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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

Friday, July 11, 1997

LEGISLATIVE REFERRAL MEMORANDUM

TO: Legislative Liaison Officer - See Distribution below

FROM: *Janet R. Forsgren*
Janet R. Forsgren (for) Assistant Director for Legislative Reference

OMB CONTACT: Collin Brown III
PHONE: (202)395-7562 FAX: (202)395-6148

SUBJECT: DEFENSE Report on S224 To permit certain beneficiaries to enroll in the FEHB program

DEADLINE: 2pm Wednesday, July 16, 1997

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President. Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: Attached is a DOD report to the Committee on Armed Services. This report addresses S. 224; a bill to permit covered beneficiaries under the military health care system who are also entitled to Medicare to enroll in the FEHB program.

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Honorable Strom Thurmond
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This is in response to your request for the views of the Department of Defense on S. 224, 105th Congress, a bill "to amend Title 10, United States Code, to permit covered beneficiaries under the military health care system who are also entitled to Medicare to enroll in the Federal Employees Health Benefit program; and for other purposes."

The Department of Defense opposes S. 224. We believe that the legislation could add significant costs to the Department. Further, this bill would have the effect of shifting resources away from military health services system activities that complement readiness, which is the primary mission of the military medical program.

S. 224 directs the Secretary of Defense to enter into an agreement with the Director of the Office of Personnel Management (OPM) to offer military medical eligible beneficiaries the opportunity to enroll in the Federal Employees Health Benefits program (FEHBP). A person enrolled would not be eligible to receive care in the facilities of uniformed services or through the Civilian Health and Medical Program of the Uniformed Services, or the TRICARE program. Eligible covered beneficiaries would include members and former members of the uniformed services, any dependents of the member, and those who are or become entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act (42 USC 1395c, et seq.), known as Medicare Part A. The administering Secretary concerned would be responsible for the government's share of the FEHBP premium, as determined by OPM. The enrolled covered beneficiary would be responsible for the beneficiary share of the FEHBP premium. OPM would operate separate risk pools for enrolled covered beneficiaries until such time as the Director of OPM determines that inclusion of enrolled covered beneficiaries would not adversely affect federal employees or annuitants covered by FEHBP.

The Department opposes this legislation because it could have a significant negative impact on the Department's health care delivery program. The provisions of the bill do not support medical readiness, which is the primary mission of military medicine. Unlike TRICARE, conversion of military health care to FEHBP shifts scarce DoD health care resources away from activities that complement readiness and toward a program that will function separate and apart from the military medical system.

The cost to the Department in terms of additional outlays could be extremely high. While not possible to estimate participation and detailed estimates given the time allotted for this letter, it should be pointed out that the Congressional Budget Office (CBO), in its July 1995 report, "Restructuring Military Medical Care," described its analysis of alternatives to the current operation of the Military Health Services System. The CBO report's principal alternative for delivery of health benefits was to enroll military beneficiaries in the FEHBP, and CBO prepared detailed estimates of the costs to the government of such a program. In brief, CBO found that the total cost to the government of a program to insure DoD eligibles in the FEHBP could cost as much as \$7.3 billion (includes the additional cost to Medicare) which represents DoD participation in premiums at the 72 percent level. Contained within this estimate, are approximately 1.2 million Medicare eligible beneficiaries, who could cost the Department \$2.3 to \$2.9 billion, costs which cannot be offset anywhere in the present federal budget.

As an alternative, the Department believes that military medicine should remain in the military treatment facility, supported by the managed care support contractor through the TRICARE program. This alternative preserves military medical readiness by ensuring our military providers are practicing as part of the medical readiness program.

The Department also believes the most viable option for improving access for the population eligible for care in military facilities and in Medicare lies in enrolling military Medicare beneficiaries in military facilities, with the Department receiving capitation payments from Medicare. The Department has reached agreement with the Department of Health and Human Services on the elements of a Military Medicare Managed Care demonstration project to test this concept, and has proposed legislation to authorize such a project. The Department is committed to improving access to our Medicare-eligible beneficiaries and believes the best method to do so is by strengthening the linkage between the Medicare program and the Defense Health Program through a Military Medicare Managed Care Program.

The Office of Management and Budget advises that, from the standpoint of the Administration's program, there is no objection to the presentation of this report for consideration of the committee.

Sincerely,

cc:
Honorable Carl Levin
Ranking Democrat

105TH CONGRESS
1ST SESSION

S. 224

To amend title 10, United States Code, to permit covered beneficiaries under the military health care system who are also entitled to medicare to enroll in the Federal Employees Health Benefits program; and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 28, 1997

Mr. WARNER introduced the following bill; which was read twice and referred to the Committee on Armed Services

A BILL

To amend title 10, United States Code, to permit covered beneficiaries under the military health care system who are also entitled to medicare to enroll in the Federal Employees Health Benefits program; and for other purposes.

- 1 *Be it enacted by the Senate and House of Representa-*
- 2 *tives of the United States of America in Congress assembled,*

1 SECTION 1. INCLUSION OF MEDICARE ELIGIBLE COVERED
2 BENEFICIARIES IN FEDERAL EMPLOYEES
3 HEALTH BENEFITS PROGRAM.

4 (a) FEHBP OPTION.—(1) Chapter 55 of title 10,
5 United States Code, is amended by inserting after section
6 1079a the following new section:

7 **“§ 1079b. Health care coverage through Federal Em-**
8 **ployees Health Benefits program**

9 “(a) FEHBP OPTION.—(1) The Secretary of De-
10 fense (after consulting with the other administering Sec-
11 retaries) and the Director of the Office of Personnel Man-
12 agement shall enter into an agreement to offer eligible cov-
13 ered beneficiaries an opportunity to enroll in a health ben-
14 efits plan offered through the Federal Employee Health
15 Benefits program under chapter 89 of title 5. The agree-
16 ment may provide for limitations on enrollment of covered
17 beneficiaries in the Federal Employee Health Benefits
18 program if the Director determines that the limitations
19 are necessary to allow for adequate planning for access
20 for services under Federal Employee Health Benefits pro-
21 gram.

22 “(2) A person covered by an enrollment in a health
23 benefits plan under paragraph (1) is not eligible to receive
24 care under this chapter in facilities of the uniformed serv-
25 ices or through the Civilian Health and Medical Program
26 of the Uniformed Services or the TRICARE program.

1 “(b) ELIGIBLE COVERED BENEFICIARIES.—A cov-
2 ered beneficiary referred to in subsection (a) is a member
3 or former member of the uniformed services described in
4 section 1074(b) of this title, or any dependent of the mem-
5 ber described in section 1076(b) of this title, who is or
6 becomes entitled to hospital insurance benefits under part
7 A of title XVIII of the Social Security Act (42 U.S.C.
8 1395c et seq.). The covered beneficiary shall not be re-
9 quired to satisfy any eligibility criteria specified in chapter
10 89 of title 5 as a condition for enrollment in a health bene-
11 fits plan offered through the Federal Employee Health
12 Benefits program pursuant to subsection (a).

13 “(c) CONTRIBUTIONS.—(1) In the case of covered
14 beneficiaries described in subsection (b) who enroll in a
15 health benefits plan offered through the Federal Employee
16 Health Benefits program pursuant to subsection (a), the
17 administering Secretary concerned shall be responsible for
18 Government contributions that the Office of Personnel
19 Management determines are necessary to cover all costs
20 in excess of beneficiary contributions under paragraph (2).

21 “(2) The contribution required from an enrolled cov-
22 ered beneficiary shall be equal to the amount that would
23 be withheld from the pay of a similarly situated Federal
24 employee who enrolls in a health benefits plan under chap-
25 ter 89 of title 5.

4

1 “(d) MANAGEMENT OF PARTICIPATION.—The au-
2 thority responsible for approving retired or retainer pay
3 or equivalent pay in the case of a member or former mem-
4 ber shall manage the participation of the member or
5 former member, and dependents of the member or former
6 member, who enroll in a health benefits plan offered
7 through the Federal Employee Health Benefits program
8 pursuant to subsection (a). The Office of Personnel Man-
9 agement shall maintain separate risk pools for enrolled
10 covered beneficiaries until such time as the Director of the
11 Office of Personnel Management determines that complete
12 inclusion of enrolled covered beneficiaries under chapter
13 89 of title 5 would not adversely affect Federal employees
14 and annuitants enrolled in health benefits plans under
15 such chapter.

16 “(e) EFFECT OF CANCELLATION.—The cancellation
17 by a covered beneficiary of coverage under the Federal
18 Employee Health Benefits program shall be irrevocable for
19 purposes of this section.

20 “(f) REPORTING REQUIREMENTS.—Not later than
21 November 1 of each year, the Secretary of Defense and
22 the Director of the Office of Personnel Management shall
23 jointly submit a report to Congress describing the provi-
24 sion of health care services to covered beneficiaries under

1 this section during the preceding fiscal year. The report
2 shall address or contain the following:

3 “(1) The number of covered beneficiaries en-
4 rolled in health benefits plans offered through the
5 Federal Employee Health Benefits program pursu-
6 ant to subsection (a), both in terms of total number
7 and as a percentage of all covered beneficiaries re-
8 ceiving health care through the health care system
9 of the uniformed services.

10 “(2) The out-of-pocket cost to enrollees under
11 such health benefits plans.

12 “(3) The cost to the Government (including the
13 Department of Defense, the Department of Trans-
14 portation, and the Department of Health and
15 Human Services) of providing care under such
16 health benefits plans.

17 “(4) A comparison of the costs determined
18 under paragraphs (2) and (3) and the costs that
19 would have otherwise been incurred by the Govern-
20 ment and enrollees under alternative health care op-
21 tions available to the administering Secretaries.

22 “(5) The effect of this section on the cost, ac-
23 cess, and utilization rates of other health care op-
24 tions under the health care system of the uniformed
25 services.”

1 (2) The table of sections at the beginning of such
2 chapter is amended by inserting after the item relating
3 to section 1079a the following new item:

"1079b. Health care coverage through Federal Employees Health Benefits pro-
gram."

4 (b) CONFORMING AMENDMENTS.—(1) Section 1072
5 of title 10, United States Code, is amended by adding at
6 the end the following:

7 "(7) The term 'TRICARE program' means the
8 managed health care program that is established by
9 the Secretary of Defense under the authority of this
10 chapter, principally section 1097 of this title, and in-
11 cludes the competitive selection of contractors to fi-
12 nancially underwrite the delivery of health care serv-
13 ices under the Civilian Health and Medical Program
14 of the Uniformed Services."

15 (2) Section 8905 of title 5, United States Code, is
16 amended—

17 (A) by redesignating subsections (d), (e), and
18 (f) as subsections (e), (f), and (g), respectively; and

19 (B) by inserting after subsection (c) the follow-
20 ing new subsection (d):

21 "(d) An individual whom the Secretary of Defense de-
22 termines is an eligible covered beneficiary under sub-
23 section (b) of section 1079b of title 10 may enroll in a
24 health benefits plan under this chapter in accordance with

1 the agreement entered into under subsection (a) of such
2 section between the Secretary and the Office and with ap-
3 plicable regulations under this chapter.”.

4 (3) Section 8906 of title 5, United States Code, is
5 amended—

6 (A) in subsection (b)—

7 (i) in paragraph (1), by striking “para-
8 graphs (2) and (3)” and inserting in lieu there-
9 of “paragraphs (2), (3), and (4)”; and

10 (ii) by adding at the end the following new
11 paragraph:

12 “(4) In the case of individuals who enroll in a health
13 plan under section 8905(d) of this title, the Government
14 contribution shall be determined under section 1079b(e)
15 of title 10.”; and

16 (B) in subsection (g)—

17 (i) in paragraph (1), by striking “para-
18 graph (2)” and inserting in lieu thereof “para-
19 graphs (2) and (3)”; and

20 (ii) by adding at the end the following new
21 paragraph:

22 “(3) The Government contribution described in sub-
23 section (b)(4) for beneficiaries who enroll under section
24 8905(d) of this title shall be paid as provided in section
25 1079b(e) of title 10.”.

1 (c) IMPLEMENTATION.—The Secretary of Defense
2 shall offer the health benefits option under section
3 1079b(a) of title 10, United States Code (as added by sub-
4 section (a)), beginning not later than January 1, 1998.

○

THE WHITE HOUSE

OFFICE OF LEGISLATIVE AFFAIRS

FAX COVER SHEET

**NOTE: THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS
CONFIDENTIAL AND INTENDED FOR THE RECIPIENT ONLY.**

DATE: 7-11

TO: Chris Jennings

FAX: ~~456-6221~~ 6-7028

FROM: CHRISTOPHER WALKER

JESSICA GIBSON

456-7500 (TEL)

456-6221 (FAX)

RE:

PAGE 1 OF 3

If there are any problems with this transmission, please
call (202) 456-7500.

United States Senate

WASHINGTON, DC 20510

July 10, 1997

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

We urge you to support the provision in the Senate version of the Balanced Budget Act of 1997 that raises the eligibility age for Medicare from 65 to 67 over 28 years. The Senate voted overwhelmingly for this change because between the years 2010 and 2030, roughly the period over which the increase occurs, the number of American workers paying the taxes that finance Medicare will increase by 5 million while the number of Medicare beneficiaries will increase by 22 million. Further, the age of eligibility for this program should reflect the length of Americans' lives, which have grown since 1965 far in excess of the modest increase proposed by the Senate.

The Administration raised three main concerns in its letter to Congress: first, that the change should be part of a separate effort; second, that it is not needed to balance the budget; and, third, that early retirees between ages 65 and 67 could become uninsured.

First, OMB Director Raines wrote in the letter that consideration of the eligibility age should be "part of a bipartisan process to address the long-term financing challenges facing Medicare." We agree. The Senate's action was precisely that. The Finance Committee unanimously passed a bill containing the eligibility age increase, and the Senate supported it on a 62-38 vote. Furthermore, while we support the creation of a commission to study Medicare's long-term future, a presidential commission you appointed has already extensively studied this proposal, and its chairman and vice-chairman identified this change as one of several which need to be made.

Second, the proposal produces enormous savings. The Administration has correctly insisted on the need to avoid an explosion in costs in the out-years of the budget. This proposal helps achieve that goal. The Bipartisan Commission on Entitlement and Tax Reform estimated this change would save \$37 billion in 2030 alone. The change also addresses the Administration's goal of making the budget

more fair to working taxpayers, since those in the work force now will benefit from making the Medicare system more fair and sound in the future.

Third, Mr. Raines expressed the Administration's concern that "early retirees between 65 and 67 may not be able to obtain affordable insurance in the private market." As you know, the age will not reach 66 until 2009 and will not reach 67 until 2026. The Administration's concern can be addressed. We recommend you work with Congress to adopt legislation that would allow retirees to buy in to Medicare at age 62, as well as private sector insurance market reforms which would address the problems faced by early retirees.

Given your eloquent calls for fairness to working families, who will benefit from strengthening Medicare in the future, and for long-term fiscal responsibility, we hope you will support this measure in conference.

Sincerely,

Ed Kerry

John Breaux

Phil Franks

Corinne Mack

Robert Stump
Max Baucus

Jim DeMint
Sam Nunn

Bob Bennett

Pat Leahy

John McCain

Ken Stange

HEALTHCARE ASSOCIATION OF NEW YORK STATE
THE HOSPITAL AND HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA
MASSACHUSETTS HOSPITAL ASSOCIATION
NEW JERSEY HOSPITAL ASSOCIATION
TEXAS HOSPITAL ASSOCIATION
CALIFORNIA HEALTHCARE ASSOCIATION
OHIO HOSPITAL ASSOCIATION
MISSOURI HOSPITAL ASSOCIATION
DELAWARE HEALTHCARE ASSOCIATION
MICHIGAN HEALTH & HOSPITAL ASSOCIATION
ILLINOIS HOSPITAL AND HEALTH SYSTEMS ASSOCIATION
NORTH CAROLINA HOSPITAL ASSOCIATION

July 16, 1997

The Honorable William Jefferson Clinton
 President of the United States
 The White House
 1600 Pennsylvania Avenue
 Washington, D.C. 20500

Dear President Clinton:

We write to ask you for your continued advocacy for the direct payment of Medicare graduate medical education (GME) and disproportionate share payments (DSH) to hospitals for Medicare beneficiaries enrolled in managed care. We appreciate your national leadership on this issue and recognize it has been crucial to the adoption of this provision by the Senate and the House Commerce Committee.

As the House-Senate conference committee meets to reconcile the Medicare provisions of the budget reconciliation bill, we urge you to continue advocating for the carve-out of GME and DSH payments from Medicare managed care rates and the direct payment of these funds to the hospitals that train physicians and treat the uninsured. Nearly 13 percent of all Medicare beneficiaries are now enrolled in managed care plans. As the Medicare program encourages the growth of managed care, the direct payment of these funds will be absolutely critical to teaching and DSH hospitals.

We, therefore, urge you to fight for full implementation of the entire carve-out provision, with the fastest possible phase-in. It is our understanding that House Republican Medicare leaders continue to oppose inclusion of this provision in the conference agreement. We respectfully urge you to stand firm in support of the carve-out and direct payment of these mission-related payments for direct graduate medical education, indirect medical education, and disproportionate share.

On behalf of the health care providers in our states, we thank you for your leadership on this issue and the outstanding efforts of your health care staff, especially Chris Jemmings and Barbara Woolley. If our associations can assist you in any way, please have your staff contact Steven Kroll of the HANYS at (518) 431-7727.

Sincerely,

Daniel Sisto
 President
 HANYS

Carolyn F. Scanlan
 President and Chief Executive Officer
 HAP

Ronald M. Hollander
 President
 MHA

Gary S. Carter, FACHE
 President and CEO
 NJHA

Terry Townsend, FACHE, CAE
 President/Chief Executive Officer
 THA

C. Duane Dauner
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C. Edward McCauley
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 NCHA

BARBARA A. MIKULSKI
MARYLAND

COMMITTEES:

APPROPRIATIONS

LABOR AND HUMAN RESOURCES

THE PRESIDENT HAS SEEN

7-17-97

SUITE 709

HART SENATE OFFICE BUILDING

WASHINGTON, DC 20510-2003

(202) 224-4654

TTY: (202) 224-5223

United States Senate

WASHINGTON, DC 20510-2003

June 27, 1997

The Honorable Bill Clinton
The President
The White House
Washington, D.C. 20500

Dear Mr. President:

Mr. President, we need presidential leadership in dealing with the solvency of Medicare. We need your leadership and active involvement to make sure that the changes in the Senate bill do not survive the House-Senate conference. If they do, then I request that you veto the bill.

I am writing to urge you to veto the budget reconciliation bill if it contains the Senate provisions that drastically change Medicare.

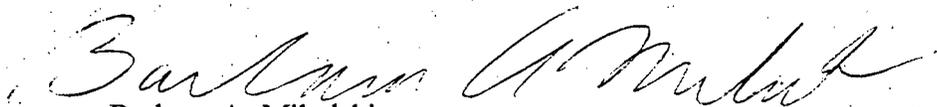
There is no doubt that the solvency of the Medicare Trust Fund is a serious, urgent issue for which there are no easy answers. Therefore, I call on you to lead a national discussion on alternatives and help arrive at a national consensus. Government governs best when it has the consent of the governed.

The budget bill is not the place to radically alter core components of the Medicare program. The Senate changed thirty years of Medicare policy in three days. We need your strong leadership, we need bipartisan cooperation, and we need a vigorous national discussion before making changes to Medicare.

The Senate bill would create a means test for Medicare premiums. Seniors could have to pay four times more in premiums starting next year. The Senate bill raises the age of eligibility for Medicare from 65 to 67. This provision could create an entire new class of uninsured older Americans. The bill also imposes a new \$5 per visit copayment on senior citizens who use home health care. We must ensure that Medicare remains affordable, accessible, undeniable, and universal.

I look forward to working with you to ensure that we keep faith with those who depend on Medicare, and to ensure that Medicare is strong now and in the future.

Sincerely,



Barbara A. Mikulski
United States Senate

THE PHOTOCOPY HAS BEEN

7-17-97

~~Army/Secret
Jennings~~

copied
Hilley
Jennings
COS

Linda -
pls. forward
to Debbie
Chang.

FAX TRANSMITTAL

From the desk of
Margaret VanAmringe
Director, Federal Relations
Joint Commission on Accreditation
of Healthcare Organizations
700 13th Sreet, N.W. Suite 950
Washington, D.C. 20005

TEL: 202.434.4525
FAX: 202.434.4592

TO: Chris Jennings
Spec. Asst to Pres. for Health Policy Develop.

FAX: (202) 456-5557

TEL: (202) 456-5560

RE:

DATE:

NOTES: JCAHO and NCAHA have put together the following documents regarding Reconciliation's debate on the roles of accreditation and Peer Review Organizations. Our biggest concerns are the avoidance of duplication of efforts at a time when managed care dollars available

PAGES, including cover sheet 5

Private Sector Accreditation Bodies Supports House Language

The nation's leading independent health care accrediting organizations support the provision in both House reconciliation bills providing the HHS Secretary with the discretionary authority to deem Medicare Plus/Choice organizations in compliance if accredited by an approved organization using standards no less stringent than those in federal law. Private sector accreditation provides a comprehensive and definitive evaluation of an organization's actual performance of those key functions that are essential to produce good outcomes of care.

Preserve External Review – Just Don't Reserve it for PROs

The House language preserves "external review", but its no longer reserved for the government's Peer Review Organizations (aka "PROs"). Accreditation is external review, and the House language allows the HHS Secretary to take full advantage of the fact that there is already considerable overlap between our accreditation processes and the activities performed by the government's PROs/PROs. The potential for even greater duplication exists now that our accreditation processes are moving towards the routine collection and incorporation of comparable performance data.

Private Sector Accreditation Maximizes Government Resources

The House language gives the HHS Secretary authority to maximize government resources and take full advantage of private sector accreditation and eliminate redundant external oversight. These partnerships will free the federal government to better focus its resources on such issues as independent adjudication of grievance, appeal, and written complaints; as well as the development, refinement, and auditing of consumer "report cards".

**Joint Commission on the Accreditation
of Healthcare Organizations (JCAHO)**

**National Committee for Quality
Assurance (NCQA)**

July 3, 1997

The Honorable William M. Thomas
Chairman, Ways and Means Health Subcommittee
1136 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Thomas:

As the nation's leading independent health care accrediting organizations, we are writing to express our strong support for the provision in both House reconciliation bills that would provide the Secretary of Health and Human Services (HHS) with the discretionary authority to deem Medicare Plus/Choice organizations in compliance if accredited by an approved organization using standards no less stringent than those in federal law.

While federal standards establish an important floor that all organizations must meet, private-sector accreditation provides a comprehensive and definitive evaluation of an organization's actual performance of those key functions that are essential to produce good outcomes of care. Providing the Secretary of HHS with the authority to take full advantage of private sector accreditation is critical to ensuring that Medicare beneficiaries receive high quality care regardless of their choices among delivery organizations. The House language provides strong incentives for organizations to meet the even higher standards of independent accreditation organizations while eliminating redundant external oversight and freeing the federal government to better focus its regulatory resources on such issues as independent adjudication of grievances, appeals, and written complaints.

While the Senate language would allow deeming for internal federal requirements, it prevents the Secretary of HHS from taking full advantage of private sector accreditation and deeming for "external review". This is true even if the private accreditation standards were more stringent than federal law. There is already considerable overlap between our accreditation processes and the activities performed by the government's Peer Review Organizations (aka "IQROs"), and the potential for even greater duplication exists now that our accreditation processes are moving towards the routine collection and incorporation of comparable performance data. The House language properly addresses this issue by giving the Secretary of HHS authority to maximize government resources and take full advantage of private sector accreditation.



Joint Commission
on Accreditation of Healthcare Organizations

7/8/97

DEAR CHRIS;

The Joint Commission and NCQA put together the following documents for discussions during Reconciliation on the appropriate roles for accreditation and Peer Review Organizations doing external review of managed care entities.

We are very concerned with the duplicative efforts of accreditation and PRO review of managed care at a time when money is tight. At one level, there is the consideration of the most effective expenditures from the Medicare Trust Fund on quality oversight, and at another level is the consideration of how resources should be spent by managed care organizations (mcos) responding to external review requirements. As the proposed constraints on managed care reimbursement take effect, there will be less money available to mcos for data collection activities and for the demands of external review agents. Therefore it is critical that we have a sensible, cost-effective external review program at the federal level -- one in which each new requirement adds value to the assessment of the mco's performance on quality measures, not redundancy. We believe that there should be recognition that PROs and accreditors are doing many of the same things now, and that the overlap will be rapidly exacerbated by the recent activities of accreditors to routinely collect performance data. For example, the JCAHO now has a mandatory requirement for collection of outcomes and other performance measurement data from the managed care entities that we accredit.

We would like to ensure the maximum flexibility for the Secretary, DHHS to use accreditors as long as accreditors live up to the Secretary's expectations. Also, the maximum use of accreditation will serve as an important incentive for mcos to become accredited - a worthwhile goal in my opinion, given that fewer than 30% of mcos eligible for accreditation have sought it.

NCQA and JCAHO thank you for your consideration. We understand that consumer groups and others have lobbied you on this issue as well. Should you have any questions, please call either myself at 202.434.4525 or Steve Lamb at NCQA 202.955.5102. We appreciate your time.

Margaret VanAmringe



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

June 23, 1997

The Honorable Trent Lott
Majority Leader
United States Senate
Washington, DC 20510

Dear Mr. Leader:

As the Senate begins consideration of S. 947, the spending-related portion of this year's budget reconciliation legislation, I am writing to transmit the Administration's views. We will transmit separately the Administration's views on the tax reconciliation bill.

While many provisions of the bill are consistent with the Bipartisan Budget Agreement, in some key areas others are not. We understand there are ongoing efforts to resolve as many issues as possible through a bipartisan Leadership amendment. Such an amendment would advance the bipartisan process which began last month with the Budget Agreement. The Administration intends to continue working closely with the Leadership on remedial amendments.

Key areas where the bill is inconsistent with the Budget Agreement include the failure to: "restore SSI [Supplemental Security Income] and Medicaid eligibility for all disabled legal immigrants who are or become disabled and who entered the U.S. prior to August 23, 1996"; assist low-income Medicare beneficiaries in paying premiums; provide Medicaid benefits for certain disabled children and the full 70 percent Federal match for Medicaid in the District of Columbia; properly implement the Medicare home health reallocation; provide for State SSI administrative fees; and achieve the agreed-upon levels of savings from spectrum auctions and related provisions.

In addition, we have significant concerns about a number of issues which the Budget Agreement did not specifically address: the lack of quality standards and protections against balance billing in private fee-for-service plans in Medicare Choice and in Medical Savings Accounts (MSAs); the added burden of new copayments for certain Medicare Part B and Medicaid beneficiaries; the higher eligibility age for Medicare recipients and the income-relating of the Medicare deductible; the failure to include all of the Administration's prudent purchasing reforms; the lack of a Federal Disproportionate Share Hospital (DSH) targeting standard; the failure to put the proper parties in charge of administering the welfare-to-work program; the proposal to privatize eligibility determinations in Texas; and the lack of adequate maintenance-of-effort requirements for Food Stamps.

The Bipartisan Budget Agreement is good for America, its people, and its future, and we are fully committed to working with Congress to see all of its provisions enacted into law by the August recess.

Items Contrary to the Bipartisan Budget Agreement

Continued SSI and Medicaid Benefits for Legal Immigrants -- While the Senate reported provision giving benefits to new applicants for a limited time is preferable to the House provision, it fails to provide sufficient assistance for the most vulnerable individuals. The Budget Agreement explicitly states: "Restore SSI and Medicaid eligibility for all disabled legal immigrants who are or become disabled and who enter the U.S. prior to August 23, 1996." As the President stated in a June 20, 1997 letter, he views this issue as of paramount importance. As the letter states: "To achieve our common goal of a signable bill that balances the budget, it is essential that the legislation that is presented to me include these provisions. I will be unable to sign legislation that does not." The reported bill fails to reflect the Agreement. As a result, in 2002 it would protect an estimated 55,000 fewer immigrants than the Budget Agreement calls for.

In addition, the President's strong preference is to cover both elderly and disabled immigrants. We will work with you to identify the necessary resources to do so.

Assistance for Low-Income Medicare Beneficiaries -- Recognizing that premiums represent a significant burden on low-income beneficiaries, the Budget Agreement allocated \$1.5 billion to ease the impact on this population of increasing Medicare premiums related to the home health reallocation. The reported bill does not include this provision.

Medicaid Benefits for Certain Disabled Children -- The Budget Agreement clearly includes the proposal to restore Medicaid for current disabled children losing SSI because of the new, more strict definition of childhood eligibility. The reported bill failed to include this proposal. We strongly urge the Senate to include this provision and retain Medicaid benefits for about 30,000 children who could lose their health care coverage in FY 1998.

DC Medicaid -- We are pleased that the reported bill includes a higher matching payment for the Medicaid program in the District of Columbia, but we are concerned that the increase is not sufficient. The matching rate proposed in the reported bill sunsets at the end of FY 2000 and is 10 percentage points lower than the matching rate of 70 percent in the FY 1998 President's budget. A 60 percent matching rate would still leave the District paying more to the Medicaid program than any other local government.

Home Health Reallocation -- The home health reallocation in the Budget Agreement is not properly reflected in the reported bill. During the negotiations, we discussed at great length the shift of home health expenditures to Part B, and all sides clearly understood that it would be immediate. The Committee's phase-in would cost two years of solvency on the Part A trust fund -- two years that we can ill afford to lose. We urge the Senate to incorporate the same provision included in the House Commerce Committee reported title.

State SSI Administrative Fees -- The reported bill fails to reflect the provision of the Budget Agreement which calls for increasing the administrative fees that the Federal Government charges States for administering their supplemental SSI payments -- the proceeds of which would be available, subject to appropriations, for Social Security Administration (SSA) administrative expenses.

Spectrum -- While the Senate reported provisions are a substantial improvement over counterpart House legislation, we continue to have serious concerns. The reported language would not achieve the full \$26.3 billion in savings and policies described in the Budget Agreement. In addition, the bill does not include two of the proposals included in the Budget Agreement -- auction of "vanity" toll free telephone numbers and the spectrum penalty fee. Additionally, the bill does not provide a firm date for terminating analog broadcasting, thus causing significant savings reductions.

We also have the following additional concerns with the reported spectrum language: the lack of authority for the Federal Communications Commission (FCC) to use economic mechanisms, other than auctions, where appropriate (i.e., user fees to create incentives for efficient spectrum management); a very expansive definition of public safety that would create loopholes permitting too many entities to be exempted from auctions; language that would protect spectrum for use by the National Aeronautics and Space Administration and the National Oceanic and Atmospheric Administration, which is contrary to the Administration's policy on managing spectrum across the government through a process managed by the National Telecommunications and Information Administration; and the lack of authority for the FCC to revoke and reactivate licenses when an entity declares bankruptcy, which is essential to preserving licenses awarded in previous auctions.

Additional Concerns

Although the Budget Agreement did not specifically address the following items, the Administration has significant concerns about them. The Administration urges the Senate to address these concerns during Floor action.

Medicare

Private Fee for Service in Medicare Choice. While the Administration supports the introduction of new plan options for Medicare beneficiaries, we believe that any new options must be accompanied by appropriate beneficiary protections. We believe that inclusion of private fee-for-service plans in Medicare Choice without balance billing or quality assurance protections is bad policy. Beneficiaries should not be exposed to billing in excess of current law protections. Also, we are concerned that this option will attract primarily healthy and wealthy beneficiaries and leave sicker and poorer beneficiaries in the more expensive, traditional Medicare program.

Medical Savings Accounts. We believe that any demonstration of this concept should be limited in order to minimize potential damage and costs to the Medicare program. We commend the Finance Committee for limiting the demonstration to 100,000 participants, but still believe that a geographically limited demonstration would be much preferable. We are also pleased that the cost-sharing and deductibles for MSAs that have been reported are similar to the provisions that were enacted under the Health Insurance Portability and Accountability Act (HIPAA). We also strongly believe that the current law limits on balance billing should be applied to this demonstration to protect beneficiaries from being subjected to any additional charges providers choose to assess. We believe this demonstration should be limited geographically for a trial period which would enable us to design the demonstration to answer key policy questions.

Home Health Copayments. We note that the bill would impose a Part B home health copayment of \$5 per visit, capped at an amount equal to the annual hospital deductible. Medicare beneficiaries who use home health services tend to be in poorer health than other Medicare beneficiaries. Two-thirds are women, and one-third live alone. Forty-three percent have incomes under \$10,000 per year. We are concerned that a copayment could limit beneficiary access to the benefit. Imposing a home health copay is not necessary to balance the budget, and any further consideration of this policy should be part of a bipartisan process to address the long-term financing challenges facing Medicare.

Medicare Eligibility Age. Raising the eligibility age for Medicare is not necessary to balance the budget, and any further consideration of this policy should be part of a bipartisan process to address the long-term financing challenges facing Medicare. Moreover, this proposal does not contain provisions to address the fact that early retirees between the ages of 65-67 may not be able to obtain affordable insurance in the private market.

Prudent Purchasing. We applaud the bill's inclusion of our inherent reasonableness and competitive bidding proposals. However, we urge the Senate to take advantage of all the prudent purchasing proposals. The Medicare program is governed by a strict set of provider payment rules that have the effect of limiting the ability of the Federal government to secure the most competitive terms available to other payers in the marketplace. We have advanced a set of proposals to allow Medicare, the nation's largest health insurer, to also take advantage of lower rates providers offer to other payers.

Income-related Deductible. The reported bill includes a proposal to income-relate the Medicare Part B deductible. While the Administration is not opposed to income relating Medicare in principle, we have a number of concerns about this proposal. First, as the President mentioned yesterday, we believe this provision is outside the confines of the underlying budget agreement. Second, we are concerned that the proposal has design flaws. It would be extremely difficult to administer. Moreover, it may not achieve its intended purpose of reducing unnecessary utilization of services because the vast majority of beneficiaries have supplemental "Medigap" policies that pay for Part B deductible costs. While we do have serious concerns about this proposal, we remain interested in discussing it, or proposals like it, in the broader context of reforms to address the long-term financing and structural challenges facing the program.

Medicare Commission. The reported bill would establish a Medicare commission. Establishing a bipartisan process that is mutually agreeable is essential to successfully address the challenges facing Medicare. We look forward to working with you on the development of the best possible bipartisan process to address the long-term financing challenges facing Medicare while simultaneously ensuring the sound restructuring of the program to provide high-quality care for our nation's senior citizens.

Medicare Choice Payments. We would prefer to limit the growth in Medicare Choice payments to Fee-for-Service Medicare, rather than having two separate growth targets. To do so may lead to an erosion of the value of the Medicare choice benefit package and expose beneficiaries to increased premiums.

Medicaid

Disproportionate Share Hospital Savings. We have concerns about the details of the allocation of the disproportionate share hospital (DSH) payment reductions among States. The bill may have unintended distributional effects among States. We recommend that the Congress revisit the FY 1998 President's budget proposal, which achieves savings by taking an equal percentage reduction off of states' total DSH spending, up to an "upper limit." Although the reported bill includes a provision to require States to develop DSH targeting plans, we are concerned that the bill does not include a federal DSH targeting standard. Without federal standards, providers with high-volume Medicaid and low-income utilization may not be sufficiently protected from reductions in the DSH program.

Medicaid Cost Sharing. The bill would allow States to require limited cost sharing for optional benefits. We are concerned that this proposal may compromise beneficiary access to quality care. Low-income Medicaid beneficiaries may forgo needed services if they cannot afford the copayments. We urge the Senate to revisit the FY 1998 President's budget proposal, which would allow nominal copayments only for HMO enrollees. This proposal would grant States some flexibility and would allow HMOs to treat Medicaid enrollees in a manner similar to non-Medicaid enrollees, without compromising access to care.

Criminal Penalties for Asset Divestiture. The reported bill would amend Section 217 of the HIPAA of 1996 to provide sanctions against those who assist people in disposing of assets in order to qualify for Medicaid. We would prefer to repeal Section 217 because we believe that the Medicaid laws in effect before the enactment of the Health Insurance and Portability and Accountability Act are sufficient to protect the Medicaid program against inappropriate asset divestiture.

Return to Work. We are pleased that the reported bill includes a provision allowing States to permit workers with disabilities to buy into Medicaid. We recommend the President's Budget proposal which would not limit eligibility for this program to people whose earnings are below 250 percent of poverty. We believe that this limit in the reported bill would not allow States sufficient flexibility to remove disincentives to work for people with disabilities.

Medicaid Payments to Puerto Rico and the Territories. We are pleased that the reported bill includes adjustments for the Medicaid programs in Puerto Rico and the territories, but we would prefer the language included in the FY 1998 President's Budget.

Children's Health

We are encouraged that the Senate reported bill includes notable improvements over the provisions reported by the House Commerce Committee. Specifically, we commend the decision not to allow use of the \$16 billion investment in areas other than insurance coverage. In addition, we are pleased to note the improved definition of benefits relative to the House Commerce Committee provisions.

While the Senate-reported bill represents a positive step forward, we are particularly concerned about the benefits definition and the lack of low income protections. It is our hope that the intent of this legislation was to ensure that children receive a benefit package that is at least commensurate with the standard Blue Cross/Blue Shield FEHBP benefit. However, the actual statutory language is much more limiting and would permit much less significant coverage. In addition, while the HHS Secretary would have discretion to define whether or not the benefit package meets the statutory requirement, she would not have the ability to ensure that low income children do not have to shoulder unrealistically high cost sharing that could lead to reduced access to needed health care. We also want to ensure that this investment is properly targeted to cover children who do not currently have health insurance. Finally, as the Administration has stated many times, we do not support limiting access to medically necessary benefits, including abortion services. We look forward to working with the Congress to resolve these important issues.

Welfare to Work

Local Program Administration -- The challenge of welfare reform -- moving welfare recipients into permanent, unsubsidized employment -- will be greatest in our Nation's large urban centers, especially those with the highest number of adults in poverty. Mayors and other local elected officials, working with private industry councils, have been entrusted by Congress with the responsibility for administration of other Federal job training funds. The Administration strongly believes that a substantial amount of all Welfare to Work funds should be managed by these entities, which have the experience to address most effectively the challenge of moving long-term welfare recipients into lasting unsubsidized employment that reduces or eliminates dependency.

The committee reported bill, however, would provide for local administration of formula grant funds only through the Temporary Assistance for Needy Families (TANF) agency. The bill's competitive grant structure would not ensure that an appropriate portion of funds outside rural areas will be administered by cities with high concentrations of adults in poverty. The Administration is concerned that the reported bill provides that the competitive grant portion would be only 25 percent of the total funds available, still further limiting resources for cities

with the greatest need. The Administration urges the Senate to follow the approach taken by the House Ways & Means Committee which would increase the share of competitively awarded funds to 50 percent and set aside a substantial portion of these funds for cities with the highest poverty populations.

Performance Bonus. The Administration is pleased that the Finance Committee included a performance bonus concept. We are concerned, however, that the performance fund simply augments the existing TANF performance fund without establishing any new expectations on grantees for additional performance using these welfare-to-work funds, or rewards for placing the hardest-to-serve in lasting, unsubsidized jobs that promote self-sufficiency. In addition, the Administration agrees with the House that the way to administer welfare-to-work grant funds so as to have the greatest likelihood of success is through the Department of Labor, the mayors, and the private industry council system.

Federal Administering Agency. The reported bill would place the program under the authority of the Secretary of Health and Human Services. While consistency with Federal TANF strategies is essential, Welfare to Work program activities should be closely aligned with the workforce development system overseen by the Secretary of Labor. The Administration therefore believes that the Secretary of Labor should administer this program in consultation with the Secretaries of HHS and HUD (as in the House bill).

Non-displacement. We understand the Senate adopted non-displacement provisions during committee action. However, we strongly urge the Senate to adopt, at a minimum, the provisions included in the House Education and the Workforce Committee-reported bill, which apply both to activities under the new Welfare-to-Work grants and TANF.

Distribution of Funds by Year. It does not appear that the bill's allocation of \$3 billion in budget authority over fiscal years 1998-2000 would, when combined with the program structure, result in an outlay pattern consistent with an estimate of zero outlays in FY 2002, as provided in the budget agreement. The Department of Labor is available to work with staff to craft provisions that satisfy this agreement.

We are pleased that the reported bill includes provisions that would address priorities, including: the provision of formula grant funds to States based on poverty, unemployment, and adult welfare recipients; a sub-state allocation of the formula grant to ensure targeting on areas of greatest need; appropriate flexibility for grantees to use the funds for a broad array of activities that offer promise of resulting in permanent placement in unsubsidized jobs; funds awarded on a competitive basis; a substantial set-aside for evaluation; and a performance fund to reward States that are successful in placing long-term welfare recipients. We look forward to working with the Congress during conference to refine these provisions.

Minimum Wage and Workfare

The reported bill appropriately refrains from modifying current law with respect to the application of the minimum wage and other worker protections for working welfare recipients under TANF. The Administration believes strongly that everyone who can work must work, and everyone who works should earn at least the minimum wage and receive the protections of existing employment laws -- whether or not they are coming off welfare.

Privatization of Health and Welfare Programs

The reported bill would allow the eligibility and enrollment determination functions of Federal and State health and human services benefits programs in the State of Texas -- including Medicaid, WIC, and Food Stamps -- to be privatized. The Administration believes that changes to current law would not be in the best interest of program beneficiaries and strongly opposes this provision. While certain program functions, such as computer systems, can currently be contracted out to private entities, the certification of eligibility for benefits and related operations (such as obtaining and verifying information about income and other eligibility factors) should remain public functions.

Food Stamps

While we support much of the Committee's approach to implementing the Agreement we are concerned that the proposal would create an estimated 100,000 fewer work opportunities over five years than proposed by the Administration's bill, which includes a specific target of 70,000 new slots each year. We are pleased that the Senate adopted a performance-based structure to reward States that provide employment and training (E&T) opportunities for individuals facing the 3-month food stamp time limit. This is highly preferable to the less accountable provisions in the House bill. The Senate's proposal should also be strengthened by conditioning receipt of the new 100 percent Federal E&T funds provided in the agreement upon a State maintaining 100 percent of their 1996 E&T spending. CBO estimates that the Senate's proposed 75 percent maintenance-of-effort requirement would result in States decreasing their E&T spending by \$89 million over 5 years. We urge the Senate to adopt provisions similar to the House maintenance-of-effort provisions.

Student Loans

We are pleased that the reported bill includes \$1.763 billion in outlay savings, including \$1 billion in Federal reserves recalled from guaranty agencies, \$160 million from eliminating a fee paid to institutions in the Direct Loan program, and \$603 million in reduced Federal student loan administrative costs. All these savings are being achieved without increasing costs or reducing benefits to students and their families.

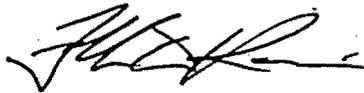
However, the Administration opposes a new provision, unrelated to the Budget Agreement, requiring administrative cost allowances (ACAs) to guaranty agencies in the Federal Family Education Loan (FFEL) Program at a rate of .85% of new loan volume, to be paid

from mandatory funding authorized under Section 458 of the Higher Education Act of 1965 (HEA) in FY 1998-2002. This provision would represent a new federal entitlement. It would also limit inappropriately the funds available to the Secretary to manage the FFEL Program effectively. Any allowance to these agencies should bear some relationship to the costs these agencies incur and not be based on an arbitrary formula. This is an issue for the upcoming HEA Reauthorization.

The Bipartisan Budget Agreement reflects compromise on many important and controversial issues, and challenges the leaders on both sides of the aisle to achieve consensus under difficult circumstances. It is critical that we do so on a bipartisan basis.

I look forward to working with you to implement this historic agreement.

Sincerely,

A handwritten signature in black ink, appearing to read 'Franklin D. Raines', written in a cursive style.

Franklin D. Raines
Director

IDENTICAL LETTER SENT TO HONORABLE THOMAS A. DASCHLE,
HONORABLE PETE V. DOMENICI, HONORABLE FRANK LAUTENBERG

Addendum: Additional Comments

Housing

We are concerned that the bill's provisions regarding FHA multifamily housing restructuring would not transform this housing in the most effective and efficient fashion. By ruling out the possibility of providing portable tenant-based assistance, the bill would limit the ability of tenants to seek out the best available housing and prevent projects from developing a more diverse mix of income levels. By establishing a preference for delegating restructuring tasks to housing finance agencies, the bill places an unnecessary constraint on HUD's ability to design the most effective partnerships. Finally, by failing to address tax issues explicitly, the bill does not resolve impediments that could discourage owners from participating in a restructuring process.

The administration is also concerned about Section 2203 of the Senate reconciliation bill which repeals federal preferences for the Section 8 tenant-based and project-based programs. The Administration has supported these repeals only if they are combined with income targeting that would replace the federal preferences. That targeting would ensure: 1) that the tenant-based program continues to serve predominantly extremely low income families with incomes below 30 percent of the area median income and 2) that all developments in the project-based program are accessible to a reasonable number of extremely low income families.

Unemployment Insurance Integrity

The reported bill fails to support the provision of the Budget Agreement that achieves \$763 million in mandatory savings over five years through an increase in discretionary spending for Unemployment Insurance program integrity activities of \$89 million in 1998 and \$467 million over five years. We urge the Senate to include in the bill provisions to authorize and guarantee the discretionary activities and the resulting savings. The Administration separately transmitted draft legislative language on June 6th to implement this provision of the Budget Agreement.

Vocational Education and TANF

The Administration is concerned with the reported bill's provision on vocational education in TANF. The agreement did not address making changes in the TANF work requirements regarding vocational education and educational services for teen parents.

Smith-Hughes

The reported bill does not include a provision that would repeal the Smith-Hughes Act of 1917, although the bill finds the agreed-upon \$29 million savings from other sources. In light of the \$1.2 billion annual appropriations under the Carl D. Perkins Vocational and Applied Technology Education Act, there is no justification for mandatory spending of \$7 million per

year under the Smith-Hughes Act. We urge the Senate to adopt the provision included in the House Education and Workforce Committee reported title, which is consistent with the Budget Agreement.

Refugee and Asylee Eligibility

The Agreement would extend the exemption period from five to seven years for refugees, asylees, and those who are not deported because they would likely face persecution back home. The Administration supports the reported language, which implements this policy and also extends the exemption to Cuban and Haitian entrants.

Other Immigrant Provisions

We urge the adoption of a provision that would provide the same exemption period for Amerasian immigrants as provided to refugees. Amerasian immigrants share many of the problems and barriers confronted by refugees and have the same level of need as refugees. The Administration is pleased that the Committee bill exempts permanent resident aliens who are members of an Indian tribe from SSI program restrictions. We urge the Senate to extend this exemption to include the five year ban on eligibility for those who enter the country after August 22, 1996. Neither of these provisions will change the spending estimates associated with the Committee bill.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

June 6, 1997

The Honorable Bill Archer
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing to express the views of the Administration on the Medicare provisions which were approved by the Subcommittee on Health on June 4, for inclusion in the FY 1998 budget reconciliation bill.

Overall, the Administration finds much to support in the bill. It incorporates many of the proposals from the FY 1998 President's Budget and is generally consistent with the Bipartisan Budget Agreement. It proposes structural reforms that constrain growth, extends the life of the Hospital Insurance Trust Fund for at least a decade, and improves preventive care benefits. All of these changes will help strengthen and modernize Medicare for the 21st century.

However, the Administration is concerned about a few of the Medicare provisions that your Committee will consider, including the following:

Home Health Reallocation

As noted in my June 5 letter to Mr. Thomas, it is our view that the home health reallocation in the Budget Agreement is not properly reflected in the Subcommittee mark. We agreed to phase in the impact of the home health shift on the Part B premium over seven years. We did not agree to shift home health spending from Part A to Part B over seven years. To do so means a loss of two years of solvency on the Part A trust fund, two years which we can ill afford to lose.

In addition, a phased-in reallocation would cause significant administrative problems regarding claims processing, appeals, and medical review for Medicare contractors.

MSAs

While we have agreed to work with you to develop a demonstration of this concept for the Medicare population, we have concerns about the size and scale of the demonstration in the bill. The Subcommittee's bill provides for a demonstration with 500,000 participants, which is much larger than any other Medicare demonstration. Moreover, the demonstration exposes

beneficiaries to any additional charges providers choose to levy without limitation. We strongly believe that the current law limits on balance billing should be applied to this demonstration. We also believe the demonstration should be limited to two states for a three year trial period, which will enable us to design the demonstration to answer key policy questions.

Medical Malpractice

We believe that the malpractice provisions in the subcommittee's mark are extraneous to the Bipartisan Budget Agreement. As you know, the Administration opposed the malpractice provisions in the vetoed Balanced Budget bill as well as those adopted in the House version of the Health Insurance Portability and Accountability Act (HIPAA). We find these provisions highly objectionable.

Preventive Benefits

While the preventive benefits are largely the same as those advanced in the President's Budget, we bring to your attention the failure to waive coinsurance for mammograms. As you know, mammography saves lives, yet many Medicare beneficiaries fail to use this benefit. Research has found that copayments hinder women from fully taking advantage of this benefit. Thus, we continue to support waiving copayments for mammograms.

Medical Education/Disproportionate Share (DSH) Carve-out

The Administration's budget would move the medical education (indirect and direct) and DSH adjustments out of managed care payment rates and redirect these funds to eligible hospitals that provide services to Medicare managed care enrollees. This is an important proposal designed to ensure that the nation's teaching hospitals and those that serve low-income populations receive the Medicare payments to which they are entitled. The Subcommittee bill dropped this policy. We urge the Committee to include this proposal.

Prudent Purchasing

As you know, the Medicare program is governed by a strict set of provider payment rules that limit the ability of the Federal government to secure the most competitive terms available to other payers in the marketplace. We have advanced a set of proposals to allow Medicare, the nation's largest health insurer, to also take advantage of lower rates providers offer to other payers. We are pleased that one of these proposals (expansion of the "Centers of Excellence" program) was adopted by the Subcommittee, but we urge the inclusion of the other proposals.

At a time when we all agree that Medicare spending has been growing too quickly and the Federal budget faces increasing pressures for scarce resources, we do not understand why the Committee would not want to take advantage of these proposals to allow Medicare to be a more prudent purchaser. We propose adopting practices that work in the private sector. We should let

them work in the public sector as well. These practices can work well to save taxpayers money and promote quality.

Children's Health

I also want to underscore the terms of the Bipartisan Budget Agreement with respect to the \$16 billion earmarked to provide up to five million additional children with health insurance coverage by 2002. Pursuant to the Agreement, the use of these funds is expressly limited to expanding Medicaid and/or creating a program of capped mandatory grants to States to finance health insurance coverage for uninsured children. No other use of these funds is countenanced by the Agreement unless it is "mutually agreeable."

Commission

We note that the Subcommittee bill includes a Medicare commission. Establishing a process that is mutually agreeable is essential to successfully address the challenges facing Medicare. We look forward to working with you on the development of the best possible bipartisan process to address the long-term financing challenges facing Medicare while simultaneously ensuring the sound restructuring of the program to provide high-quality care for our nation's senior citizens.

The Bipartisan Budget Agreement reflects compromise on many important and controversial issues, and challenges the leaders on both sides of the aisle to achieve consensus under difficult circumstances. It is critical that we continue to work together on a bipartisan basis to that end.

I look forward to working with you to implement this historic Agreement.

Sincerely,



Franklin D. Raines
Director

Identical Letter Sent to the Honorable Charles Rangel

Addendum

MedicarePlus

The bill permits beneficiaries to be locked into a MedicarePlus plan for as long as 9 months, after a lengthy transition period. We continue to support the monthly disenrollment option as an important safety valve for managed care enrollees who are dissatisfied with their managed care plan. Moreover, we would support the ability of these enrollees to opt to purchase any Medigap plan of their choice upon disenrollment.

We have expressed concerns to the Subcommittee about balance billing limits in MedicarePlus plans and anticipate a resolution of this issue such that MedicarePlus beneficiaries maintain their current law managed care protections against excessive cost-sharing (including those prohibiting balance billing).

Medigap Reforms

The President's bill advanced a number of important Medigap reforms including annual open enrollment (as well as including information about Medigap plans in the annual open enrollment season informational materials), community rating, open enrollment for disabled and ESRD beneficiaries when they become entitled to Medicare, and portability protections similar to those enacted last year in HIPAA for the under 65 population. Many of these important protections were also advanced by bipartisan bills including those sponsored by Representatives Johnson and Dingell. We urge your reconsideration of the merits of these proposals. They ensure that Medicare beneficiaries are able to purchase affordable Medigap policies to fill in the many areas not covered by Medicare. Medicare beneficiaries should be able to choose which Medigap plans to purchase, or MedicarePlus plans to enroll in, without artificial constraints.

Survey and Certification User Fee Proposal

The Subcommittee mark does not contain a provision allowing HCFA to require state survey agencies to impose fees on health care providers for initial surveys required as a condition of participation in the Medicare program. This provision would authorize states to collect and retain fees from health care providers to cover the cost of initial surveys. Under the Bipartisan Budget Agreement, the discretionary funding level for HCFA Program Management assumes enactment of this mandatory, government receipt fee proposal.

DSH Payments

We support the Subcommittee's proposal to freeze Medicare DSH adjustments for hospitals that serve a disproportionate share of low-income individuals; however, we are concerned that this proposal must be drafted to protect DSH hospitals, as was intended in the President's Budget proposal. In particular, the President's proposal freezes, for two years, the actual DSH adjustment. This ensures that the hospital's DSH mark-up (a hospital-specific

percentage increase on all of the hospital's inpatient Medicare payments) will remain constant for the next two years while the Secretary of HHS develops a new proposal for the DSH formula (a requirement that is also in your proposal).

However, our reading of the Subcommittee's mark on the DSH freeze shows that the DSH adjustment will not be frozen, but rather that the base payment amounts will be frozen for purposes of DSH. This would not protect DSH hospitals that would face decreased funding as a result of SSI eligibility changes enacted as part of welfare reform. We recommend adoption of the President's language on the DSH freeze.

Medicare Secondary Payer (MSP)

The Subcommittee's bill limits the time period that Medicare can recover mistaken primary payments from the primary insurer to three years. Unfortunately, because we must utilize information from tax returns which is then matched against information from the Social Security Administration, by the time we receive data it is already one year, and sometimes two years, old. We must then match this information against Medicare files before a questionnaire can be sent to identified employers to determine if a Medicare beneficiary (or their spouse) had coverage through the group health plan of an employer. Thus, a three year limit on when Medicare could recover mistaken payments would effectively mean that no mistaken primary payments could be collected.

Hospital Outpatient Department (OPD) Coinsurance Waiver

While we support allowing hospitals to reduce coinsurance for beneficiaries without being charged with a kickback violation, we would urge the Committee to include language barring such hospitals from charging the Medicare program for bad debt for such waived coinsurance. We suggest that hospitals make an election with the Secretary where they choose on an across-the-board basis for all beneficiaries to waive coinsurance and consequently do not bill Medicare for the waived coinsurance. Such a policy will permit proper monitoring on bad debt.

Mark-up of Drugs

The Administration package contains a proposal to eliminate physician and supplier mark-ups for covered Medicare drugs. We made this proposal to eliminate excessive Medicare payments -- Medicare often pays 15 to 20 percent more than the physician's acquisition cost for the drug -- and to protect beneficiaries from excess charges. We appreciate the Committee's interest in this issue, but we do not believe that the proposal goes far enough to eliminate excessive Medicare payments and does not contain the beneficiary protections that we believe are essential.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

July 2, 1997

The Honorable John R. Kasich
Chairman
Committee on the Budget
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

As the Conferees begin to consider this year's budget reconciliation bill, I am writing to transmit the Administration's views on the House and Senate versions of the spending bill on reconciliation, H.R. 2015. The Administration will separately transmit its views on the tax provisions.

We are pleased that the House and Senate adopted many provisions that are consistent with the Bipartisan Budget Agreement, reflecting the continuing bipartisan cooperation that we will need to fully implement the agreement and balance the budget. In several areas, however, the House and Senate bills violate the agreement. In other areas outside the scope of the agreement, we have very strong concerns about the reported provisions. We have raised a number of these issues in letters to you and to the authorizing committee chairmen and ranking members throughout House and Senate consideration of the separate reconciliation spending bills.

On the pages that follow, we have outlined noteworthy provisions of the House and Senate bills with which we agree, others that we believe violate the budget agreement, and still others about which we have concerns.

We expect and will insist that the final budget legislation conform to the budget agreement. In addition, we look forward to working with you to craft a final conference report that is free of objectionable provisions, resolves the other major policy differences between us, and balances the budget by 2002 in a way that we can all be proud of. We hope to meet that goal before the August recess.

We look forward to working with you.

Sincerely,

A handwritten signature in black ink, appearing to read 'F. D. Raines', with a stylized flourish at the end.

Franklin D. Raines
Director

Enclosure

cc: Senate Conferees
House Committee Chairmen and Ranking Members

Identical letter sent to Honorable Pete V. Domenici,
Honorable John M. Spratt Jr., and Honorable Frank R. Lautenberg

THE ADMINISTRATION'S DETAILED VIEWS:**THE HOUSE AND SENATE RECONCILIATION BILLS ON SPENDING****Medicare**

We applaud the House and Senate for reporting bills that largely conform to the underlying principles of the budget agreement. Both bills achieve the necessary level of Medicare savings — although we still await final scoring of the Senate provisions from the Congressional Budget Office (CBO) — and would extend the life of the Hospital Insurance Trust Fund by at least 10 years; provide structural reforms that will give beneficiaries more informed choices among competing health plans; establish prospective payment systems for home health agencies, skilled nursing facilities, and hospital outpatient departments; incorporate prudent purchasing reforms; and provide the funds to establish a wide array of cost-effective preventive benefits, including mammography and colorectal screening. We look forward to working with your staffs on the many technical issues related to ensuring that these provisions are implemented correctly.

We are pleased that the Senate has included provisions in its bill to require managed care and fee-for-service demonstrations of Medicare reimbursement to the Departments of Defense (DOD) and Veterans Affairs — a concept known as Medicare subvention. We are encouraged that these provisions are similar to our own Medicare subvention legislation, which we transmitted to Congress on February 7, 1997. We look forward to working with the Conferees to develop a bill that addresses Administration concerns about the fee-for-service and payment rate components of the DOD demonstration.

Notwithstanding these achievements, both the House Ways and Means and Senate bills contain a provision that we believe is inconsistent with the budget agreement. During our negotiations over the agreement, we discussed at great length the reallocation of home health expenditures to Medicare Part B. All sides clearly understood that the reallocation would be immediate. Both bills, however, phase in the reallocation, which costs two years of solvency in the Part A trust fund — two years that we can ill afford to lose. We urge the Conferees to incorporate the provisions in the House Commerce Committee title of the House bill, reallocating home health spending consistent with the budget agreement.

The Administration has significant concerns with other provisions of the two bills, concerns that we urge the Conferees to address.

Beneficiary Contributions to a Balanced Budget. We worked very hard during the budget negotiations to set a beneficiary contribution to a balanced budget that was fair and equitable — applying the Part B premium, over several years, to the home health reallocation and maintaining the Part B premium equal to 25 percent of program costs. Other provisions of the Senate bill, however, would go beyond the budget agreement and introduce new, inadequately developed proposals.

- *Raising the Medicare Eligibility Age.* The Senate bill raises the eligibility age for Medicare from 65 to 67 over a period of years. Raising the eligibility age is not necessary to balance the budget, and consideration of this policy should be part of a bipartisan process to address the long-term financing challenges facing Medicare. Moreover, early retirees between 65 and 67 may not be able to obtain affordable insurance in the private market. The Administration is concerned about the potential loss of coverage for any American, and we urge the Conferees to drop the provision as part of this bill.
- *Imposing Home Health Copayments.* The Senate bill would impose a Part B home health copayment of \$5 per visit, capped at an amount equal to the annual hospital deductible. Most home health users who lack Medigap or Medicaid protections are poor and will face financial burdens that may result in reduced access to needed care. Those beneficiaries who have Medigap or Medicaid will have no real incentive to reduce utilization. We do not need to impose a home health copay to balance the budget, and any further consideration of this policy should be part of a bipartisan process to address the long-term financing challenges facing Medicare. We urge the Conferees to drop this provision as part of this bill.
- *Income-relating the Part B Premium.* The Senate bill would income-relate the Medicare Part B premium. While we do not oppose income-relating Medicare in principle, we have a number of concerns about this proposal. First, we do not need income-related beneficiary contributions to Medicare to balance the budget. Second, we have serious concerns about how an income-related premium will be administered. Administration by the Department of Health and Human Services (HHS), which has no access to individual beneficiary income data, would be impractical and very expensive, and we have previously said that only the Treasury Department could administer such a policy in the short run. Moreover, the administering agency would require substantial additional resources to undertake this new responsibility. Finally, we believe that this provision, which completely eliminates any Part B premium subsidy for the highest-income beneficiaries, could lead these beneficiaries to drop Medicare coverage, thus leaving poorer, typically less healthy, beneficiaries in the Medicare risk pool and thereby increasing their premiums. While we have serious concerns about this proposal as drafted, we remain interested in discussing it, or proposals like it, in the broader context of reforms to address the long-term financing and structural challenges facing the program.

Threat to Beneficiary Protections. The Administration strongly supports the introduction of new options for Medicare beneficiaries in both the fee-for-service and managed care sectors. We also believe, however, that any new options must both provide value beyond that offered by the traditional Medicare program and include beneficiary protections. The Senate bill includes several provisions that violate these principles, and we urge the Conferees to drop them.

The first provision allows beneficiaries to choose a so-called "private fee-for-service" option under the Medicare Choice program. We are concerned that private fee-for-service plans in Medicare Choice represent bad policy, particularly given the fact that these plans will be subject to no balance billing or quality protections. We are also concerned that this option will attract primarily healthy and wealthy beneficiaries and leave sicker and poorer beneficiaries in the more expensive, traditional Medicare program. In addition, it could disproportionately attract rural beneficiaries if the few providers in their area choose to leave traditional Medicare and form private fee-for-service plans.

The second provision would allow physicians to obtain private contracts from beneficiaries whereby the beneficiary would agree to pay whatever the physician charged (i.e., waive balance billing limits) and agree not to submit a bill to or collect anything from Medicare. The beneficiary would be totally responsible for out-of-pocket expenses for the physician's entire bill, even though the service would be covered by Medicare if the bill were submitted to Medicare. As a result, we are concerned that private agreements could become licenses for physicians to coerce beneficiaries, exposing beneficiaries to unlimited liability and making meaningless the Medicare coverage they have paid for.

The third provision would allow Durable Medical Equipment (DME) suppliers to bill Medicare beneficiaries for amounts beyond cost-sharing for "upgraded" DME items, while still accepting assignment. Beneficiaries already have the option of choosing upgraded DME under current law. We are concerned that this new option undermines limits on beneficiaries' out-of-pocket payments and, as a result, could permit suppliers to take advantage of beneficiaries.

Medical Savings Accounts. We believe that any demonstration of this concept should be limited in order to minimize potential damage and costs to Medicare. We commend the Senate for limiting the demonstration to 100,000 participants, but we believe a successful demonstration could be structured with fewer participants. In any case, we want this demonstration to be as small as possible. We also commend the Senate for limiting cost-sharing and deductibles to amounts enacted under the Health Insurance Portability and Accountability Act (HIPAA). But, we still prefer a geographically-limited demonstration that applies current law limits on balance billing to protect beneficiaries from additional provider charges. We urge the Conferees to limit this demonstration numerically (within the numbers outlined above) and geographically for a trial period (two States for three years), enabling us to design the demonstration to answer key policy questions.

Preventive Benefits. We are pleased that the preventive benefits in the House and Senate bills are largely the same as those in the President's budget. Unlike the budget, however, the House and Senate bills do not waive all cost sharing (coinsurance and deductibles) for mammograms. Research shows that copayments hinder women from fully taking advantage of this benefit. We urge the Conferees to modify the House and Senate provisions to waive all cost sharing for mammograms.

Medigap. The President's budget advanced a number of important Medigap reforms, including annual open enrollment, community rating, initial open enrollment for disabled and kidney dialysis beneficiaries, and various portability provisions. We are disappointed that neither the House or Senate adopted certain of these reforms. The Senate bill took the largest strides toward these important reforms, providing for an initial open enrollment period for disabled beneficiaries and a trial period for managed care enrollees. We urge the Conferees to adopt at least the Senate provisions, and to fully consider the President's suggested additional reforms.

Medical Malpractice. The House bill includes malpractice provisions that are extraneous to the budget agreement. The Administration has consistently made it clear that we find these provisions objectionable, and we urge the Conferees to delete them.

Provider Sponsored Organizations. Another step forward in both bills is their inclusion of provider sponsored organizations (PSOs) as Medicare options. We are concerned, however, about the lack of minimum private enrollment requirements and aspects of the PSO definition, and we look forward to working with the Conferees on these issues.

Managed Care Payments. We agree that the current unjustifiable geographic variation in payments to managed care plans should be remedied as part of the reconciliation bill. We prefer the House proposal, which mitigates the geographic variation in payments and maintains the link to fee-for-service payments, along with an adjustment for adverse selection. Various payment provisions in the Senate bill, some of which are individually justifiable, together have a significant negative impact on areas with a high managed care enrollment and could lead to abrupt changes in additional benefits now provided to Medicare enrollees. The Senate proposal also ties growth in managed care payments to growth in gross domestic product (GDP). We prefer a less disruptive payment proposal and one that ties growth in payments to growth in fee-for-service Medicare. Limiting managed care payment growth to GDP effectively creates two growth rates for Medicare payments, leading to an erosion of the value of the Medicare Choice benefit package and exposing beneficiaries to increased premiums.

Managed Care Risk Adjustment. The Senate bill includes immediate implementation of an untried, "new enrollee" risk adjustment methodology that would be applied in an inequitable manner (exempting some plans) and that would be replaced by a different revised

methodology two years later. We prefer to implement a managed care risk adjustment methodology once -- and sooner. Therefore, we support the House provisions on risk adjustment, modified to authorize the collection of hospital discharge data immediately and to authorize implementation of the risk adjustment methodology in 2000.

Medical Education/Disproportionate Share (DSH) Carve-out. The President's 1998 budget proposed to move medical education (indirect and direct) and DSH adjustments out of managed care payment rates and redirect them to eligible hospitals that provide services to Medicare managed care enrollees. This important proposal would ensure that the Nation's teaching hospitals and those that serve low-income populations receive the Medicare payments to which they are entitled. The Senate and the House Commerce Committee adopted these provisions, and we urge the Conferees to adopt them as well.

Managed Care Enrollment. We urge adoption of the Senate provisions with regard to open enrollment. The House bill permits beneficiaries to be locked into a MedicarePlus plan for as long as nine months, after a lengthy transition period. We continue to support the monthly disenrollment option as an important safety valve for managed care enrollees who are dissatisfied with their managed care plan.

Managed Care Quality. Both the House and Senate bills go far to ensure quality in Medicare managed care. The House bill, however, has an objectionable provision allowing external quality review requirements to be met through accreditation. The House bill also contains a similar provision in its Medicaid title. We prefer maintaining a true requirement for external quality review to protect beneficiaries in this rapidly changing marketplace, as the Senate bill provides.

Medicare Commission. Both the Senate and House bills would establish a Medicare commission. We believe strongly that a mutually agreeable, bipartisan process is essential to successfully address the long-term financing challenges facing Medicare. We look forward to working with you to develop the best possible bipartisan process to address those challenges while simultaneously ensuring the sound restructuring of Medicare to continue to provide high-quality care for our Nation's senior citizens.

Office of Competition. The Senate bill would create an Office of Competition within HHS to administer competitive pricing demonstrations. We believe this provision would create unnecessary duplication of staff and resources within HHS and become a potential source of confusion for Medicare beneficiaries and plans. We are also concerned about certain aspects of the competitive pricing demonstration, and we look forward to working with the Conferees to ensure that the demonstration authority would lead to valid and verifiable results.

Hospital Payment Systems. We have several concerns with various House and Senate provisions relating to hospital payments, including: the Senate provision to move the hospital update to a calendar year basis while leaving all other changes to PPS payments on a fiscal year basis, thus requiring two separate payment rules; the Senate provision on hospital transfers, which does not include home health agencies and which we believe creates a strong, unjustified payment bias to use home health services for post acute care; and the Senate provision to provide large bonus payments for certain PPS-exempt facilities, which could lead to a significant redistribution of funds among PPS exempt facilities.

Medicare Disproportionate Share Payments (DSH). We look forward to working with Congress to develop a new adjustment for hospitals that serve a disproportionate share of low-income individuals. We want to improve the current adjustment to create a better measure of services to indigent populations so that we can better target DSH payments. But, we oppose any cuts to the current DSH adjustment in the interim. We have proposed to freeze the adjustment for the next two years to ensure that vulnerable hospitals serving large numbers of uninsured and under-insured patients are not burdened with excessive cuts.

Medicare Secondary Payer (MSP). Both the House and Senate bills limit the time period for MSP recovery to three years after the date of service. We urge the Conferees to adopt a five-year time limit, consistent with the President's proposal. The IRS/SSA data match does not provide information in a timely enough manner to be able to recover overpayments within a three-year window. We also urge the Conferees to adopt our insurer reporting proposals.

Implementation Issues. We are concerned about how the full scope of the House and Senate provisions would affect HHS' administrative abilities and resources necessary to implement them. We urge the Conferees to consider changes in the effective dates of the provisions so they are consistent with the funding levels that the budget agreement provided to the Health Care Financing Administration (HCFA).

Medicaid

We commend the House and Senate for reporting bills that conform to many of the Medicaid reform principles of the budget agreement. Both achieve savings through lower disproportionate share hospital payments (DSH) and greater State flexibility. Both bills give States more flexibility to manage their Medicaid programs by repealing the Boren amendment, allowing managed care without Federal waivers, and eliminating unnecessary administrative requirements. We also commend the Senate for including managed care quality standards that are consistent with the President's consumer protection framework.

Nevertheless, the House and Senate bills contain provisions that are inconsistent with the budget agreement.

First, the budget agreement includes a provision to restore Medicaid for current disabled children losing Supplemental Security Income (SSI) because of the new, more strict definition of childhood eligibility. The Senate bill does not include this proposal. The House bill allows, but does not require, States to provide Medicaid benefits for about 30,000 children who could lose their health care coverage in fiscal 1998. We strongly urge the Conferees to conform to the budget agreement by including the provision from the President's budget that would guarantee coverage to these children, and allocate the necessary funds for this purpose.

Second, the budget agreement includes a 70 percent Federal matching payment for Medicaid in the District of Columbia. We are pleased that the Senate bill includes a higher matching payment, but we are concerned that it is not sufficient; it sunsets at the end of fiscal 2000 and is 10 percentage points lower than the 70 percent that the budget agreement called for. A 60 percent matching rate would still leave the District paying a higher share of its Medicaid program than any other local government. We urge the Conferees to include the provision from the agreement.

The budget agreement also includes adjustments for the Medicaid programs in Puerto Rico and the territories. We are pleased that the Senate includes adjustments for those programs, but we would prefer that the Conferees include the language in the President's 1998 budget.

The Administration has significant concerns with other House and Senate provisions that we urge the Conferees to address.

Assistance for Low-Income Medicare Beneficiaries. The Senate bill includes \$1.5 billion in premium assistance for low-income beneficiaries through a Medicare block grant to States. The House provides \$1.5 billion to expand eligibility to Medicaid but does so, in part, through an administratively complex formula subsidizing only a portion of the Part B premium. We prefer a simpler approach that would finance the cost of the full Part B premium through Medicaid. In addition, we object to the Senate provision that sunsets this assistance in 2002; low-income senior citizens will still need this assistance after that date.

Medicaid Cost Sharing. The Senate bill would allow States to require limited cost sharing for optional benefits. We are pleased that a Senate amendment would bar States from imposing cost sharing on children under 18 in families with incomes below 150 percent of poverty. But, we are still concerned that the bill may compromise beneficiary access to quality care. Low-income elderly and disabled Medicaid beneficiaries may forgo needed services if they cannot afford the copayments.

Disproportionate Share Hospitals -- Allocation to States. We have concerns about the House and Senate allocations and levels of DSH payment reductions among States. As in the DSH policy of the 1993 budget reconciliation bill, this year's policy should address past abuses without causing undue hardship on any State. We are seriously concerned, however,

that the House and Senate bills may have unintended distributional effects among States. We urge the Conferees to adopt the President's 1998 budget proposal, which takes an equal percentage off of States' total DSH spending up to an "upper limit," ensuring that States with the highest DSH spending do not bear most of the impact.

Disproportionate Share Hospitals -- Targeting to Hospitals. The House bill does not retarget DSH funds. The Senate bill would require States to develop DSH targeting plans, but it does not include a Federal DSH targeting standard. As we have said previously, we believe that significant DSH savings should be linked to a Federal standard for targeting the remaining DSH funds to needy hospitals. Without such standards, providers with high-volume Medicaid and low-income utilization may not be sufficiently protected from DSH reductions.

In addition, the House bill would require States to make DSH payments directly to qualifying hospitals, and would not allow States to make DSH payments through capitation payments to managed care organizations. The Senate bill does not include this provision. We urge the Conferees to adopt the House provision, ensuring that all eligible hospitals receive a Federal DSH payment regardless of their contract, or lack of a contract, with a particular HMO.

§1115 Extensions and Provider Tax Waiver. The House and Senate bills would extend expiring §1115 Medicaid waivers. The Senate would deem approved §1115 waivers without regard to whether they will increase spending. In addition, the Senate bill would deem provider taxes as approved for one State. We have serious concerns about these provisions and would like to work with the Conferees to address the underlying problems.

Return to Work. We are pleased that the Senate bill would allow States to allow workers with disabilities to buy into Medicaid. But we urge the Conferees to adopt the version of this proposal from the President's 1998 budget, which would not limit eligibility for this program to people whose earnings are below 250 percent of poverty. We believe that the Senate-proposed limit would not give States enough flexibility to remove disincentives to work for people with disabilities.

Criminal Penalties for Asset Divestiture. The Senate bill would amend Section 217 of the Health Insurance and Portability and Accountability Act 1996 (HIPAA) to provide sanctions against those who help people to dispose of assets in order to qualify for Medicaid. We prefer to repeal section 217 because we believe that the Medicaid laws in effect before HIPAA are sufficient to protect Medicaid against inappropriate asset divestiture.

Management Information. The President's 1998 budget included a major reduction in unnecessary administrative burdens on the States, but ensured that States collect sufficient information to effectively manage their Medicaid programs. The House approach would require States to show that their State-designed systems meet outcome-based performance

standards and would permit the collection and analysis of person-based data. The Senate did not include this provision. We urge the Conferees to adopt the House provision.

Alaska FMAP Change. The Senate bill would increase Alaska's Federal Medical Assistance Percentage (FMAP) above the level of the current law formula. While we have consistently supported efforts to examine alternatives to the current Medicaid matching structure, we believe that changing the FMAP for Alaska alone is unwarranted and does not address the underlying inequities in the current system.

Children's Health

We are pleased that the children's health initiative is in both the House and Senate bills. In fact, the Senate bill goes beyond the \$16 billion that the budget agreement provides, adding another \$8 billion, which is a portion of the revenue from a 20-cent increase in the tobacco tax.

We support a 20-cent increase in the tobacco tax — we agree that it complements the budget agreement — and we endorse the idea of using all of the revenues raised by such an increase for initiatives that focus on the needs of children and health. We urge the Conferees to invest all of these funds wisely in order to ensure meaningful coverage for millions of uninsured children. In addition, we especially support the Senate provisions for benefits and cost sharing.

Notwithstanding these achievements, we have serious concerns about the following House and Senate provisions, which we urge the Conferees to address.

Sunset of Tobacco Tax Revenue for Children's Health. Although we commend the Senate for supporting the use of the tobacco tax for children's health, we urge the Conferees to continue this funding after 2002. A sudden drop in funding in 2003 would cause many of the newly-insured children to lose their coverage.

Meaningful Benefits, Cost Sharing/Direct Services. The budget agreement calls for the children's health investment to go for health insurance coverage. Thus, we support the Senate's definition of benefits and its limits on cost sharing, the latter of which will ensure that low-income children do not shoulder unrealistically high costs that could lead to reduced access to needed health care. We do not support the direct services option of the House bill because we are concerned that a State could spend all of its money on one benefit or to offset the effects of the DSH cuts on certain hospitals, and that children would not be assured appropriate coverage. In our view, this provision does not fulfill the commitment of the budget agreement to provide "up to five million additional children with health insurance by 2002."

Funding Structure. We support the straightforward funding structure of the House bill. But its proposal for different matching rates for Medicaid and the grant option could discourage States from choosing Medicaid. We believe Medicaid is a cost-effective approach to covering low-income children, and we support using the same matching rates for both options. In addition, we support the House provision that gives States the flexibility to spend their grant money on Medicaid, a grant program, or a combination of the two. The Senate bill requires States to choose between Medicaid and a grant option.

Eligibility. The Senate bill includes a ceiling of 200 percent of poverty. We agree that the funds should first go for insurance coverage for low-income uninsured children, but we believe income ceilings would limit States' flexibility to design programs that best fit their needs.

Use of Funds. We want to ensure that the investment in children's health goes to cover children who currently lack insurance, rather than replace existing public or private funds for children's health insurance. Thus, we support a strong maintenance of effort provision and the prohibition on using provider taxes and donations to fund the State share of the program. In addition, we want to ensure that the funds are used in the most cost-effective manner to provide coverage to as many children as possible. Therefore, we do not support provisions that allow States to pay for family coverage or pay the employee's share of employer sponsored insurance.

Expansion of the "Hyde Amendment"

Both the House and Senate bills would expand the Hyde Amendment prohibitions on Medicaid payment for abortion services to include spending on the children's health initiative, and to codify these prohibitions in permanent law. This provision could deny access to abortion services to poor women to the extent that States choose to use the children's health funding to offer family coverage, as the House bill would permit. As we have repeatedly said, we do not support limiting access to medically necessary benefits, including abortion services.

In addition, the Senate bill contains a provision that redefines the term "medically necessary services" in the context of managed care sanctions to exclude abortion services except under certain circumstances. We oppose this attempt to further constrain the availability of abortion services through this provision, and we strongly urge the Conferees not to begin writing into the Medicaid law permanent, restrictive definitions of what are "medically necessary" services -- an issue that is more appropriately decided by health professionals.

Multiple Employer Welfare Arrangements (MEWAs)

The House bill allows for Multiple Employer Welfare Arrangements (MEWAs) by including language from H.R. 1515, the "Expansion of Portability and Health Insurance Coverage Act of 1997," while the Senate bill includes no such provisions. We strongly oppose including provisions from H.R. 1515 because the bill has inadequate consumer protections and could lead to premium increases for small businesses and employees who may bear the burden of adverse selection. H.R. 1515 would transfer the regulation of a large health insurance market away from the States by preempting State laws under the Employee Retirement Income Security Act ("ERISA"). This far-reaching proposal demands much greater analysis and discussion. We also oppose the provision of the House and Senate bills that would allow a religious fraternal benefit society plan to establish a Medicare Choices plan; it would set a precedent for allowing association health plans (such as those allowed under the House MEWA language) to become Medicare Choice providers.

Continued SSI and Medicaid Benefits for Legal Immigrants

We are pleased with several provisions in the House and Senate bills. Both bills would grandfather immigrants who were receiving SSI benefits as of August 22, 1996, as the President indicated he would support in a June 20 letter to Budget Committee Chairman Kasich and Ranking Member Spratt. Both bills also extend the exemption period from five to seven years for refugees, asylees, and those who are not deported because they would likely face persecution back home.

We are pleased that the Senate bill, which restores SSI and Medicaid eligibility for all legal immigrants who are or become disabled and who entered the U.S. prior to August 23, 1996, implements the budget agreement. The House bill, however, does not. It fails to fully restore SSI and Medicaid benefits for all legal immigrants who are or become disabled and who entered the U.S. prior to August 23, 1996. As the President stated in his June 20 letter, he will not sign legislation that does not include the policy, as the budget agreement calls for, that protects disabled immigrants. Compared to the budget agreement, the House bill would protect 75,000 fewer immigrants by 2002. We strongly urge the Conferees to adopt the Senate approach.

In addition, if resources are available, we urge the Conferees to support several other Senate provisions. The Senate bill restores Medicaid coverage for future immigrant children; provides SSI and Medicaid to immigrants who are too disabled to satisfy the requirements to naturalize; and provides the same exemption period for Amerasian and Cuban Haitian immigrants as for refugees. We look forward to working with you on these matters.

Additional Work Slots for Individuals Subject to the Food Stamp Time Limits

The budget agreement included \$1.5 billion in additional Food Stamp funding to encourage work and give States the flexibility to exempt individuals from Food Stamp time limits due to hardship. The agreement specifically states that existing Food Stamp Employment and Training funds will be redirected and new capped mandatory funding added "to create additional work slots for individuals subject to the time limits," and it provides \$1 billion for this purpose.

We appreciate that the House and Senate bills would implement the 15 percent hardship exemption, consistent with the agreement. But, we are concerned that both bills create significantly fewer job opportunities than the five-year target of 350,000 slots -- 70,000 a year -- that the negotiators discussed. We are particularly concerned about the House bill, which would create 100,000 fewer slots than the President's proposal and about 40,000 fewer than the Senate approach over five years. The House bill also does not reflect the agreement because it does not target the funding to workslots for individuals facing the time limits. We believe the final bill should follow the Senate approach in targeting funds to work slots that meet the welfare reform law's tough requirements for Food Stamp recipients, and establishing performance standards to reward States that create additional work opportunities. We urge the Conferees to follow the Senate approach, with the House maintenance of effort provision, to make it fully consistent with the budget agreement.

Welfare to Work

We are pleased that the House and Senate bills would address many of our priorities for the welfare-to-work program to some degree, including: the provision of formula grant funds to States based on poverty and adult welfare recipients; a sub-State allocation of the formula grants to ensure targeting on areas of greatest need; appropriate flexibility for grantees to use the funds for a broad array of activities that offer the promise of permanent placement in unsubsidized jobs; some funds awarded on a competitive basis; and a substantial set-aside for evaluation. We look forward to working with the Conferees to refine these provisions.

We continue to be concerned, however, about several priority issues. In some cases, only one Chamber has adequately addressed our concerns; in others, neither has. The issues that concern us the most are highlighted below, and we urge the Conferees to address them.

Targeting Welfare-to-Work Funding to Cities and Counties with Large Poverty Populations. The challenge of welfare reform -- moving welfare recipients into permanent, unsubsidized employment -- will be greatest in large urban centers, especially those with the highest number of adults in poverty. Recognizing this fact, the budget agreement provided that funds be allocated and targeted to areas with high poverty and unemployment. While

both the House and Senate bills include formulas to target funds to these areas to some degree, of the three provisions in conference, the Ways and Means provision of the House bill best accomplishes this goal through its division of funds between formula (50 percent) and competitive (50 percent); its formula grant sub-State allocation factors and method of administration; and its reserving of 65 percent of competitive grants for cities with large poverty populations. We urge the Conferees to adopt the Ways and Means proposal.

Local Program Administration. The budget agreement provided not only that welfare-to-work funds be targeted to high-poverty and high unemployment areas, but that a share of them go to cities and counties. We strongly believe that cities and other local areas should manage a substantial amount of all welfare-to-work funds. These entities can most effectively move long-term welfare recipients into lasting unsubsidized employment that cuts or ends dependency. Recognizing this fact, the House provisions use existing structures to help accomplish this goal. We urge the Conferees to adopt these provisions.

Federal Administering Agency. Both bills would require consistency with Federal TANF strategies and focus resources on achieving the goal of moving long-term welfare recipients into lasting jobs. We agree with the need for consistency and with the goal, and we believe we can most effectively achieve it if we closely align welfare-to-work activities with the workforce development system that the Secretary of Labor oversees. Thus, we believe the Secretary should administer this program in consultation with the Secretaries of HHS and HUD, as included in titles V and IX of the House bill.

Performance Fund. We are pleased that the Senate recognized the value of a performance bonus concept. The Senate performance approach, however, simply augments the existing TANF performance fund in 2003, with no link to the performance that welfare-to-work funds achieve. We want to work with the Conferees to develop an effective mechanism to provide needed incentives and rewards for placing more of the hardest-to-serve in lasting unsubsidized jobs that promote self-sufficiency. A possible approach could include requiring the Governors to use a share of their discretionary funds to reward high-achieving welfare-to-work programs.

Distribution of Funds by Year. The House provides for a two-year program, with \$1.5 billion in 1998 and in 1999. The Senate bill provides for a three-year program. We want to work with the Conferees to ensure that the final bill includes an outlay pattern consistent with an estimate of zero outlays in fiscal 2002, as the budget agreement calls for. Congress could modify the Senate proposal, for instance, by requiring that no resources are spent after fiscal 2001.

Minimum Wage and Workfare

We applaud the Senate for not modifying current law with respect to applying the minimum wage and other worker protections for working welfare recipients under TANF. The minimum wage and welfare work requirement proposals in the House-passed bill were not part of the budget agreement and, had they come up in the negotiations, we would have strongly opposed them. We believe strongly that everyone who can work must work, and everyone who works should earn at least the minimum wage and receive the protections of existing employment laws — regardless of whether they are coming off welfare.

As a result, we continue to have serious concerns that certain welfare recipients would not enjoy the status of employees under the House bill and, thus, would not receive worker protections. Although the House bill moves toward ensuring that welfare recipients in work experience and community service receive the minimum wage, it fails to provide an effective enforcement mechanism. Also, while the House bill contains some protections against discrimination and threats to health and safety, we believe that its limited grievance procedures are inadequate to ensure welfare recipients receive the same protections as regular employees, and regular employees receive protection against displacement. In addition, the Administration strongly believes that we must retain the welfare law's strict emphasis on work and oppose provisions to permit States to count additional time spent in activities such as job search toward the work requirements.

We urge the Conferees to adopt the Senate position on the minimum wage, which makes no changes to current law, and to extend the Senate provisions on grievance procedures and worker protections to all working welfare recipients under TANF.

Non-Displacement

While we support the Senate provisions that include worker displacement language from H.R. 1385 (the House-passed job training reform bill), we urge the Conferees to apply these enhanced non-displacement protections to all welfare recipients moving from welfare to work, as the House does, not just to welfare-to-work funds. In addition, we urge the Conferees to accept the House provision that ensures that the Federal Government will not pre-empt State non-displacement laws that provide greater worker protections than Federal law.

Unemployment Insurance

We are pleased that the House and Senate have included the Unemployment Trust Fund ceiling adjustment and special distribution to the States that were part of the budget agreement.

The House bill also includes the provision of the agreement that achieves \$763 million in mandatory savings over five years by authorizing an increase in discretionary spending for unemployment insurance "program integrity" activities of \$89 million in 1998 and \$467 million over five years. We urge the Conferees to adopt the House language. In addition, we are seeking budget process provisions to allow for discretionary funding for these activities and the resulting savings.

Repeal of Maintenance of Effort Requirement on State Supplementation of SSI Benefits

We are pleased that the Senate bill does not repeal the maintenance of effort requirement on State supplementation of SSI benefits. We strongly oppose the House provision, which would let States significantly cut, or even eliminate, benefits to nearly 2.8 million poor elderly, disabled, and blind persons. Congress instituted the maintenance of effort requirement in the mid-1970s to prevent States from effectively transferring Federal benefit increases from SSI recipients to State treasuries. The House proposal also could put at risk low-income elderly and disabled individuals who could lose SSI entirely and possibly then lose Medicaid coverage. We opposed this proposal during last year's welfare reform debate, and we urge the Conferees to follow the Senate approach and not repeal the State maintenance of effort requirement for State supplementation of SSI benefits.

Spectrum

We support a number of the spectrum-related provisions in the Senate and House bills. We believe, however, that the Senate bill is more consistent with the goals and targets in the budget agreement, and we urge the Conferees to use it as the basis for conference negotiations. Specifically, the Senate bill provides for reimbursing Federal agencies for the costs of relocating to new spectrum bands, so that the Federal Communications Commission (FCC) can auction, for commercial use, the spectrum that they are now using. This key provision is essential to prevent agencies from making future multi-billion dollar requests for additional discretionary funding.

We have other significant concerns with both bills. First, they fall over \$6 billion short of the savings targets of the budget agreement. They both fail to include two proposals that the agreement specifies -- the auction of "vanity" toll-free telephone numbers (which would raise \$0.7 billion) and the spectrum fee (which would raise \$2 billion). In addition, neither bill contains a firm date for terminating analog broadcasting (as the budget agreement assumed), which reduced the CBO's scoring of the House bill by \$2.9 billion, and of the Senate bill by \$3.4 billion. Any delay in returning analog broadcast spectrum will likely impede the rapid build-out of digital technology, delay job creation and consumer benefits, and reduce revenues from spectrum auctions. We urge the Conferees to conform the final bill to these provisions of the budget agreement.

We also request that the Conferees delete the House language that specifies spectrum bands and bandwidth for reallocation; repeals the FCC's fee retention authority; waives the duopoly/newspaper cross-ownership rules; and accelerates payments from the universal service fund. These provisions conflict with good telecommunications policy, and with sound and efficient spectrum management policy. We also urge the Conferees to amend the overly expansive definition of "public safety" of the bills; to delete mandated minimum bid requirements; and to include provisions that would authorize the FCC (1) to revoke and reassign licenses when an entity declares bankruptcy, and (2) to use economic mechanisms (such as user fees), other than auctions. We support Senate provisions requiring the FCC to explain its rationale if it cannot accommodate relocated users in commercial spectrum and to consult with the Secretary of Commerce and the Attorney General on assigning new spectrum made available for public safety.

TANF Transfers to Title XX

We oppose the House provision to allow States to divert TANF funds away from welfare-to-work efforts to other Title XX social service activities. The Senate bill includes no such provision. The budget agreement did not address making changes in the Title XX transfers provisions, and we strongly urge the Conferees to drop these provisions.

Vocational Education in TANF

We are concerned with the House and Senate provisions on vocational education in TANF. The House bill includes two sets of provisions – one from the Ways and Means Committee, the other from the Education and Workforce Committee – which narrow the base of eligible recipients against which the cap on vocational education applies. The Ways and Means Committee excluded teen parents in school from the cap, and set the cap at 30 percent of the narrower base. The Senate bill maintains the existing base, but removes teen parents who attend school from the 20 percent cap on vocational education. The budget agreement did not address changes in TANF work requirements regarding vocational education and educational services for teen parents, and we urge the Conferees to drop these provisions.

State SSI Administration Fees

The House bill includes a provision, consistent with the budget agreement, to raise the fees that the Federal Government charges States for administering their State supplemental SSI payments and to make the increase available, subject to appropriations, for SSA administrative expenses. This proposal would collect about \$380 million over five years, to be spent upon receipt for this purpose. The Senate bill does not reflect this provision of the budget agreement, and evidently assumes that the Appropriations Committee will implement

the proposal. The agreement, however, anticipated revenue from this proposal over the full five years and, as part of the reconciliation bill, Congress should raise the fees and make the increased revenue available, subject to appropriations. Consequently, we urge the Conferees to adopt the House provision.

Housing

We are pleased that the House and Senate bills include provisions to produce savings by reforming the FHA Assignment program and making appropriate reductions to Section 8 annual adjustment factors. We are concerned, however, about two additional provisions of the Senate bill.

The Senate bill would not transform FHA multifamily housing restructuring in the most efficient, effective fashion. By ruling out the possibility of portable tenant-based assistance, the bill would limit tenants' ability to find the best available housing and prevent projects from developing a more diverse mix of income levels. By establishing a preference for delegating restructuring tasks to housing finance agencies, the bill places an unnecessary constraint on HUD's ability to design the most effective partnerships. Finally, since Congress did not address tax issues explicitly, the Senate bill does not resolve impediments that could discourage owners from participating in a restructuring process.

We oppose the inclusion, in the reconciliation bill, of Section 2203 of the Senate bill, which repeals Federal preferences for low-income or disadvantaged individuals for the Section 8 tenant-based and project-based programs. We have supported such repeals only if they come with income targeting that would replace the Federal preferences. That targeting would ensure: (1) that the tenant-based program continues to mostly serve extremely low income families, with incomes below 30 percent of the area median income, and (2) that all developments in the project-based program are accessible to a reasonable number of extremely low-income families. We are working with Congress on this issue in the broader context of separate public housing reform legislation.

Privatization of Welfare Programs

The House bill would allow for privatizing eligibility and enrollment determination functions in Medicaid and Food Stamps. While certain program functions, such as computer systems, can now be contracted out to private entities, the certification of eligibility for benefits and related operations (such as obtaining and verifying information about income and other eligibility factors) should remain public functions. Thus, we strongly oppose the House provision, and we urge the Conferees to drop it.

Student Loans

We are pleased that both bills include \$1.8 billion in outlay savings, including \$1 billion in Federal reserves recalled from guaranty agencies, \$160 million from an end to the fee paid to institutions in the Direct Loan program, and \$603 million in reduced Federal student loan administrative costs. All of these provisions are consistent with the budget agreement, and the savings are achieved without raising costs on, or reducing benefits to, students and their families.

But, we oppose a provision in both bills, unrelated to the budget agreement, requiring administrative cost allowances (ACAs) to guaranty agencies in the Federal Family Education Loan (FFEL) program at a rate of .85% of new loan volume -- paid from mandatory funding authorized under Section 458 of the Higher Education Act of 1965 (HEA) from 1998 to 2000. This provision would create a new Federal entitlement, and it would inappropriately limit the funds available to the Secretary to effectively manage the FFEL Program. Any allowance to these agencies should bear some relationship to the costs these agencies incur, and should not be based on an arbitrary formula. This is an issue more appropriately left for the Higher Education Act (HEA) reauthorization.

We strongly prefer the House language for cutting student loan administrative costs. It specifies that the Education Department may use administrative funds authorized under section 458 of the HEA to operate the FFEL program and the Direct Loan program. Under the Senate language, the Secretary would lack adequate funds to administer the FFEL program effectively.

We also oppose a House provision that would stipulate that an 18.5 percent guaranty agency retention allowance on default collections that result from defaulted loans reentering repayment through loan consolidation. This provision, now specified in regulation and letters as "up to" 18.5 percent, would codify this share at 18.5 percent without regard to the actual expenses that the guaranty agencies incur. This issue also should be resolved in the upcoming HEA reauthorization.

Smith-Hughes

We are pleased that the House bill would repeal the Smith-Hughes Act of 1917 and is consistent with the budget agreement. The Senate bill does not include such a provision, although it finds the agreed-upon \$29 million savings from the student loan programs. In light of the \$1.2 billion annual appropriation under the Carl D. Perkins Vocational and Applied Technology Education Act, we see no justification for \$7 million in mandatory spending a year under Smith-Hughes. We urge the Conferees to adopt the House provision.

Budget Process

On budget process, the House and Senate bills generally follow the budget agreement. We appreciate the provisions to extend the discretionary caps to 2002 at the levels in the agreement, to create a firewall between defense and non-defense spending for 1998-99, to provide an adjustment for international arrears and for an IMF quota increase and the New Arrangements to Borrow, and to otherwise extend and update the Budget Enforcement Act along the lines of the budget agreement.

In some respects, however, the House or Senate bills are not fully consistent with the budget agreement. For instance, both bills provide that only net deficit increases in the prior year, rather than both increases and decreases, would count under the paygo "lookback" procedure. In addition, the House bill is inconsistent with the agreement (and with the Senate bill) with regard to "paygo" requirements.

In other respects, the bills include provisions about which we have serious concerns. For instance, the House bill does not provide for the transportation reserve funds that the budget resolution established for highways, Amtrak and transit. Also, one or both of the House and Senate bills do not include several technical changes to fully extend the Budget Enforcement Act. These changes include a budget authority allowance for technical estimating differences between CBO and OMB, as current law provides; a reserve fund for unemployment integrity to carry out the mandatory savings of the agreement; and a technical change to the existing Continuing Disability Reviews (CDR) adjustment to account for the conversion of obligation limitations to budget authority. In addition, the House bill would require a cumbersome notification procedure for the detailed scoring of each paygo or appropriations bill.