment procedure for mathematical or clerical errors, the taxpayer must be given an explanation of the asserted error and a period of 60 days to request that the IRS abate its assessment. The IRS may not proceed to collect the amount of the assessment until the taxpayer has agreed to it or has allowed the 60-day period for objecting to expire. If the taxpayer files a request for abatement of the assessment specified in the notice, the IRS must abate the assessment. Any reassessment of the abated amount is subject to the ordinary deficiency procedures.

The request for abatement of the assessment is the only procedure a taxpayer may use prior to paying the assessed amount in order to contest an assessment arising out of a mathematical or clerical error. Once the assessment is satisfied, however, the taxpayer may file a claim for refund if he or she believes the assessment was made in error.

Committee Provisions

A. Deny EIC Eligibility for Prior Acts of Recklessness or Fraud

Present Law

The accuracy-related penalty, which is imposed at a rate of 20 percent, applies to the portion of any underpayment that is attributable to (1) negligence, (2) any substantial understatement of income tax, (3) any substantial valuation overstatement, (4) any substantial overstatement of pension liabilities, or (5) any substantial estate or gift tax valuation understatement (sec. 6662). Negligence includes any careless, reckless, or intentional disregard of rules or regulations, as well as any failure to make a reasonable attempt to comply with the provisions of the Code.

The fraud penalty, which is imposed at a rate of 75 percent, applies to the portion of any underpayment that is attributable to fraud (sec. 6663).

Neither the accuracy-related penalty nor the fraud penalty is imposed with respect to any portion of an underpayment if it is shown that there was a reasonable cause for that portion and that the taxpayer acted in good faith with respect to that portion.

Reasons for Change

The Committee believes that taxpayers who fraudulently claim the EIC or recklessly or intentionally disregard EIC rules or regulations should be penalized for doing so.

Committee Proposal

A taxpayer who fraudulently claims the EIC would be ineligible to claim the EIC for a subsequent period of 10 years. In addition, a taxpayer who erroneously claims the EIC due to reckless or intentional disregard of rules or regulations would be ineligible to claim the EIC for a subsequent period of two years. These sanctions would be in addition to any other penalty imposed under present law. The determination of fraud or of reckless or intentional disregard of rules or regulations would be made in a deficiency proceeding (which would provide for judicial review).

Effective Date

The proposal would be effective for taxable years beginning after December 31, 1996.

B. Recertification Required When Taxpayer Found to be Ineligible for EIC in Past

Present Law

If an individual fails to provide a correct TIN and claims the EIC, such omission is treated as a mathematical or clerical error. Also, if an individual who claims the EIC with respect to net earnings from self employment fails to pay the proper amount of self-employment tax on such net earnings, the failure is treated as a mathematical or clerical error for purposes of the amount of EIC claimed. Generally, taxpayers have 60 days in which they can either provide a correct TIN or request that the IRS follow the current-law deficiency procedures. If a taxpayer fails to respond within this period, he or she must file an amended return with a correct TIN or clarify that any self-employment tax has been paid in order to obtain the EIC originally claimed.

The IRS must follow deficiency procedures when investigating other types of questionable EIC claims. Under these procedures, contact letters are first sent to the taxpayer. If the necessary information is not provided by the taxpayer, a statutory notice of deficiency is sent by certified mail, notifying the taxpayer that the adjustment will be assessed unless the taxpayer files a petition in Tax Court within 90 days. If a petition is not filed within that time and there is no other response to the statutory notice, the assessment is made and the EIC is denied.

Reasons for Change

The Committee believes that the requirement of additional information to determine EIC eligibility is prudent for taxpayers who have incorrectly claimed the EIC in the past.

Committee Proposal

A taxpayer who has been denied the EIC as a result of deficiency procedures would be ineligible to claim the EIC in subsequent years unless evidence of eligibility for the credit is provided by the taxpayer. To demonstrate current eligibility, the taxpayer would be required to meet evidentiary requirements established by the Sec-

retary of the Treasury. Failure to provide this information when claiming the EIC would be treated as a mathematical or clerical error. If a taxpayer is recertified as eligible for the credit, the taxpayer would not be required to provide this information in the future unless the IRS again denies the EIC as a result of a deficiency procedure. Ineligibility for the EIC under the proposal would be subject to review by the courts.

Effective Date

The proposal would be effective for taxable years beginning after December 31, 1996.

C. Due Diligence Requirements for Paid Preparers

Present Law

There are several penalties that apply in the case of an understatement of tax that is caused by an income tax return preparer. First, if any part of an understatement of tax on a return or claim for refund is attributable to a position for which there was not a realistic possibility of being sustained on its merits and if any person who is an income tax return preparer with respect to such return or claim for refund knew (or reasonably should have known) of such position and such position was not disclosed or was frivolous, then that return preparer is subject to a penalty of $250 with respect to that return or claim (sec. 6694(a)). The penalty is not imposed if there is reasonable cause for the understatement and the return preparer acted in good faith.

In addition, if any part of an understatement of tax on a return or claim for refund is attributable to a willful attempt by an income tax return preparer to understate the tax liability of another person or to any reckless or intentional disregard of rules or regulations by an income tax return preparer, then the income tax return preparer is subject to a penalty of $1,000 with respect to that return or claim (sec. 6694(b)).

Also, a penalty for aiding and abetting the understatement of tax liability is imposed in cases where any person aids, assists in, procures, or advises with respect to the preparation or presentation of any portion of a return or other document if (1) the person knows or has reason to believe that the return or other document will be used in connection with any material matter arising under the tax laws, and (2) the person knows that if the portion of the return or other document were so used, an understatement of the tax liability of another person would result (sec. 6701).

Additional penalties are imposed on return preparers with respect to each failure to (1) furnish a copy of a return or claim for refund to the taxpayer, (2) sign the return or claim for refund, (3) furnish his or her identifying number, (4) retain a copy or list of the returns prepared, and (5) file a correct information return (sec. 6695). The penalty is $50 for each failure and the total penalties imposed for any single type of failure for any calendar year are limited to $25,000.

Reasons for Change

The Committee believes that more thorough efforts by return preparers are important to improving EIC compliance.

Committee Proposal

Return preparers would be required to fulfill certain due diligence requirements with respect to returns they prepare claiming the EIC. The penalty for failure to meet these requirements is $100. This penalty would be in addition to any other penalty imposed under present law.

Effective Date

The proposal would be effective for taxable years beginning after December 31, 1996.

CHAPTER 2—INCREASE IN THE PUBLIC DEBT

STATUTORY DEBT LIMIT INCREASE

In addition to the spending and revenue reconciliation bills, the Senate Finance Committee has been reconciled with increasing the statutory limit on the public debt to $5.950 trillion. The current debt ceiling of $5.5 trillion is expected to be reached in early 1998. The Chairman's mark includes the required increase to $5.950 trillion.

It is assumed that the $5.950 trillion limit will be sufficient to allow the government to operate until sometime in late 1999. The debt limit bill has been included in the spending reconciliation instructions to the Finance Committee.

CHAPTER 3—MISCELLANEOUS

REGARDING THE ACCURACY OF THE CONSUMER PRICE INDEX (CPI)

Inclusion of S. Res. 50 into the Chairman's mark. S. Res. 50 expresses the Sense of the Senate that the current CPI does not accurately reflect true changes in the cost of living. It refers to the Boskin Commission report which concluded that the Consumer Price Index overstates the cost of living in the U.S. by 1.1 percentage points.

> *Resolved,* That it is the sense of the Senate that all cost-of-living adjustments required by statute should accurately reflect the best available estimate of changes in the cost of living.

United States Senate
COMMITTEE ON
GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510-6250

June 19, 1997

The Honorable Pete Domenici
Chairman
Committee on the Budget
United States Senate
Washington, DC 20510

Dear Pete:

In accordance with the Budget Resolution Conference Agreement, I am transmitting herewith the reconciliation provisions adopted by the Committee on Governmental Affairs by voice vote with a quorum present at a business meeting held on June 17, 1997.

As requested, attached to this letter of transmittal is the legislative language for Title VI of the Reconciliation bill, as well as report language. The Congressional Budget Office has not yet provided the cost estimate, and this will be forwarded as soon as it is available.

The Committee has met the savings based on the policy assumptions set forth in the instructions. However, there may be a discrepancy in the CBO scoring based on whether the pay increases assumed by President in the out years are counted.

The Committee has also adopted language to change the formula for computing the government's share of Federal Employee Health Benefit premiums to address the expiration of the current "phantom" formula in FY 1999. A full explanation of the new formula is included in the report language.

I look forward to working with you on any additional issues that may arise when the Reconciliation bill is considered by the full Senate.

Sincerely,

Fred Thompson
Chairman

FT/stm

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

June 19, 1997

Honorable Fred Thompson
Chairman
Committee on Governmental Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommendations of the Senate Committee on Governmental Affairs.

The estimate shows the budgetary effects of the committee's proposals over the 1998-2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. The estimate assumes that the reconciliation bill will be enacted by October 1; the estimate could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Paul Cullinan, who can be reached at 226-2820.

Sincerely,

James V. Blum
for June E. O'Neill

Enclosure

cc: Honorable John Glenn
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Reconciliation recommendations of the Senate Committee on Governmental Affairs (Title VI)

Summary: Title VI would make a number of changes affecting the retirement and health insurance programs for federal employees and annuitants. It would also end a payment currently required from the Treasury to the United States Postal Service, as well as require the sale of two government properties. In total, these provisions would reduce on-budget direct spending by $3.0 billion, increase off-budget outlays by $44 million, realize asset sale receipts of $540 million, and increase federal revenues by $1.8 billion over the 1998–2002 period. Part of these savings would result from increasing the amount of retirement costs charged to agency appropriations by a total of $2.9 billion over the 1998–2002 period.

This title contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act of 1995 (UMRA) and would impose no costs on state, local, and tribal governments. By increasing contributions required of federal employees to the civilian retirement system, the legislation would impose a private-sector mandate with a cost exceeding the statutory threshold.

Estimated cost to the Federal Government: The estimated impact of the reconciliation recommendations of the Senate Committee on Governmental Affairs on direct spending and revenues through 2002 is shown in the following table. Tables in the basis of estimate provide more detail on the various subtitles, and the appendix table displays the budgetary effects through 2007.

The outlay impacts of changes proposed in Title VI fall in budget functions 370 (commerce and housing credit), 550 (health), and 950 (undistributed offsetting receipts).

ESTIMATED EFFECTS OF THE RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS ON DIRECT SPENDING AND REVENUES

	By fiscal years, in millions of dollars—					
	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Repeal of Transitional Appropriation for the U.S. Postal Service:						
On-Budget	0	−35	−34	−33	−32	−31
Off-Budget	0	35	9	0	0	0
Total Budget	0	0	−25	−33	−32	−31
Increase Agency Contributions to CSRS and FSRDS	0	−597	−580	−563	−548	−565
Modify Government Contributions under FEHB	0	0	−5	−7	−7	−8
Total, Direct Spending:						
On-Budget	0	−632	−619	−603	−587	−604
Off-Budget	0	35	9	0	0	0
Total Budget	0	−597	−610	−603	−587	−604
ASSET SALES [1]						
Governors Island, New York	0	0	0	0	0	−500
Union Station Air Rights	0	0	0	0	0	−40
Total, Asset Sales	0	0	0	0	0	−540

ESTIMATED EFFECTS OF THE RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS ON DIRECT SPENDING AND REVENUES—Continued

	By fiscal years, in millions of dollars—					
	1997	1998	1999	2000	2001	2002
REVENUES						
Increase Employee Contributions to CSRS, FERS, FSRDS, and FSPS	0	0	208	413	551	598

[1] Based on criteria established in the 1998 budget resolution, CBO has determined that proceeds from the asset sales in this bill should be counted in the budget totals for purposes of Congressional scoring. Under the Balanced Budget Act, however, proceeds from asset sales are not counted in determining compliance with the discretionary spending limits or pay-as-you-go requirements.

Note.—Components may not add to totals because of rounding.

Basis of estimate

Subtitle A, Civil Service

The committee recommends changes in law affecting civilian employees of the federal government as well as enrollees in the Federal Employees Health Benefits (FEHB) program. The changes would affect the contributions made by both the employee and the employing agency for retirement and health benefits.

Employing Agency Contributions for Civilian Retirement. Subtitle A would increase the contribution rates paid by federal agencies on behalf of their employees. CBO estimates that offsetting receipts (collections by the civilian retirement trust funds) would increase by $597 million in 1998 and $2.9 billion over the five-year period.

Under the Civil Service Retirement System (CSRS) and the Foreign Service Retirement and Disability System (FSRDS), each federal agency matches the employee contribution of 7.0, 7.5, or 8.0 percent, depending on the type of employee. Under the Federal Employees Retirement System (FERS) and the Foreign Service Pension System (FSPS), the agency contributes an amount equal to a percentage of basic pay which, when added to the employee contribution, equals the normal cost of FERS. The normal cost is the percentage of an employee's salary required to be contributed each year over the employee's working career to fully finance, with interest, all retirement benefits. The current normal cost for FERS used to determine most agency contributions is 12.2 percent and is scheduled to decline to 11.4 percent for most agencies in fiscal year 1998. Because employee contributions cover 0.8 percent of the normal cost, most agencies now contribute 11.4 percent of each employee's salary to FERS; the contribution will fall to 10.6 percent in 1998. Agencies that employ those workers with special retirement provisions, like Congressional employees, Members of Congress, firefighters, and law enforcement personnel, are required to pay a higher percentage of salary to the retirement system, because these personnel have more costly retirement benefits and a greater normal cost.

This legislation would increase matching contributions for CSRS and FSRDS by non-postal agencies by raising the contribution rate by 1.51 percentage points (to 8.51 percent for most employees) in October 1997, and an additional 0.09 percentage points in October 2001. In October 2002, the rate would return to its current level. Agency contributions are recorded as offsetting receipts of the re-

tirement trust fund. Since CSRS and FSRDS are closed systems (federal employees hired after January 1, 1984, are covered under FERS and FSPS), CBO expects the increase in contributions to decline each year after 1998. The legislation would maintain agency contributions for FERS and FSPS at current levels, despite the fact that employee contributions are being increased.

ESTIMATED BUDGETARY EFFECTS OF SUBTITLE A, CIVIL SERVICE

	By fiscal years, in millions of dollars—					
	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Spending Under Current Law:						
Receipts of Employer Contributions to Civilian Retirement	−16,366	−16,913	−17,160	−17,886	−18,520	−19,368
Federal Employees Health Benefits	3,920	4,165	4,474	4,907	5,256	5,655
Postal Service:	.....	.....	.....	.....	.....	.....
On-Budget	36	35	34	33	32	31
Off-Budget	1,380	2,654	−964	−1,262	−532	224
Total Budget	1,416	2,689	−930	−1,229	−500	255
Proposed Changes:						
Increase Agency Contributions to CSRS and FSRDS by 1.51 percent in October 1997 and an additional 0.09 percent in October 2001	0	−597	−580	−563	−548	−565
Government Contributions under FEHB	0	0	−5	−7	−7	−8
Repeal of Transitional Appropriation for the U.S. Postal Service:	.....	.....	.....	.....	.....	.....
On-Budget	0	−35	−34	−33	−32	−31
Off-Budget	0	35	9	0	0	0
Total Budget	0	0	−25	−33	−32	−31
Total Proposed Changes	0	−597	−610	−603	−587	−604
Spending Under Title VI:						
Receipts of Employer Contributions to Civilian Retirement	−16,366	−17,510	−17,740	−18,449	−19,068	−19,933
Federal Employees Health Benefits	3,920	4,165	4,469	4,900	5,249	5,647
Post Service:	.....	.....	.....	.....	.....	.....
On-Budget	36	0	0	0	0	0
Off-Budget	1,380	2,689	−955	−1,262	−532	−224
Total Budget	1,416	2,689	−955	−1,262	−532	224
REVENUES						
Increase Employee Contributions to CSRS,FERS, FSRDS, and FSPS by 0.25 percent in January 1999, an additional 0.15 percent in January 2000, and another 0.1 percent in January 2001	.....	.....	208	413	551	598

Employee Contributions for Civilian Retirement. This legislation would also increase contributions by federal employees to the civilian retirement systems. CBO estimates that revenue from additional employee contributions would total $208 million in 1999 and $1.8 billion over the 1999–2002 period.

Under current law, most workers covered by CSRS and FSRDS contribute 7 percent of their basis pay to the retirement trust fund but pay no Social Security taxes. Employees covered by FERS and FSPS pay 6.2 percent in Social Security taxes (up to the ceiling on Social Security taxable wages) and 0.8 percent to the retirement

trust fund. Certain groups of employees contribute slightly more for federal retirement coverage and in turn receive more generous benefits. Law enforcement personnel, firefighters, air traffic controllers, and Congressional employees contribute 7.5 percent of salary to CSRS. Members of Congress and certain judicial officials contribute 8 percent. Employees with special retirement provisions pay an extra 0.5 percent of pay if enrolled in FERS or FSPS.

The legislation would set the contribution rate at 7.5 percent for all CSRS and FSRDS employees (except Congressional staff, firefighters, and law enforcement personnel, whose contribution rates would rise to 8 percent, and Members of Congress and certain judges and magistrates, whose rates would rise to 8.5 percent). FERS employees would also fact the 0.5 percent contribution hike. These increases in contribution rates would be phased in over three years: 0.25 percentage points in January 1999, another 0.15 percentage points in 2000, and 0.1 percentage points in 2001. The contribution rates would remain 0.5 percentage points higher than under current law until the end of calendar year 2002, at which time the rates would return to their current level.

Based on data from the Office of Personnel Management (OPM), CBO estimates that the fiscal year 1997 payroll base covered by CSRS and FERS is $80 billion for non-postal employees and about $25 billion for postal employees. This estimates uses CBO's baseline projection of General Schedule pay raises—which run about 3.0 percent annually—to project the payroll base after 1997. CSRS and FERS each currently cover about one-half of federal payroll. CBS estimates that the percentage of total payroll covered by CSRS will decline by 2 to 3 percentage points each year, while the FERS payroll will grow at the same rate.

Government Contributions to Federal Employees Health Benefits. This portion of the bill modifies the procedures for determining the share of health insurance premiums that the federal government pays on behalf of its employees and retirees. The FEHB program provides health insurance coverage for 4 million workers and annuitants, as well as their 4.6 million dependents and survivors. The payments on behalf of annuitants are considered direct spending and payments for employees are funded out of annul appropriations for the agencies that employ them. In 1997, the FEHB costs for annuitants are estimated to be $3.9 billion.

The current formula used to calculate the federal share of premiums is based on the costs of five plans currently in the FEHB package and a "phantom" plan that acts as a placeholder for a former plan. The dollar amount of the maximum federal contribution is computed as 60 percent of the average costs of these six plans. However, in no plan can the federal contribution exceed 75 percent of the premium. The law establishing the current formula expires in 1999.

The committee's recommendations would change the dollar limit on the federal contribution to 72 percent of the weighted average of the premiums of all plans to which federal workers and annuitants subscribe. CBO estimates the new formula would establish a maximum contribution that would be very slightly lower than under the current formula. CBO estimates that the direct spending

savings from the provisions would amount to less than $10 million annually through 2002.

Postal Service Transitional Payments. Under current law, the United States Postal Service (USPS) receives a mandatory appropriation for compensation to individuals who sustained injuries while employed by the former Post Office Department. This legislation would terminate this annual payment, effective October 1, 1997.

CBO estimates that enacting this legislation would reduce on-budget direct spending by $35 million in fiscal year 1998, and that annual savings would decline to $31 million by fiscal year 2002. The USPS would have to continue to pay the costs that have been covered by the appropriation out of its own revenues. Thus, this legislation would cost the USPS, and off-budget agency, $35 million in fiscal year 1998. Consistent with CBO's projections, we expect that the USPS would recover the additional cost of the transitional expenses by raising postal rates, which we assume will occur January 1, 1999. The net budgetary impact, combining on-budget and off-budget effects, would be zero for fiscal year 1998, savings of $25 million in 1999, and savings averaging $32 million annually for fiscal years 2000 through 2002.

Subtitle B—GSA Property Sales

Sale of Governors Island, New York. Section 6011 would direct the General Services Administration (GSA) to sell at fair market value all federal land and property located on Governors Island in New York Harbor. The bill would grant new York City and New York State a right of first offer to purchase all or part of the island. Proceeds from the sale would be deposited in the general fund of the U.S. Treasury as miscellaneous receipts. Based on information obtained from local agencies, GSA, and others, CBO estimates that selling the 172-acre island would generate offsetting receipts of about $500 million. Because the bill would prohibit the sale of this property before fiscal year 2002, we estimate that the $500 million would be deposited into the Treasury in that year. We estimate that until then the federal government would spend about $10 million annually to maintain the island, assuming appropriation of the necessary amounts. Such costs would be incurred under current law in 1998, but the costs for continued maintenance after 1998 are not likely to occur in the absence of this legislation.

Until recently, Governors Island was used by the U.S. Coast Guard as a major command center. That agency is in the process of closing the facility. Current plans call for relocation and certain restoration activities to be completed by the end of 1998. Disposition of the site under existing law is uncertain and could include transfers to other federal agencies, conveyances at no cost to non-federal agencies for public benefit uses, donations to nonprofit groups for homeless shelters, or sale. (Disposal of the island may not be possible without Congressional approval). In any event, CBO believes that the federal government would realize little or no money from disposal of the island in the absence of legislation. Enacting section 6011 would ensure that the island would be sold rather than given away or retained by the federal government.

The value of Governors Island cannot be determined precisely in the absence of formal appraisals, which have not yet been conducted. Based on available information, we estimate that sale of this asset would generate about $500 million. The proceeds would depend on whether disposal would occur in one transaction or as a combination of partial sales and on a variety of other factors, including future economic conditions and local zoning decisions. Thus, the government could receive considerably less than $500 million or as such as $1 billion. Moreover, conditions that might be imposed on the sale by federal agencies could delay or prevent any sale from taking place, as could expectations of restrictive zoning requirements.

Finally, until the island is sold, GSA and the Coast Guard would have to maintain the property and provide for security, transportation,and utilities. Based on information provided by the affected agencies and assuming appropriation of the necessary amounts, we estimate that costs for these purposes would total about $10 million annually, beginning in 1999.

Union Station Air Rights. Section 6012 would compel Amtrak to convey the air rights that it owns behind the District of Columbia's Union Station to the Administrator of the General Services administration. The Administrator would then be required to sell these air rights and other air rights that the federal government owns behind Union Station.

CBO estimates that selling the 16.5 acres of rights would yield $40 million in asset sale receipts in fiscal year 2002. This estimate assumes that Amtrak would convey its air rights to the federal government so they can be sold. If Amtrak does not convey the air rights on or before December 31, 1997, the bill would prohibit Amtrak from obligating any of its federal grant money after March 1, 1998.

Estimated impact on State, local, and tribal governments: Title VI contains no intergovernmental mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

The bill provides the city and state of New York the right of first refusal in the purchase of Governors Island. Should either entity, or the two in partnership, choose to acquire the property in whole, CBO estimates that it would cost them approximately $500 million.

Estimated impact on the private sector: Title VI would impose a new private-sector mandate as defined in UMRA by increasing the contributions required of federal employees to the civilian retirement systems. Contributions to the civilian retirement systems, which are compulsory withholdings made by the government, are equivalent to a tax on the wages of federal employees and are classified as a revenue in the federal budget. Therefore, the increase in required contributions constitutes a new enforceable duty and represents a private-sector mandate under UMRA. CBO estimates that the direct costs of the new private-sector mandate in Subtitle A would be $1.9 billion form January 1999 until January 2003, at which time contribution rates would return to their current level. The following table shows the direct costs of increasing mandatory retirement contributions by federal employees.

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002	2003	Total
Direct costs of increasing employee contributions to CSRS, FERS, FSRDS and FSPS	0	208	413	551	598	153	1,923

Estimate prepared by—Federal Cost: Civilian Retirement—Paul Cullinan; Federal Employees Health Benefits—Jeffrey Lemieux; Governors Island—Deborah Reis; Union Station Air Rights—Clare Doherty. Impact on State, Local, and Tribal Government: Theresa Gullo, Impact on the Private Sector: Matthew Eyles.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

ESTIMATED BUDGETARY EFFECTS OF RECOMMENDATIONS OF SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS, 1998–2007

[By fiscal year in millions of dollars]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998–2002	1998–2007
DIRECT SPENDING												
Increase Agency Contributions to CSRS and FSRDS by 1.51 percent in October 1997 and an additional 0.09 percent in October 2002[1]	−597	−580	−563	−548	−565	0	0	0	0	0	−2853	−2853
Government Contributions under FEHB	0	−5	−7	−7	−8	−9	−9	−10	−11	−12	−28	−78
Repeal of Transitional Appropriation for the U.S. Postal Service:												
On-budget	−35	−34	−33	−32	−31	−30	−29	−28	−27	−26	−165	−305
Off-budget	35	9	0	0	0	0	0	0	0	0	44	44
Total budget	0	−25	−33	−32	−31	−30	−29	−28	−27	−26	−121	−261
Direct Spending Total:												
On-budget	−632	−619	−603	−587	−604	−39	−38	−38	−38	−38	−3045	−3236
Off-budget	35	9	0	0	0	0	0	0	0	0	44	44
Total budget	−597	−610	−603	−587	−604	−39	−38	−38	−38	−38	−3001	−3192
ASSET SALES[2]												
Sale of Governors Island	0	0	0	0	−500	0	0	0	0	0	−500	−500
Sale of Air Rights at Union Station	0	0	0	0	−40	0	0	0	0	0	−40	−40
REVENUES												
Increase Employee Contributions to CSRS and FERS by 0.25 percent in January 1999, an additional 0.15 percent in January 2000, another 0.1 percent in January 2001[3]	.....	208	413	551	598	153	0	0	0	0	1770	1923

[1] Estimates for this policy in the Bipartisan Budget Agreement were CBO's reestimates of the 1.51 percent increase under the President's FY98 Budget assumptions for pay raises, and totalled $2.933 billion over five years. The savings were $597 million in 1998, $591 million in 1999, $586 million in 2000, $582 million in 2001, and $577 million in 2002.

[2] Based on criteria established in the 1998 budget resolution, CBO has determined that proceeds from the asset sales in this title should be counted in the budget totals for the purposes of Congressional scoring. Under the Balanced Budget Act, however, proceeds from asset sales are not counted in determining compliance with the discretionary spending limits or the pay-as-you-go requirement.

[3] Estinates for this policy in the Bipartisan Budget Agreement were those presented in the President's 1998 Budget. Those estimates indicated additional revenues of $1,829 billion over the five-year period, with $214 million in 1999, $423 million in 2000, $571 million in 2001, and $621 million in 2002.

Note. Components may not add to totals because of rounding.

COMMITTEE ON GOVERNMENTAL AFFAIRS

RECONCILIATION—TITLE VI

PURPOSE AND SUMMARY

To comply with the instructions of the conference agreement on the concurrent budget resolution (H. Con. Res. 84), which instructs the Committee on Governmental Affairs to report changes in law within its jurisdiction that provide savings in direct spending and revenues totaling $5.456 billion over the five-year period, FY 1998 to FY 2002, the committee makes the following legislative recommendations:

(1) Increase Civil Service Retirement System (CSRS) Agency Contributions by 1.51 percent beginning October 1997 through September 2001, and 1.6 percent in FY 2002.

(2) Increase Employee Contributions to CSRS and the Federal Employees Retirement System (FERS) by 0.25 percent in January 1999, and additional 0.15 percent in January 2000, and another 0.10 percent in January 2001, with the cumulative .5 percent retained for 2002.

(3) Reform the formula for computation of the government's share of Federal Employees Health Benefit Program (FEHBP).

(4) Repeal of Transitional Appropriation for the U.S. Postal Service for workers compensation.

(5) Asset Sales to include: (a) Governors Island, New York, and (b) Air Rights at Union Station, Washington, D.C.

SECTION-BY-SECTION SUMMARY

Subtitle A—Civil Service and Postal Provisions

Section 6001. Increased contributions to Federal civilian retirement systems

(1) All Federal agencies, except for the United States Postal Service, would be required to increase their payment to the Civil Service Retirement and Disability Fund for each individual employee enrolled in the Civil Service Retirement System (CSRS). For the first four fiscal years, 1998 through 2001, contributions are increased by 1.51 percent each year above the percentage an agency is now contributing. For the fiscal year 2002, the contribution is increased to 1.6 percent in order to meet the specific direct spending target for the year 2002. However, if it is determined that the CBO scoring for this policy change will be based on the assumption of the President's pay raises in future years, the committee recommends that the contribution rate remain at 1.51 percent for 2002.

The 1.51 percent increase in employer contributions does not apply to the United States Postal Service which currently contrib-

utes the full actuarial cost of each employee's retirement under CSRS.

There is no increase in the agency contribution for the Federal Employees Retirement System (FERS) because that plan is actuarially fully funded.

(2) The legislation further requires increased individual employee contributions. The increase in employee contributions to CSRS will apply to all employees participating in that system including Members of Congress, congressional employees, law enforcement officers, firefighters, Capital Police, bankruptcy judges, judges for the U.S. Court of Appeals for the Armed Forces, U.S. magistrates, Claims Courts judges, and employees of the United States Postal Service. The increased contribution shall also apply to individuals participating in the Central Intelligence Agency or Foreign Service retirement systems.

The amount deducted from basic pay for an individual participating in CSRS will be increased above the level in effect on the date of enactment by .25 percent in 1999, by an additional .15 percent in 2000, and by an additional .10 percent in 2001. The increase will then remain constant at .5 percent through 2002.

The repayment for any military service between January 1, 1999, and December 31, 2002, for which an employee or a Member of Congress would like to receive retirement credit under CSRS, would be at the contribution rate in effect for employees during the period for which such credit is provided.

Likewise, the legislation provides that repayment for any covered volunteer service between January 1, 1999, and December 31, 2002, for which an employee or Member of Congress would like to receive retirement credit under CSRS would be at the contribution rate in effect for employees during the period for which such credit is provided.

The legislation also requires increased employee contributions from all employees participating in the Federal Employees Retirement System (FERS), including members of Congress, congressional employees, law enforcement officers, firefighters, Capital Police, bankruptcy judges, judges for the U.S. Court of Appeals for the Armed Forces, U.S. magistrates, Claims Court judges, and employees of the United States Postal Service. The increased contribution shall also apply to individuals participating in the Central Intelligence Agency or Foreign Service retirement systems. These employees are required to increase their contributions to FERS by .25 percent in 1999, an additional .15 percent in 2000, and by an additional .10 percent in 2001. The increase in the contribution over the percentage an employee currently pays into the system will then remain at .5 percent through 2002.

This subsection provides that repayment for any military service between January 1, 1999, and December 31, 2002, for which an employee or Member of Congress would like to receive retirement credit under FERS would reflect the increased employee contributions resulting in the following repayment percentages: calender year 1999, 3.25 percent; calender year 2000, 3.4 percent; calender years 2001–2002, 3.5 percent.

In addition, this subsection provides that the repayment for any covered volunteer service between January 1, 1999 and December

31, 2002 for which an employee or Member of Congress would like to receive retirement credit under FERS would reflect the increased employee contributions resulting in the following repayment percentages: calender year 1999, 3.25 percent; calender year 2000, 3.4 percent; calender years 2001–2002, 3.5 percent.

This subsection also prohibits agencies from reducing their contribution to FERS for each individual employee by a percentage equal to any percentage increase in individual employee contributions. Under current law, agency contributions would automatically decrease with any increase in employee contributions. The section prohibits the Postal Service and all other Federal agencies from reducing their contributions to FERS.

The effective date for the increased contributions for employees and agencies is the first day of the first pay period beginning on or after January 1, 1999.

Section 6002. Government contributions under the Federal Employees Health Benefits Program

The Federal Employee Health Benefit Program (FEHBP) "Fair Share" formula language contained in the Committee's reconciliation language serves as a replacement for the outdated "Big Six" Phantom formula, set to expire in 1999. Rather than extending the Phantom formula for a third time, the Committee, assisted by the Office of Personnel and Management (OPM), devised a new weighted average formula that maintains the current government share of approximately 72 percent of the premium (with the enrollee paying the remainder).

The Fair Share formula is based upon a determination of the average of the subscription charges in effect on the beginning date of each contract year with respect to Self Only and Family enrollments (including Postal Service enrollees). This is done by weighting the premiums of each currently participating and continuing plan by the actual distribution of enrollees by plan and option as reflected in the most recent semi-annual enrollment report that has been produced by OPM.

After the average Self Only and Family premiums have been determined, each is multiplied by 72 percent to set the maximum dollar government contribution. The formulation continues the 75 percent limitation on the actual government contribution to any specific plan. That limit preserves the cost sharing principle that has existed in the program since 1974, promoting cost-conscious plan selection by assuring that enrollees always pay some amount toward the cost of their insurance. The 72 percent maximum government contribution in combination with the 75 percent cap results in an average government contribution of roughly 71 percent, and is intended to mirror the distribution under current law.

The Fair Share formulation is tied to the reality of the FEHBP, not to an artificial index. Because it takes actual premiums and enrollee choice into complete account, it will always be an accurate reflection of what is occurring within the FEHBP. It will not be affected by plan mergers, withdrawals, enrollment gains or losses, or the experience of a single plan, any of which can significantly affect a contribution formula based on a small number of plans. The effective date is the first day of the contract year that begins in 1999.

Use of the Fair Share formula results in a budget savings of $28 million, as scored by the Congressional Budget Office (CBO).

Background and Need for Legislation

Under current law, the government's share of FEHBP premiums is determined independently for Family and Self Only coverage. By law, the federal contribution is based on a two-part formula, generally referred to as the "Big Six" formula. The first part of the formula limits the government's contribution to a flat dollar amount equal to 60 percent of the simple average of the premiums for the high-option benefits offered by six plans: two government-wide plans, the two largest Health Maintenance Organizations (HMOs), and the two largest government organization plans. The second part of the formula further limits the government's contribution to 75 percent of the premium for the plan selected by the enrollee. Thus, enrollees pay at least 25 percent of the total premium of the plan in which they enroll.

Until 1990, the two government-wide high-option plans were Blue Cross/Blue Shield and Aetna. However, in 1990, Aetna dropped out of the FEHBP altogether. In order to prevent Aetna's withdrawal from causing premiums to be based on 60 percent of the simple average of the premiums in the remaining five plans (which would have decreased the government's share and increased the enrollees" share), Congress enacted legislation establishing a "proxy" plan (sometimes referred to as the "phantom" plan) with a premium calculated as if the Aetna high-option plan were still part of the program. This phantom plan was originally authorized through 1993, but in that year Congress extended it through 1998, with a one percent reduction in the proxy plan premium in 1997 and 1998.

If current law is allowed to expire and a Big Five, simple average formula becomes the "default" formula in 1999, the government's costs would decrease and enrollee costs would increase. That is, costs would be shifted from the federal government to employees and retirees. The Office of Management and Budget (OMB) estimates that the reduction in the government's costs would be roughly $1 billion in calendar year 1999. Currently, on average, the government pays 71 percent of total premium costs. Under a Big Five simple average formula, the government's share would be about 67 percent, on average.

The Committee believes it is necessary to establish in law a new formula—specifically, the Fair Share formula—designed not only to modernize the current formula, but to avoid the large reduction in the government contribution, and the attendant increase in cost to the enrollee, which will occur in 1999 if current law is allowed to expire.

Section 6003. Repeal of authorization of transitional appropriations for the United States Postal Service

This section of the legislation repeals the permanent authorization of transitional appropriations for the United States Postal Service workers" compensation. Under the 1970 Postal Reorganization Act, Post Office Department employees who were already receiving workers compensation payments remained the responsibil-

ity of the federal government. The United States Postal Service would instead be required to assume payment without federal reimbursement. The five-year cost savings is $165 million.

Subtitle B—GSA Property Sales

Section 6011. Sale of Governors Island, New York

This section requires the Administrator of the General Services Administration to sell Governors Island, New York, at fair market value. The sale is scheduled to occur in the year 2002. The State of New York and the City of New York are given the right of first offer to purchase all or part of the property. The proceeds of the sale will be deposited in the general fund of the U.S. Treasury and credited as miscellaneous receipts.

Governors Island is located in New York City harbor, south of Manhattan and west of Brooklyn. It houses the largest Coast Guard facility in the world, Support Center New York, which provides support for commands stationed on the island. The 172-acre island is surrounded by a seawall and is reached by ferry from Manhattan.

Section 6012. Sale of air rights

The Administrator of General Services is authorized and directed to sell, before the end of fiscal year 2002, at fair market value, the air rights north of Union Station, Washington, DC. There are approximately 16.3 acres of air rights, or air space above train tracks that could be developed into commercial property, with parking. In 1992 these air rights were valued by an appraisal performed for GSA at $50,000,000. This figure is net of any cost to build a platform, or lid, which is necessary to support the development of a building.

These air rights are bounded on the south by Union Station, on the east by the CSX property and Second St. NE., on the north by K St. NE. and on the west by 1st St. NE. The H St. NE. overpass cuts through the air rights, running east-west. These air rights are currently owned by the Department of Transportation, and AMTRAK. AMTRAK is required to transfer, at no cost, its air rights, estimated to be approximately 10.6 acres, to the Department of Transportation. The Administrator of General Services would then sell the air rights in a manner to be determined.

United States Senate
COMMITTEE ON LABOR AND HUMAN RESOURCES
WASHINGTON, DC 20510-6300

June 18, 1997

The Hon. Pete V. Domenici
Chairman
Committee on the Budget
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

In order to comply with the reconciliation instructions contained in the conference agreement on the fiscal year 1998 budget resolution, I am transmitting the recommendations of the Committee on Labor and Human Resources for deficit reduction.

The committee's work is embodied in the enclosed legislative and report language and is based on preliminary estimates by the Congressional Budget Office. As you know, because of the committee's limited jurisdiction over mandatory spending, the whole of our $1.792 billion in savings is derived from the administration of the student loan program. In our efforts to meet the instruction, we gave priority to preserving two viable student loan programs.

The result is legislation that distributes spending reductions equitably between the federal direct lending program and the Federal Family Education Loan program. Our recommendations also include a recall formula and timetable designed to ensure that the recall of excess guaranty agency cash reserves does not jeopardize the viability of smaller guaranty agencies.

I hope these recommendations will assist you in assembling the budget reconciliation package and look forward to working with you on the floor and in conference.

Sincerely,

James M. Jeffords
United States Senator

JMJ:sg
Enclosure

ADDITIONAL VIEWS

The Democratic members of the State Labor and Human Resources Committee unanimously opposed that part of Section 7103 of the Chairman's mark that mandates the payment of an Administrative Cost Allowance to guaranty agencies. The majority's proposal changes current law by transforming a discretionary payment of an Administrative Cost Allowance (ACA) to guarantly agencies into a coporate entitlement. This issue was specifically discussed during the negotiations that resulted in the budget agreement, and was rejected.

The Democratic members view the inclusion of this section as an unnecessary corporate entitlement and as contrary to the budget deal. Money for an Administrative Cost Allowance has been appropriated and has been paid to guaranty agencies by the Department of Education, rendering this language unnecessary. Senator Dodd proposed an amendment to strike that section of the majority's proposal, which was defeated by a vote of 10 to 8, along party lines.

The majority's discussion of guaranty agency budgets should not be understood as reflecting Congress's rationale for the payments. The payments have not been based on a thorough analysis by the Committee of guaranty agencies' needs, functions, past use of funds, future use of funds, or other sources of funds.

The majority's determination to create a corporate entitlement contrasted with the Democrats' desire to reduce costs for student. Senator Kennedy introduced an amendment that would have reduce the origination fees on student loans by 2%. This amendment was fully paid for by reducing the federal insurance rates paid on defaults and by reducing the retention allowance for guaranty agencies. Proposals to reduce certain insurance rates and retention allowances were included in the Republicans' reconciliation proposal of 1995. Senator Kennedy's amendment was defeated along party lines, by a vote of 10 to 8. To accommodate the majority's desire to mandate the payment of the ACA, Senator Kennedy then proposed to modify his amendment by including the payment of the ACA while still providing these immediate benefits for students. This was also defeated along party lines, by a vote of 10 to 8.

The majority opposed these changes by stating that the structure of the guaranty agencies would be reconsidered during the upcoming reauthorization of the Higher Education Act. The Chairman also stated that payment of the ACA would be reconsidered during the reauthorization process. Even so, amendment offered by Senator Harkin that would have limited the provision regarding ACA to one year—the expected time for the reauthorization—was defeated, again along strict party lines. The Committee did unanimously accept Senator Harkin's amendment to restrict the use of interest on the restricted accounts from the guaranty agency reserves to activities to prevent student defaults.

The Democratic members were reassured by the Chairman's statement that all payments to guaranty agencies would be reviewed during the reauthorization of the Higher Education Act. In light of this assurance and in the spirit of the bapartisan budget agreement, the majority of the Democrats voted for final passage of the Chairman's mark, by a margin of 7–1.

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

June 19, 1997

Honorable James M. Jeffords
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommendations of the Senate Committee on Labor and Human Resources.

The estimate shows the budgetary effects of the committee's proposals over the 1998-2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the resolution instructions in the budget resolution. This estimate assumes the reconciliation bill will be enacted by October 1, 1997.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Deborah Kalcevic who can be reached at 226-2820 and Marc Nicole (for state and local government impacts) who can be reached at 225-3220.

Sincerely,

James L Blum

for June E. O'Neill

Enclosure

cc: Honorable Edward M. Kennedy
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Reconciliation Recommendations of the Senate Committee on Labor and Human Resources (Title VII)

Summary: Title VII of the reconciliation bill would make three changes in the federal administrative costs and federal cash management of the student loan programs, which under current law are expected to guarantee or issue about 40 million new loans totaling $160 billion over the next five years. The revisions to the program would leave program eligibility and loan capital financing unchanged. In combination, the proposed changes would lower program costs by $239 million in 1998 and $1.8 billion over the 1998–2002 period.

This title contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act of 1995 (UMRA). Public institutions of higher education could lose federal subsidies totaling up to $20 million in fiscal year 1998 and $155 million over the 1998–2002 period. This title contains no private-sector mandates as defined in UMRA.

Estimated cost to the Federal Government: CBO estimates the committee's proposals would reduce federal outlays by $239 million in 1998, $1.1 billion in 2002, and $1.8 billion over the 1998–2002 period. The estimated budgetary impact of these proposals over the 1998–2002 period is shown in the following table. The appendix table shows the budgetary effects through 2007.

The budgetary impact of Title VII falls within budget function 500 (education, training, employment, and social services).

ESTIMATED BUDGETARY IMPACT OF THE RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
Spending current law:						
Budget authority	1,009	3,911	3,567	3,367	3,418	3,533
Estimated outlays	578	3,378	3,325	3,162	3,138	3,223
Proposed changes: Section 7001—guaranty agency reserves:						
Budget authority	.....	.....	.....	.....	.....	−1,028
Estimated outlays	.....	.....	.....	.....	.....	−1,028
Section 7002—direct loan processing fee:						
Budget authority	.....	−35	−35	−40	−40	−45
Estimated outlays	.....	−20	−30	−35	−35	−40
Section 7003—section 458 funds:						
Budget authority	.....	−421	−140	−45	0	0
Estimated outlays	.....	−219	−203	−120	−50	−12
Subtotal, proposed changes:						
Budget authority	.....	−456	−175	−85	−40	−1,073
Estimated outlays	.....	−239	−233	−155	−85	−1,080
Spending under reconciliation recommendations:						
Budget authority	1,009	3,455	3,392	3,282	3,378	2,460
Estimated outlays	578	3,139	3,092	3,007	3,053	2,143

Basis of estimate: Management and Recovery of Reserves. Section 7001 of this bill would require that the 36 guaranty agencies currently participating in the guaranteed student loan program return $1.028 billion of their cash reserve funds to the federal government in 2002. The net cash reserves held by guaranty agencies have been growing in recent years due to recent changes in law

that expanded borrowing levels and resulted in increased premium collections and lower default claims. As of September 1996, these agencies had combined net cash reserves of just over $2 billion. The amount to be recalled exceeds the amount needed by these agencies to operate over the next five years. The bill would recall more of the funds from agencies with proportionately larger cash reserves. The CBO estimate assumes that the agencies would continue to receive insurance premiums, reinsurance payments, and federal administrative cost allowances, which are all provided for under current law. If these revenues were to be diminished, CBO would reassess the likelihood that the recall target could be attained.

Repeal of Direct Loan Origination Fees to Institutions of Higher Education. Section 7002 would eliminate the separate per loan federal subsidy to schools or alternate originators to process applications for direct student loans. Direct payments to schools have been prohibited in the last two appropriations bills, allowing payment only to alternate originators. Eliminating these mandated payments would save $20 million in 1998 and $160 million over the 1998–2002 period. The proposal would not prevent the Secretary of Education from using funds available under the capped administrative entitlement fund (Section 458 moneys) to pay either schools or alternate originators to process the applications for direct student loans.

Funds for Administrative Expenses. The Department of Education's Section 458 capped administrative entitlement fund would be reduced by $604 million over the five-year period to a new five-hear total of $3.1 billion. Section 7003 would set new annual limits for this fund at $532 million in 1998, $610 million in 1999, $705 million in 2000, and $750 million in 2001 and 2002. The current five-year cumulative ceiling would be eliminated, and funds would be available for obligation until expended.

Estimated impact on State, local, and tribal governments: This title contains no intergovernmental mandates as defined in UMRA. Enactment of this title would eliminate the requirement that the federal government help cover the cost of originating direct student loans. CBO estimates that public institutions of higher education could lose federal subsidies totaling up to $20 million in fiscal year 1998 and $115 million over the 1998–2002 period.

Estimated impact on the private sector: Enactment of Title VII would impose no private-sector mandates as defined under UMRA.

Estimate prepared by: Federal Cost: Deborah Kalcevic, Impact on State, Local, and Tribal Governments: Marc Nicole, Impact on Private Sector: Bruce Vavrichek.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

APPENDIX TABLE: ESTIMATED BUDGETARY EFFECTS OF TITLE VII; RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

[In millions of dollars, by fiscal year]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998–2007 Total
CHANGES IN DIRECT SPENDING											
Student loans:											
Estimated budget authority	−456	−175	−85	−40	−1,073	−45	−50	−50	−55	−55	−2,084
Estimated outlays ...	−239	−233	−155	−85	−1,080	−42	−45	−45	−50	−50	−2,024

BUDGET RECONCILIATION BILL PROVISIONS AFFECTING FEDERAL STUDENT LOAN PROGRAMS AS PASSED BY THE COMMITTEE ON LABOR AND HUMAN RESOURCES—JUNE 11, 1997

(Assumes Enactment Prior to October 1, 1997 and Assumes All Changes Effective Upon Enactment)

SAVINGS OVER 5 YEARS (1998–2002)=$1.792 BILLION

The budget agreement approved by the Senate reflects the strong bipartisan support for education. The agreement provides for $35 billion in education related tax provisions, and assumes increased Federal support for Special Education, Head Start, and funding for literacy programs. The budget agreement supports providing an additional $7.6 billion for Pell Grants allowing the maximum grant to grow from $2,700 to $3,000.

In addition, the subsidy for student loans is assumed to grow from $3.9 billion in 1998 to $4.1 billion in 2002. This will support growth in Federal student loan volume from $28.8 billion in 1998 to $35.8 billion in 2002.

Summary of submission

The Senate Budget Resolution requires $1.792 billion in savings over five years from mandatory spending under the jurisdiction of the Committee on Labor and Human Resources. The savings required by the agreement and submitted by the Committee will not increase costs, reduce benefits, or limit access to loans for students and their families. In accordance with the budget agreement, this proposal attempts to maintain an equitable balance in the savings that are taken from the Federal Family Education Loan Program (FFEL) and the federal direct lending program (FDLP).

The budget submission approved by the Committee on Labor and Human Resources was approved by a vote of 17–1. It achieves the required savings by recalling $1.028 billion in excess guaranty agency reserves, eliminating the $10 direct loan origination fee and reducing the Department of Education's entitlement for the administration of the federal student loan programs by $604 million.

SECTION-BY-SECTION ANALYSIS OF LABOR COMMITTEE RECONCILIATION SUBMISSION

Section 7001: Management and recovery of guaranty agency reserves

Equitable shares

The Committee's proposal requires that the guaranty agencies return $1.028 billion of their current excess cash reserves to the Federal Treasury in Fiscal Year 2002. The Secretary shall require each guaranty agency to return excess reserve funds based on each agency's equitable share. This share will be calculated based upon the excess reserve funds held by the agency as of September 30, 1996. For the purposes of determining each agency's equitable share, the calculation of the reserve ratio will include transfers of the liabilities to each agency of the outstanding loans from the merged agencies as well as transfers of the reserves from the merged agencies. The Secretary will then calculate the equitable shares by requiring each agency with a reserve ratio in excess of 1.12% to return reserves above 1.12%. In addition, each agency will also return an equal percentage of their remaining reserves until the total reserve return of $1.028 billion is achieved.

The formula used to determine an agency's equitable share is designed to avoid jeopardizing the viability of those agencies with fewer excess cash reserves. The failure to maintain a well functioning program would result in students' experiencing disruption or difficulty in obtaining federal student loans.

Restricted accounts

Each agency shall establish a restricted account of its own choosing with approval from the Secretary. Each agency shall, consistent with current law, invest the reserves placed within the restricted accounts in obligations issued or guaranteed by the United States or in other similarly low-risk securities.

An amendment offered by Senator Harkin and adopted by the Committee during markup limits guaranty agency use of interest earnings from these accounts to activities to reduce student loan defaults.

Orderly recall

This section establishes a timetable for the orderly recall of the $1.028 billion in excess guaranty agency reserves over the next five years. In each of the five years covered under this agreement, 20% of the total amount recalled shall be placed in the restricted accounts. In FY 1998, each agency with cash reserves in excess of 2% will contribute the amount in excess of 2% to its restricted account. The Secretary of Education will, in addition, require each agency to contribute an equal proportion of its equitable share to the restricted accounts until 20% of the $1.028 billion to be recalled under this section has been transferred into the restricted accounts. In each of fiscal years 1999–2002, each agency shall transfer one-fourth of the total amount remaining of its equitable share into its restricted account. If, on September 1, 2002, the total amount contained within the restricted accounts is less than $1.028

billion, the Secretary shall require the return of the amount of the shortage from other reserve funds held by guaranty agencies.

The formula provided in the Committee's budget submission upholds the Committee's commitment to require guaranty agencies to annually deposit into a restricted account 20% of the $1.028 billion in excess cash reserves. However, the formula is designed to specifically address the concern that a uniform annual recall of 20% of the excess reserves from each individual agency may be too drastic a reduction for certain agencies to withstand. An across-the-board recall of 20% of excess reserves could risk placing certain agencies in questionable financial standing which could disrupt student access to federal loans through the FFEL program.

Limitations on recall authority

In order to ensure that sufficient reserve funds will be available to fulfill the purposes of this section, restrictions have been placed on the Secretary's recall authority during the five year period covered by the budget agreement. The Secretary may not recall additional excess reserves under 422 (g)(1)(A) of the Higher Education Act and any other reserve funds returned under other authorities within subsection (g)(1) shall be transferred to the restricted accounts and applied toward the amount recalled in the Section 7001.

Minimum reserve ratio

From 1994–1996 the minimum reserve level which each guaranty agency was required to maintain increased from .5% to 1.1%. The minimum reserve level that must be maintained by each guaranty agency is returned to .5%.

Section 7002: Elimination of the direct lending loan origination payment

The authority to make the Federal payment of $10 per loan to schools and/or alternative originators that make direct loans is repealed. This repeal extends for five years a provision currently contained within the FY 1997 Labor, HHS, Education and Related Agencies Appropriations Bill and will provide savings of $160 million over five years.

Section 7003. Reductions in section 458 expenditures

The bipartisan budget agreement preserves a commitment to maintaining two viable student loan programs and calls upon the Committee on Labor and Human Resources to "achieve an equitable balance of savings between the direct student loan program and the guaranteed student loan program." In order to preserve this balance, $604 million in savings are required from the Department of Education's entitlement account to administer the federal direct lending program. The Department will continue to receive $3.2 billion in this account over the next five years.

Section 458 of the Higher Education Act provides funds to the Secretary of Education for the administration of the direct lending and FFEL programs as well as the administrative cost allowance paid to guaranty agencies. Amendments to the Higher Education Act enacted in 1993 provided mandatory spending authority of $750 million for this account in FY 1998. The current funding base-

line for this account provides over $3.9 billion over the next five years. This level of funding is not needed in view of the current and projected volume for the direct lending program, which is lower than initially estimated. Accordingly, the Labor and Human Resources Committee proposal reduces authority for direct lending administration expenditures in Section 458.

In accordance with current law, the payment of administrative costs allowances to guaranty agencies are to be provided by the Department of Education from funds available in Section 458. In order to ensure that the savings required under Section 7003 are not redirected by the Department of Education to the FFEL program, and to ensure that the "equitable balance in savings" is maintained between the two programs, the Committee has included a provision limiting ACA payments to .85 basis points and capping these expenditures to ensure the timely continued payment of the administrative cost allowance to guaranty agencies.

The allegation has been raised by the Administration that the ACA payments constitute a new and unnecessary corporate entitlement. This allegation is not true. Section 428(f) of the Higher Education Act provided for the payment of ACA for any fiscal year prior to 1994 on the basis of 1% of every new loan insured by a guaranty agency during the fiscal year. In the 1993 Budget Reconciliation Act, the payment of ACA was incorporated into section 458 of the Higher Education Act. Conference report language accompanying the reconciliation act (P.L. 103–66) directed the Department to pay "on a timely basis . . . an amount equivalent to that . . . received under the administrative cost allowance provision . . . And that the payment will come from the administrative funds provided under section 458". In 1994 and 1995 the Department of Education paid the guaranty agencies an annual fee equal to 1% of the new loans insured by the agencies in that year. P.L. 104–134, providing FY 1996 appropriations, and P.L. 104–208, providing FY 1997 appropriations, reduced the ACA payment to .85% and capped these expenditures at $170 million in FY96 and $150 million in FY97. The CBO cost estimate which accompanies this report assumes that guaranty agencies will continue to receive "insurance premiums, reinsurance payments, and federal administrative cost allowances, which are all provided for under current law. If these revenues were to be diminished, CBO would reassess the likelihood that the recall target could be attained."

Consistent with current appropriations law, the administrative cost allowance paid to the guaranty agencies out of this account will be reduced to .85% of every new loan. In order to preserve the balance between the savings drawn from the direct lending program and the savings drawn from the FFEL program these payments will be capped at $170 million in each of Fiscal Years 1998 and 1999. ACA payments will be capped at the current CBO baseline of $150 million in each of Fiscal Years 2000, 2001, and 2002.

In the absence of changes to the structure of guaranty agencies, the Committee believes current law and procedure for the payment of administrative cost allowances to guaranty agencies are necessary.

The guaranteed student loan program (FFEL) serves 80% of the institutions of higher education in this country and provides over

60% of total student loan volume. In light of the importance of this program to students, and the fact that nearly one-half of the guaranty agency reserves are being recalled, the Committee believes that these ACA payments must be stabilized. Failure to stabilize these payments could jeopardize the viability of smaller agencies and jeopardize the reserve fund recall that is authorized under section 7001.

Section 7004. Extension of student aid programs

This section provides for a simple extension of three provisions of the Higher Education Act dealing with loan programs. These extensions are required for Congressional Budget Office scoring purposes.

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

June 12, 1997

Honorable Pete V. Domenici
Chairman
Committee on the Budget
United States Senate
Washington, DC 20510

Dear Pete:

On June 12, 1997, the Committee on Veterans Affairs met in open session and approved proposed changes in laws within the jurisdiction of the Committee to reduce direct spending outlays by $681,000,000 in fiscal year 2002, and $2,733,000,000 for fiscal years 1998 through 2002.

The Committee-approved legislative language, report language, and a Congressional Budget Office cost estimate on the legislative language are enclosed.

Sincerely,

Arlen Specter

AS/wft

Enclosures

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

June 19, 1997

Honorable Arlen Specter
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommendations approved by the Senate Committee on Veterans' Affairs on June 12, 1997.

The estimate shows the budgetary effects of the committee's proposals over the 1998-2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. This estimate assumes the reconciliation bill will be enacted by October 1, 1997; the estimate could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Shawn Bishop, Sunita D'Monte, and Mary Helen Petrus, who can be reached at 226-2840.

Sincerely,

for June E. O'Neill

Enclosure

cc: Honorable John D. Rockefeller IV
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Reconciliation Recommendations of the Senate Committee on Veterans' Affairs (Title VIII)

Summary: Title VIII would extend through 2002 provisions of the Omnibus Reconciliation Act of 1990 (OBRA) that affect programs for veterans, make the authority of the Department of Veterans Affairs to spend certain receipts subject to appropriations, and round down cost-of-living adjustments (COLAs) for veterans' disability compensation. CBO estimates the recommendations would reduce direct spending by $247 million in 1998 and about $3.8 billion over the 1998–2002 period; they would raise spending subject to appropriations by $543 million in 1998 and $3.1 billion over the five-year period. The recommendations contain no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995 (UMRA), but they would increase Medicaid costs for state governments beginning in fiscal year 1999.

Estimated cost to the Federal Government: The estimated budgetary impact of the committee's recommendations over the fiscal years 1998 through 2002 is shown in Table 1. The projected impact over 10 years is shown in Table 6, which appears at the end of this estimate.

Receipts for Medical Care

The committee's recommendations contain provisions that would extend the authority of the Department of Veterans Affairs (VA) to collect certain receipts and would replace current permanent authority to spend certain receipts with authority to spend receipts subject to annual appropriation. The combined budgetary effects are shown in Table 2. In total, these provisions would reduce direct spending by $1.7 billion over the 1998–2002 period, and they would raise spending subject to appropriation by $3.1 billion over the five-year period.

Hospital Per Diems and Medical Care Copayments. Section 8021 would extend through September 30, 2002, VA's authority to collect per diem payments for inpatient hospitalizations and nursing home care and other copayments for medical services provided to certain veterans. Under current law, veterans are subject to these copayments if they have no service-connected disability or a disability rated as less than 10 percent disabling, have high enough income, and are treated for a nonservice-connected ailment. Extending these provisions of law, which expire on September 30, 1998, would result in collections of about $2 million in 1999 and $11 million over the 1999–2002 period.

TABLE 1.—ESTIMATED BUDGETARY IMPACT OF TITLE VIII, FISCAL YEARS 1998–2002

(By fiscal year, in millions of dollars)

	1997	1998	1999	2000	2001	2002
VETERANS PROGRAMS						
Spending under current law for veterans programs[1]:						
Estimated budget authority	39,126	41,323	43,484	44,649	45,826	47,043
Estimated outlays	39,445	41,793	43,378	46,287	43,920	46,971

TABLE 1.—ESTIMATED BUDGETARY IMPACT OF TITLE VIII, FISCAL YEARS 1998–2002—Continued

(By fiscal year, in millions of dollars)

	1997	1998	1999	2000	2001	2002
Proposed changes in direct spending:						
Estimated budget authority	0	−159	−1,111	−1,156	−1,206	−1,259
Estimated outlays	0	−247	−1,072	−1,198	−1,160	−1,256
Proposed changes in spending, subject to appropriations:						
Estimated authorization level	0	604	615	639	666	694
Estimated outlays	0	543	608	636	663	691
Spending under Title VIII for veterans programs:						
Estimated budget authority	39,126	41,768	42,988	44,132	45,286	46,478
Estimated outlays	39,445	42,089	42,914	45,725	43,423	46,406
MEDICAID						
Spending under current law for Medicaid:						
Estimated budget authority	98,599	105,308	113,619	122,861	132,792	143,783
Estimated outlays	98,599	105,308	113,619	122,861	132,792	143,783
Proposed changes:						
Estimated budget authority	0	0	282	280	283	292
Estimated outlays	0	0	282	280	283	292
Spending under Title VIII for Medicaid:						
Estimated budget authority	98,599	105,308	113,901	123,141	133,075	144,075
Estimated outlays	98,599	105,308	113,901	123,141	133,075	144,075
TOTAL PROPOSED CHANGES IN DIRECT SPENDING						
Estimated budget authority	0	−159	−829	−876	−923	−967
Estimated outlays	0	−247	−790	−918	−877	−964

Note: The budgetary impact of the recommendations would fall under budget function 700 (Veterans' affairs) and 550 (health).
[1] CBO's baseline for budget function 7000 with adjustments for anticipated inflation.

In addition, this section would extend through September 30, 2002, VA's authority to collect copayments for outpatient medications that are prescribed for nonservice-connected conditions. The copayment would apply to all veterans, except those who have service-connected disability rated at 50 percent or more or whose income falls below a certain threshold. CBO estimates that these collections would amount to about $36 million in 1999 and $152 million over the 1999–2002 period.

Medical Care Cost Recovery. Section 8022 would extend through September 30, 2002, VA's authority to collect from third-party insurers the cost of treating veterans with a service-connected disability for nonservice-connected ailments. CBO estimates that collections would amount to about $195 million in 1999 and $829 million over five years, based on VA's recent experience and adjustments for anticipated inflation.

Medical Care Collections Fund. Action 8023 would replace VA's permanent authority to spend some of the medical care collections with the authority to spend all medical care collections subject to annual appropriation. Eliminating VA's authority under current law would save about $641 million in direct spending over the 1998–2002 period. Authorizing the appropriation of all amounts that VA would collect over that period would cost about $3.1 billion.

Income Verification. Section 8014 would allow VA to use data from the IRS to verify the incomes of veterans receiving benefits from VA, including medical care. Under current law, veterans whose income falls below a certain level qualify for free medical treatment. Veterans who receive free treatment, but are later found to be ineligible through income verification, could be charged

the standard Medicare deductible ($760) for the first 90 days of care, and a $10 daily copayment. These payments revert to the Treasury as mandatory receipts. CBO estimates that VA would collect about $17 million in 1999 and $71 million over the 1999–2002 period as a result of this extension of its authority to verify incomes.

TABLE 2.—BUDGETARY IMPACT OF PROPOSED CHANGES AFFECTING VETERANS MEDICAL CARE

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Net receipts under current law from medical care:						
Estimated budget authority	−466	−485	−242	−252	−262	−273
Estimated outlays	−466	−485	−242	−252	−262	−273
Proposed changes:						
Estimated budget authority	0	−118	−373	−387	−404	−422
Estimated outlays	0	−118	−373	−387	−404	−422
Net receipts under title VIII from medical care:						
Estimated budget authority	−466	−603	−615	−639	−666	−695
Estimated outlays	−466	−603	−615	−639	−666	−695
SPENDING SUBJECT TO APPROPRIATION						
Spending under current law for medical care:						
Estimated authorization level[1]	17,013	17,622	18,228	18,856	19,511	20,194
Estimated outlays	17,005	17,934	18,033	18,618	19,264	19,938
Proposed changes:						
Estimated authorization level	0	604	615	639	666	694
Estimated outlays	0	543	608	636	663	691
Spending under title VIII for medical care:						
Estimated authorization level	17,013	18,226	18,843	19,495	20,177	20,888
Estimated outlays	17,005	18,477	18,641	19,254	19,927	20,629

[1] CBO's baseline with adjustments for anticipated infation.

Housing

Veterans housing would be affected by four provisions. As shown in Table 3, these provisions would reduce direct spending by $1.0 billion over the 1998–2002 period.

Home Loan Fees. Section 8032 would raise the origination fee on direct loans and section 8012 would extend through 2002 two provisions of law pertaining to the veterans home loan program that expire on September 30, 1998. VA often acquires property when a guaranteed loan goes into foreclosure and issues a new direct loan (called a vendee loan) when the property is sold. Section 8032 would raise the fee on vendee loans, from 1 percent to 2.25 percent of the loan amount, to match the premium charged by the Federal Housing Administration. CBO estimates that collections would rise by about $13 million a year.

Under one provision that would be extended, VA would charge certain veterans a fee of 0.75 percent of the total loan amount. CBO estimates this provision would affect about $209,000 loans each year and raise collections by about $150 million a year. Under current law, veterans can reuse their home loan guarantee benefit if their previous debt has been paid in full. The second provision of this section would require VA to collect a fee of 3 percent of the total loan amount from veterans who reuse this benefit. CBO estimates this fee would apply to about 30,000 loans each year and raise collections by about $57 million a year.

Withholding of Payments and Benefits. Section 8033 would permit VA to collect certain loan guarantee debts by reducing any federal salary or federal income tax return refund due to a veteran or surviving spouse. Under current law, before VA could use these means, either it would have to obtain the written consent of the debtor or the debt would have to be due to a court determination. Based on information from VA, CBO estimates this provision would raise collections by $90 million in 1998 from a stock of loans that originated several years ago. There would be no effect after 1998 because this provision does not apply to debts from the home loan program as it currently operates.

Liquidation Sales. Section 8013 would extend from 1998 through 2002 a provision of law that requires VA to consider the losses it might incur when selling a property acquired through foreclosure. Under current law, VA follows a formula defined in statute to decide whether to acquire the property or pay off the loan guarantee instead. The formula requires appraisals that may be valid at the time they are made, but do not account for changes in market conditions that may occur while VA prepares to dispose of the property. This provision would require VA to take account of losses from changes in housing prices that the appraisal does not capture. Losses of this type might be prevalent when housing prices are particularly volatile or if appraisals were biased for other reasons. Since 1978, VA has suffered a resale loss every year except 1993 and 1994. Recent losses average about $2,500 per home. Assuming this provision applies to approximately 2,000 homes each year, CBO estimates it would save $5 million a year.

Enhanced Loan Asset Sales. Section 8011 would extend from December 31, 1997, through December 31, 2002, VA's authority to guarantee the real estate mortgage conduits (REMICs) that are used to market vendee loans. Vendee loans are issued to the buyers of properties that VA acquires through foreclosures. VA then sells these loans on the secondary mortgage market by using REMICs. By guaranteeing the certificates issued on a pool of loans, VA obtains a better price but also assumes some risk.

Because recent history indicates that receipts would increase by about 0.3 percent of sales, CBO estimates that this provision would save about $5 million a year based on sales of $1.6 billion. If this provision were not enacted, VA could market vendee loans under other provisions of law. Nevertheless, this provision would permit VA to realize a better price for a package of vendee loans than if it used a REMIC program of the Government National Mortgage Association.

TABLE 3.—BUDGETARY IMPACT OF PROPOSED CHANGES TO THE VETERANS HOME LOAN PROGRAM

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
Spending under current law for veterans housing programs:						
Estimated budget authority	−627	145	296	310	311	308
Estimated outlays	−695	71	229	252	256	261
Proposed changes:						
Estimated budget authority	0	−16	−233	−232	−229	−224

TABLE 3.—BUDGETARY IMPACT OF PROPOSED CHANGES TO THE VETERANS HOME LOAN PROGRAM—Continued

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
Estimated outlays	0	−106	−233	−232	−229	−224
Spending under title VIII for veterans housing programs						
Estimated budget authority	−627	129	63	78	82	84
Estimated outlays	−695	−35	−4	20	27	37

Pensions

Veterans pensions would be affected by two provisions. As shown in Table 4, these provisions would reduce direct spending for veterans' pensions and increase spending for Medicaid, resulting in a net spending reduction of $0.7 billion over the 1999–2002 period.

Pension Limitation for Medicaid-Eligible Veterans in Nursing Homes. Section 8015 would extend from September 30, 1998, to September 30, 2002, the expiration date on a provision of law that sets a $90 per month limit on pensions for any veteran without a spouse or child, or for any survivor of a veteran, who is receiving Medicaid coverage in a Medicaid-approved nursing home. It also allows the beneficiary to retain the pension instead of having to use it to defray nursing home costs.

Based on VA's experience under current law, this estimate assumes that the extension of the expiration date would affect approximately 16,000 veterans and 27,000 survivors. According to VA, average savings were about $12,000 for veterans and $8,000 for survivors in 1996. Higher Medicaid payments to nursing homes would offset some of the savings credited to VA. New savings would increase from $129 million in 1999 to $174 million in 2002.

Income Verification. Current law authorizes VA to acquire information on income reported to the Internal Revenue Service (IRS) to verify income reported by recipients of VA pension benefits. This authorization expires on September 30, 1998. Section 8014 would extend the expiration date to September 30, 2002. This estimate is based on VA's recent experience, which has shown that about $4 million in new savings is achieved annually through this income match. Savings would grow from $4 million in 1999 to $16 million in 2002 as a new cohort of veterans becomes subject to income verification each year.

TABLE 4.—BUDGETARY IMPACT OF PROPOSED CHANGES TO VETERANS PENSIONS

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
VETERANS PENSIONS						
Spending under current law, for veterans pensions:						
Estimated budget authority	2,975	2,975	3,427	3,454	3,513	3,608
Estimated outlays	2,975	2,989	3,399	3,751	3,203	3,604
Proposed changes:						
Estimated budget authority	0	0	−452	−454	−463	−483
Estimated outlays	0	0	−415	−491	−426	−482
Spending under title VIII for veterans pensions:						
Estimated budget authority	2,975	2,975	2,975	3,000	3,050	3,125
Estimated outlays	2,975	2,989	2,984	3,049	2,777	3,122

TABLE 4.—BUDGETARY IMPACT OF PROPOSED CHANGES TO VETERANS PENSIONS—Continued

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
MEDICAID						
Spending under current law for Medicaid:						
Estimated budget authority	98,599	105,308	113,619	122,861	132,792	143,783
Estimated outlays	98,599	105,308	113,619	122,861	132,792	143,783
Proposed changes:						
Estimated budget authority	0	0	282	280	283	292
Estimated outlays	0	0	282	280	283	292
Spending under title VIII for Medicaid:						
Estimated budget authority	98,599	105,308	113,901	123,141	133,075	144,075
Estimated outlays	98,599	105,308	113,901	123,141	133,075	144,075
TOTAL PROPOSED CHANGES IN DIRECT SPENDING						
Estimated budget authority	0	0	−170	−174	−180	−191
Estimated outlays	0	0	−133	−211	−143	−190

Compensation

The budget resolution baseline assumes that monthly payments of disability compensation to veterans and monthly payments of dependency and indemnity compensation (DIC) to their survivors are increased by the same cost-of-living adjustment (COLA) payable to Social Security recipients. The results of the adjustments are rounded to the nearest dollar. Section 8031 would require VA to round down, to the next lower dollar, adjustments to disability compensation and DIC through 2002. CBO estimated the savings from this provision using the current table of monthly benefits and the number of beneficiaries assumed in the baseline. As shown in Table 5, savings from this section would be about $23 million in 1998, growing to $128 million in 2002.

Estimated impact on State, local, and tribal governments: This title contains no intergovernmental mandates as defined in UMRA. It would, however, increase Medicaid costs for state governments. CBO estimates that states would spend an additional $213 million for the Medicaid program in fiscal year 1999 and an additional $857 million between 1999 and 2002. Under UMRA, these costs would not be considered costs of a mandate because states have the flexibility to offset them by reducing their programmatic or financial responsibilities elsewhere in the Medicaid program.

TABLE 5.—BUDGETARY IMPACT OF PROPOSED CHANGES TO VETERANS COMPENSATION

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Spending under current law for veterans compensation:						
Estimated budget authority	16,082	16,742	17,366	17,809	18,243	18,680
Estimated outlays	15,942	16,687	17,314	19,257	16,723	18,643
Proposed changes:						
Estimated budget authority	0	−25	−53	−83	−110	−130
Estimated outlays	0	−23	−51	−88	−101	−128
Spending under title VIII for veterans compensation:						
Estimated budget authority	16,082	16,717	17,313	17,726	18,133	18,550
Estimated outlays	15,942	16,664	17,263	19,169	16,622	18,515

The proposal would extend until September 30, 2002, the limitation on the monthly pension that certain veterans in nursing homes could receive. Under current law, this limitation will expire on September 30, 1998. The effect of the extension would be to require the Medicaid program to continue covering 100 percent of the nursing home expenses of certain veterans after fiscal year 1998. Under current law, the Department of Veterans Affairs and the veterans themselves would have paid these costs.

Estimated impact on the private sector: This bill would impose no new private-sector mandates as defined in UMRA.

Estimate prepared by: Federal Cost: Shawn Bishop (medical care), Sunita D'Monte (housing), and Mary Helen Petrus (compensation and pension). Impact on State, local, and tribal governments: Marc Nicole. Impact on the private sector: Rachel Schmidt.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

TABLE 6.–ESTIMATED BUDGETARY EFFECTS OF TITLE VIII, FISCAL YEARS 1998–2007; RECONCILIATION RECOMMENDATIONS OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

[In millions of dollars, by fiscal year]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998–2007 Total
CHANGES IN VETERANS PROGRAMS											
Medical care receipts:											
Estimated budget authority	−118	−373	−387	−404	−422	−145	−151	−157	−163	−170	−2,490
Estimated outlays	−118	−373	−387	−404	−422	−145	−151	−157	−163	−170	−2,490
Housing:											
Estimated budget authority	−16	−233	−232	−229	−224	0	0	0	0	0	−934
Estimated outlays	−106	−233	−232	−229	−224	0	0	0	0	0	−1,024
Pensions:											
Estimated budget authority	0	−452	−454	−463	−483	0	0	0	0	0	−1,852
Estimated outlays	0	−415	−491	−426	−482	0	0	0	0	0	−1,814
Compensation:											
Estimated budget authority	−25	−53	−83	−110	−130	0	0	0	0	0	−401
Estimated outlays	−23	−51	−88	−101	−128	0	0	0	0	0	−391
Total veterans programs:											
Estimated budget authority	−159	−1,111	−1,156	−1,206	−1,259	−145	−151	−157	−163	−170	−5,677
Estimated outlays	−247	−1,072	−1,198	−1,160	−1,256	−145	−151	−157	−163	−170	−5,719
CHANGES IN MEDICAID											
Estimated budget authority	0	282	280	283	292	0	0	0	0	0	1,137
Estimated outlays	0	282	280	283	292	0	0	0	0	0	1,137
TOTAL CHANGE IN DIRECT SPENDING											
Estimated budget authority	−159	−829	−876	−923	−967	−145	−151	−157	−163	−170	−4,640
Estimated outlays	−247	−790	−918	−877	−964	−145	−151	−157	−163	−170	−4,582
CHANGES IN SPENDING SUBJECT TO APPROPRIATION											
Veterans' medical care:											
Estimated budget authority	604	615	639	666	694	429	446	465	483	503	5,544
Estimated outlays	543	608	636	663	691	456	447	463	481	501	5,488

TITLE VIII—VETERANS' PROGRAMS

INTRODUCTION

Section 104 of the Concurrent Resolution on the Budget for Fiscal Year 1998, H. Con. Res. 84, requires that the Senate Committee on Veterans' Affairs report changes in laws within its jurisdiction that would reduce outlays by $681,000,000 in fiscal year 2002 and by $2,733,000,000 in fiscal years 1998 through 2002.

On June 12, 1997, the Committee met in open session and, by a recorded vote of 11–0, agreed to recommend legislation that would reduce the deficit by $2,733,000,000 in fiscal years 1998 through 2002, and by $681,000,000 in fiscal year 2002.

On June 19, 1997, the Director of the Congressional Budget Office (CBO) transmitted to the Chairman of the Committee on Veterans' Affairs, Senator Arlen Specter, a letter estimating the outlay savings which would be achieved by enactment of each of the measures outlined in this report. Those estimates are specified below.

SUBTITLE A—EXTENSION OF CURRENT AUTHORITIES

1. *Extension of Enhanced Loan Asset Sale Authority*. Section 8011 of the Committee legislation would amend section 3720(h)(2) of title 38, United States Code, to extend the current authorization period of that provision to December 31, 2002.

Section 3720(h) authorizes VA to guarantee the timely payment of principal and interest to purchasers of real estate mortgage investment conduits (REMICs). REMICs are used to "bundle" and market to investors a number of vendee loan notes—that is, notes on loans financing the purchase of real estate acquired by VA due to veterans' defaults on VA-guaranteed home loans (see discussion below)—so that they may be sold for cash under favorable terms. Under this authority, VA guarantees to REMIC purchasers that principal and interest will be paid timely. That assurance facilitates the marketing of REMIC securities and enhances their value in the marketplace. It thus increases the return to the Treasury when such securities are sold.

VA's authority to guarantee the timely payment of principal and interest under section 3720(h) expires on December 31, 1997. Section 8011 would extend the expiration date of that authority to December 31, 2002.

Savings/Revenue

According to CBO, enactment of section 8011 would reduce the deficit by $25 million in outlays in fiscal years 1998—2002, and by $5 million in outlays in fiscal year 2002.

2. *Extension of Home Loan Fees*. Section 8012 of the Committee legislation would amend section 3729(a)(4) of title 38, United

States Code, to extend the current authorization period of that provision to October 1, 2002.

Section 3729 of title 38, United States Code, specifies fees that will be paid by borrowers who obtain home purchase loans guaranteed, insured, or made by VA.

For borrowers obtaining the first such loan, fees generally range from 0.50% to 2.0% of the loan amount, depending on the amount of down payment to be paid by the borrower and the type of military or naval service (active duty vs. selected reserve) upon which eligibility for home loan benefits is based. Pursuant to subsection (a)(4) of section 3729, an additional fee of 0.75% is added to the fees set forth in section 3729, except as otherwise specified, for "first use" loans closed between September 30, 1993, and October 1, 1998.

With respect to borrowers obtaining subsequent housing assistance loans, section 3729 specifies that the fee to be charged shall be 3.0% of the total loan amount. This provision applies to loans which close between September 30, 1993 and October 1, 1998.

As noted, the above-summarized fee schedules apply to home loans closed between September 30, 1993, and October 1, 1998. Section 8012 would extend the expiration date of those fee schedules to October 1, 2002.

Savings/Revenue

According to CBO, enactment of section 8012 would reduce the deficit by $822 million in outlays over fiscal years 1998—2002, and by $199 million in outlays in fiscal year 2002.

3. *Extension of Procedures Applicable to Liquidation Sales on Defaulted Home Loans Guaranteed by VA.* Section 8013 of the Committee legislation would amend section 3732(c)(11) of title 38, United States Code, to extend the current authorization period of that provision to October 1, 2002.

Section 3732 specifies that VA has two options when a property, the financing of which is guaranteed under the VA Home Loan Guaranty Program, goes into foreclosure. VA may simply pay off the guaranty. Alternatively, VA may elect to purchase the property securing the loan in default and resell it if VA concludes that a resale of the property would be less costly to VA than a simple payment of the guaranty and would be, therefore, more advantageous to the Government.

The provisions of law authorizing VA to elect to exercise the latter option of acquiring and reselling the property when it is to VA's advantage are set out in subsection (c) of section 3732. Subsection (c), however, applies only with respect to properties financed with VA-guaranteed home loans which close before October 1, 1998. Section 8013 would extend the authorization period of subsection (c) to loans closed before October 1, 2002.

Savings/Revenue

According to CBO, enactment of section 8013 would reduce the deficit by $20 million in outlays in fiscal years 1998–2002, and by $5 million in outlays in fiscal year 2002.

4. *Extension of Income Verification Authorities.* Section 8014 of the Committee legislation would amend section 5317(g) of title 38,

United States Code, to extend the current expiration date of that provision to September 30, 2002.

Eligibility for certain benefits and medical services provided by VA is means tested—that is, eligibility for those benefits and medical services is governed by, among other variables, the potential beneficiary's annual income. Under section 5317(g) of title 38, United States Code, VA is authorized to verify income data furnished to VA by the applicant for benefits or medical services by accessing income-relevant records of the Department of Health and Human Services/Social Security Administration and the Department of the Treasury/Internal Revenue Service.

As is noted above, VA's income verification authority, as specified in titles 26 and 38 of U.S. Code, expires on September 30, 1998. Section 8014 would extend that expiration date to September 30, 2002.

Savings/Revenue

According to CBO, enactment of section 8014 would reduce the deficit by $40 million in outlays with respect to benefits, and $71 million in outlays with respect to medical services, over fiscal years 1998–2002, and by $16 million in outlays with respect to benefits, and $19 million in outlays with respect to medical services, in fiscal year 2002.

5. *Extension of Limitation on Pension for Certain Recipients of Medicaid-Covered Nursing Home Care.* Section 8015 of the Committee legislation would amend section 5503(f)(7) of title 38, United States Code, to extend the current expiration date of that provision to September 30, 2002.

Section 5503(f) of title 38, United States Code, specifies that VA beneficiaries receiving Medicaid-financed nursing home care shall not be entitled to receive VA pension payments in excess of $90 per month if the beneficiary has no spouse or dependent child. In the absence of such a limit, pension beneficiaries without dependents would not ultimately receive a higher monthly benefit even though their initial pension payment would exceed $90. Rather, their pension payments, beyond a small monthly personal allowance (approximately $45 in most States), would be forfeited to pay for their nursing home care. Thus, VA pension payments would effectively fund Medicaid obligations in the absence of section 5503(f).

Under the terms of section 5503(f), VA pension payments, under the circumstances outlined above, are reduced to $90 per month. However, the $90 payment is "protected." That is, VA pension may not be tapped to pay for Medicaid-provided care. In effect, while VA beneficiaries receive a reduced pension payment under section 5503(f), they are allowed to retain all of that payment notwithstanding State-imposed personal allowance limits. Thus, their position is better, from a monthly cash flow standpoint, than it would have been absent section 5503(f).

Section 5503(f) is currently scheduled to expire on September 30, 1998. Section 8015 would extend that expiration date to September 30, 2002.

Savings/Revenue

According to CBO, enactment of section 8015 would reduce the deficit by $637 million in outlays over fiscal years 1998–2002, and by $174 million in outlays in fiscal year 2002.

SUBTITLE B—COPAYMENT AND MEDICAL CARE COST RECOVERY

1. *Extension of Authority To Require That Certain Veterans to Make Copayments in Exchange for Receiving Hospital and Medical Care.* Section 8021(a) of the Committee legislation would amend an existing provision of law in section 8013(e) of the Omnibus Budget Reconciliation Act of 1990, Public Law 101–508, 38 U.S.C. § 1710 note ("OBRA '90"), to extend the current expiration date of that provision to September 30, 2002.

Current law provides that veterans who are not eligible for VA care on a priority basis under subsections (a)(1) and (a)(2) of section 1710 of title 38, United States Code, may receive care from VA to the extent resources and facilities are available if they agree to make copayments for such care. In OBRA '90, Congress added to the already existing Medicare deductible-based copayment requirements a requirement that veterans pay an additional per diem charge of $5 for nursing home care and $10 for hospital care. Prior to enactment of OBRA '90, veterans not eligible for priority care from VA paid only full or partial Medicare deductibles as specified in subsection (f). OBRA '90 also eliminated distinctions among non-service-connected veterans with incomes above the "means-test" basis for priority eligibility for hospital care and medical services under subsection (a)(2) of section 1710, thereby requiring that all such veterans make copayments.

The OBRA '90 requirements that VA charge per diems and collect copayments from all non-service-connected veterans with income above the "means-test" limit are currently scheduled to expire on September 30, 1998. Section 8021(a) would extend that expiration date to September 30, 2002.

Savings/Revenue

According to CBO, enactment of section 8021(a) would result in collections of $11 million in fiscal years 1999–2002.

2. *Extension of Authority To Require That Certain Veterans to Make Copayments in Exchange for Receiving Outpatient Medications.* Section 8021(b) of the Committee legislation would amend section 1722A of title 38, United States Code, to extend the current expiration date of that provision to September 30, 2002.

Section 1722A of title 38, United States Code, specifies that, except as itemized below, veterans who receive outpatient medical care from the Department of Veterans Affairs (VA) for the treatment of non-service-connected disabilities or medical conditions are required to pay $2.00 for each 30-day supply of medications furnished by VA in connection with that treatment. Two classes of veteran-patient are exempted from this copayment requirement: veterans having a service-connected disability rated at 50% or higher; and veterans having an annual income which equals, or is less than, the maximum amount they would be eligible to receive

under VA's pension program, 38 U.S.C. §1521, were they eligible for benefits under that program.

The $2 copayment requirement, which was originally enacted as part of OBRA '90, is currently scheduled to expire on September 30, 1998. Section 8021(b) would extend that expiration date to September 30, 2002.

Savings/Revenue

According to CBO, enactment of section 8021(b) would result in collections of $152 million in fiscal years 1999–2002.

3. *Extension of Authority for Medical Care Cost Recovery.* Section 8022 of the Committee legislation would amend section 1729(a)(2)(E) of title 38, United States Code, to extend the current authorization date of that provision to October 1, 2002.

Section 1729 of title 38, United States Code, authorizes VA, when it furnishes medical services to certain veteran-patients for non-service-connected disabilities and medical conditions, to collect the reasonable cost of providing such services from third party payers, generally, the veteran-patient's health plan or health insurance carrier, if any. This provision applies to, among other categories of care, care for non-service-connected disabilities and medical conditions sustained by veteran-patients who have service-connected disabilities, but only with respect to treatment provided before October 1, 1998.

As is noted, VA authority to recover costs from the third party payers, if any, of service-connected veterans applies only with respect to treatment provided before October 1, 1998. Section 8022 would extend that authorization period until October 1, 2002.

Savings/Revenue

According to CBO, enactment of section 8022 would result in collections of $829 million in fiscal years 1999–2002.

4. *Retention by VA of Medical Care Receipts.* Section 8023 of the Committee legislation would authorize VA to retain funds collected under the authorities specified in sections 8021 and 8022, and to spend such monies on VA medical care.

Under current law, copayments and receipts from health care plans and insurance carriers are remitted to the United States Treasury. Section 8023 would authorize VA, for the first time, to retain such funds. The provision would provide for maximum incentives for collecting such funds by mandating that all such monies be remitted to the Veterans Integrated Service Network ("VISN") which had collected them.

It is the Committee's judgment that such receipts will be maximized if the collecting VISN has a full incentive to pursue such funds aggressively. Consistent with this judgment, it is the Committee's expectation that VA headquarters will remit funds to the VISNs promptly. It is the Committee's expectation, further, that VA headquarters will not reduce the allocation of other funds made available to the VISNs to account for a VISNs relative success in collecting medical care cost recovery receipts. If funds are not retained by the VISN—and reductions in other funding streams to offset medical care cost recovery receipts would be the functional

equivalent of nonretention of such receipts—the VISNs will not perform their collection mission as required.

Savings/Revenue

According to CBO, enactment of section 8023 would result in savings of $641 in direct spending outlays in fiscal years 1998–2002, and $139 million in direct spending outlays in fiscal year 2002.

SUBTITLE C—OTHER MATTERS

1. *Rounding Down of Cost-of-Living Adjustments in Compensation and DIC Rates.* Section 8031 of the Committee legislation would require that cost-of-living adjustments made to VA disability compensation, and dependency and indemnity compensation (DIC), payments under chapters 11 and 13 of title 38, United States Code, for fiscal years 1998 through 2002 would be rounded down.

Monthly payments made by VA under chapters 11 and 13 of title 38, United States Code, are in whole dollar amounts. While such monthly payments are not "automatically" adjusted, or indexed, to reflect increases (or decreases) in the cost-of-living, typically they are adjusted annually to reflect such increases. The budget baseline assumes that when monthly amounts paid to VA beneficiaries are so recomputed (by multiplying the prior year's payment amount by a percentage amount supplied by the United States Department of Labor to reflect its estimate of the prior year's increase in the cost of living), the products of those mathematical computations will be rounded "normally" when they are adjusted to whole dollar amounts. That is, the baseline assumes that if the recomputed monthly payment amount is a fractional dollar amount of $0.50 or more, it will be rounded up to the next higher dollar amount, and if it is a fractional dollar amount of $0.49 or less, it will be rounded down to the next lower dollar amount.

Section 8031 requires that such recalculations of compensation and DIC payments made for fiscal years 1998 through 2002 will be rounded down to the next lower whole dollar amount irrespective of the fractional dollar amount which is yielded when the prior year's payment amount is multiplied by the cost-of-living index increase. Thus, some beneficiaries would receive $1 per month less in benefits than they might have otherwise received under the budget baseline assumption of "normal" rounding. Section 8031 also specifies that, for fiscal years 1996 through 2002, the fractional increase in monthly benefit amounts will not be more than the percentage increase granted to recipients of benefits under title II of the Social Security Act, 42 U.S.C. § 401 *et seq.*

Savings/Revenue

According to CBO, enactment of section 8031 would reduce the deficit by $391 million in outlays in fiscal years 1998–2002, and by $128 million in outlays in fiscal year 2002.

2. *Increase in Home Loan Fees for the Purchase of Repossessed Homes from VA.* Section 8032 of the Committee legislation would amend section 3729 of title 38, United States Code, to increase fees charged by VA for VA financing to purchasers of properties acquired by VA due to default. This section would increase that fee from 1.0 to 2.25 percent of the total loan amount.

Fees charged by VA in connection with the Home Loan Guarantee program are specified in section 3729 of title 38, United States Code. Under current law, the fee charged for VA financing of sales of VA-acquired properties is 1.0% of the total loan amount.

Section 8032 would increase the fee charged by VA for financing of sales of VA-acquired properties to 2.25%.

Savings/Revenue

According to CBO, enactment of section 8032 would reduce the deficit by $67 million in outlays in fiscal years 1998–2002, and by $15 million in outlays in fiscal year 2002.

3. *Withholding of Payments and Benefits.* Section 8033 of the Committee legislation would amend section 3726 of title 38, United States Code, to authorize VA to refer certain loan guaranty debts to the Internal Revenue Service for offset of income tax refunds, and in cases where the debtor is a Federal employee, to the debtor's employing agency for salary offset.

Under current law, Federal agencies other than VA are restricted from assisting VA in collecting one type of debt to VA—loan guaranty debts. Other agencies may not withhold or offset payments to veterans to satisfy that type of debt to VA unless the debtor consents in writing or a court has determined the debtor is liable to VA for the debt. By contrast, other debts to VA may be offset by other Federal agencies.

Section 8033 would authorize VA, with appropriate notice to the debtor and after affording an opportunity for the debtor to request forbearance or a waiver of the debt, to refer loan guaranty debts, like other debts, to the IRS and, where applicable, to the debtor's employing Federal agency for offset.

Savings/Revenue

According to CBO, enactment of section 8033 would reduce the deficit by $90 million in outlays in fiscal years 1998–2002.

F. Rollcall Vote in the Budget Committee

Rollcall vote on the Domenici motion to report the reconciliation measure to the Senate was as follows:

Yeas: 19	Nays: 3
Domenici	Hollings
Grassley	Sarbanes
Nickles[1]	Durbin[1]
Gramm	
Bond	
Gorton	
Gregg[1]	
Snowe[1]	
Abraham	
Frist[1]	
Grams	
Smith	
Lautenberg	
Conrad[1]	
Boxer[1]	
Murray[1]	
Wyden	
Feingold	
Johnson	

[1]Indicates the Senator voted by proxy.

○