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**AGRICULTURE COMMITTEE
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FAX TRANSMISSION COVER SHEET

TO: Chris Jennings

DATE: July 19, 1997

FAX #: _____

NO. OF PAGES FOLLOWING: 5

___ THE HONORABLE CHARLES W. STENHOLM

___ AUER, LOIS

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Comments: Use as helpful

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The Coalition

July 11, 1997

The Honorable Bill Clinton
The White House
Washington, DC 20500

Dear Mr. President:

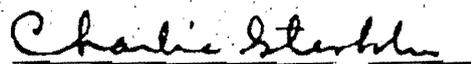
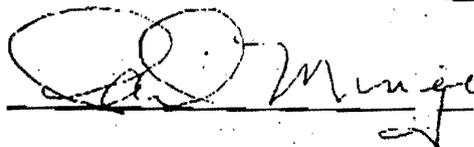
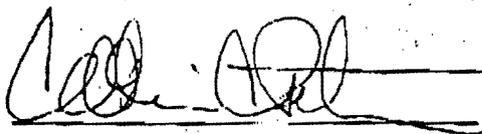
As members of the Coalition, we look forward to working with you to enact a credible balanced budget plan built on sound, sustainable policies that have bipartisan support. We applaud the work that you and others have done to bring us to this point. However, we recognize that much work remains to be done to enact legislation to implement the balanced budget agreement.

As you know, we proposed a balanced budget plan that was based on the twin principles of credible deficit reduction and sound public policy. While we are pleased that the budget agreement reflects the policies in the Coalition budget in several areas, we are concerned that many of the policies contained in the agreement fall short of the principles outlined in the Coalition budget. While we recognize that the budget agreement limits the flexibility of the conferees and the administration to make dramatic changes in the plan, we believe that it is possible to address many of our concerns within the scope of the conference and the budget agreement.

The attached document outlines our priorities in the upcoming conference. We will evaluate a conference report based on five basic principles. First, it must provide credible deficit reduction. Second, it must include comprehensive budget enforcement provisions. Third, tax cuts must be targeted to productive investments, small businesses and farmers. Fourth, the Medicare and Medicaid policies should reduce the long-term growth of these programs while protecting the availability and quality of care. Finally, provisions in the agreement providing increased funds for priority programs should be structured to accomplish the goals of the program in the most cost-effective manner possible. We will enthusiastically support reconciliation legislation that incorporates these principals.

We look forward to working with you to enact a balanced budget plan that we can all be proud of. Thank you for your consideration.

Sincerely,



Allen Boyd

Jim Turner

Marion Berry

Virgil Good

Norman Smith

Scotty Barber

Tai Hall

Mike McIntyre

Ann Pinner

Jim Turner

Chill

BUD CRAMER

Credible Deficit Reduction

We remain concerned that the budget agreement would postpone the overwhelming majority of the deficit reduction until the final years of the plan and allows the deficit to remain at unacceptably high levels for the next three years. The final reconciliation legislation we enact this year should put the deficit on an immediate glidepath to balance by 2002. Just as importantly, the policies we enact should move us toward a unified budget surplus that allows us to ultimately balance the budget without relying on trust fund surpluses, instead of policies that may cause the deficit to increase after 2002. Although the parameters of the budget agreement and the scope of the conference limit the ability to improve the deficit glidepath in the budget, there are several steps that we urge you take:

- **Maximize savings in conference.** In programs such as Medicare where the House and Senate have approved different methods of achieving the savings targets, the conferees should combine the proposals from both bills wherever possible to achieve the maximum amount of savings.
- **No backloaded tax cuts.** Tax proposals with costs that mushroom in the next century, such as indexation of capital gains and backloaded IRAs, should not be included in the conference report.
- **Steady growth of tax cuts.** The tax bill should be structured to ensure that the size of the tax cut does not grow substantially faster than the growth of the economy.

Budget Enforcement

Passage of a reconciliation bill that is projected to balance the budget by 2002 does not guarantee that the budget will actually be balanced in 2002. Inclusion of comprehensive budget enforcement provisions applied to all portions of the budget is critical to ensuring that this budget agreement meets its promise of balancing the budget by 2002. The Bipartisan Balanced Budget Enforcement Act has several key features:

- **Budget targets.** Establishes budget targets for each year from 1998 through 2002 based on the projected deficit, spending and revenue levels in the budget agreement. The President's budget and Congressional budget resolutions must meet the targets in each year unless Congress explicitly votes to change the targets.
- **Increased accountability.** Requires Congress and the President to take corrective action if the deficit increases because spending grows faster than expected or revenues are lower than projected.
- **Enforcing spending and revenue levels.** Establishes an enforcement mechanism that would be triggered if Congress and the President fail to take action. The enforcement mechanism would be targeted to the portion of the budget that causes a problem. Spending programs that grow faster than this budget assumes would be sequestered; the phase-in of tax cuts would be delayed if revenues are lower than assumed under this budget.
- **Limitation on emergency spending.** Restricts the ability of Congress and the President to evade budget rules by limiting the use of the exception for emergency spending.

Targeting tax cuts to productive investments, small businesses and farmers

The tax bill should be structured to encourage investment in activities that promote economic growth and jobs without causing the budget to become unbalanced after 2002. Specifically, we support:

- **Immediate estate tax relief.** The exemption for closely held businesses should be immediately increased to \$1 million, and the unified exemption should be increased to \$1.2 million by 2004.
- **Capital gains reduction for long-term investments.** The capital gains tax reduction should reward long-term investments that create jobs and economic growth through a sliding-scale exclusion based on the amount of time the asset was held.

Sustainable Medicare and Medicaid policies

We were pleased that the budget agreement contained significant savings in Medicare and Medicaid. Controlling the growth of spending on health care entitlements is essential to putting the federal budget on a sound footing. However, more important than the savings numbers are the policies developed to achieve these programs. We encourage you to support policies that reduce the long-term growth of these programs while protecting the availability and quality of care, particularly in rural areas.

- **Provider Sponsored Organizations.** Allowing health care providers to form Provider Sponsored Organizations is extremely important, particularly given the magnitude of reimbursement reductions that hospitals and other providers must absorb under the budget agreement. It is important that the PSO provisions address the special needs of rural providers. We support federal certification for Provider Sponsored Organizations with a federal ceiling for solvency standards. PSOs applying for federal waivers to participate in the Medicare program should only be required to comply with federal requirements. We generally support the overall definition of PSO in the House bill, but believe that the provisions in the Senate bill allowing PSOs to qualify on the basis of "substantial shared financial risk" is critical for rural providers.
- **Equity in managed care payments** The disparity in payments for risk contractors in rural and underserved areas must be addressed in order to ensure that seniors in rural areas can benefit from expanded choice in the Medicare program. We support the immediate establishment of a payment floor sufficient to attract managed care plans and the rapid implementation of a blended national area rate to achieve a 50/50 blend by 2002.
- **Medicare education carve-out** We support a permanent and reliable funding source for teaching hospitals. This can best be accomplished through the creation of a GME and teaching hospital trust fund within the Medicare program funded by removing medical education and DSH adjustments from the AAPCC, as the Senate and House Commerce Committee bills would do.
- **Medicare Commission** We believe any Medicare reforms enacted this year be accompanied by the a process to monitor the impact of the reforms enacted on the Medicare program and the health care system and to make recommendations regarding additional reforms to further strengthen and preserve the Medicare program.

- **Allocation of payments for Disproportionate Share Hospitals** We are concerned about the allocation of DSH savings among States. Reforms of the DSH program should address past abuses of the program, but should not penalize states that have legitimately accessed DSH funds consistent with the purpose of the program. We encourage you to work to reduce DSH funding in a manner that distributes the cuts more evenly among the states.
- **Targeting of DSH payments to hospitals.** Given the reduction in federal DSH spending, it is extremely important that the remaining DSH funds be targeted to institutions that serve the highest proportion of Medicaid and low-income populations and are therefore in greatest need of assistance. As you know, many rural hospitals fall into this category. DSH savings should be linked to a federal standard targeting the remaining funds to needy hospitals. In addition, DSH payments should be made directly to hospitals, and should not be linked to managed care contracts.
- **Medicaid payments to hospitals and nursing homes** We believe that the repeal of the Boren amendment must be accompanied by safeguards to protect hospitals and nursing homes from dramatic reductions in Medicaid reimbursements. We strongly support the House language establishing a payment floor for payments to hospitals and nursing homes for 18 months. We also support the Senate language requiring a public process in Medicaid rate-setting.

Effective use of funds for new initiatives

Many of us have reservations about providing increased funding for new programs as part of a plan to balance the budget, but we recognize that the new initiatives are an important part of this agreement. Given our limited financial resources, it is extremely important that the new funds be used in the most efficient manner possible. All new programs, or increased funds for existing programs, should contain safeguards to ensure that the funds are used for the purposes intended by the agreement and directed to programs and activities that most effectively accomplish the goals of the agreement.

- **Distribution of welfare to work funds through competitive grants.** A substantial amount of the welfare to work funds should be distributed through competitive grants to reward innovative programs at the local level that move welfare recipients into private sector employment.
- **Performance bonus for successful welfare to work programs.** A significant portion of the welfare to work funds should be reserved for bonus payments to reward states who demonstrate success in using welfare to work funds to move hard-to-serve welfare recipients into private sector employment. Performance bonus payments should reward performance directly attributable to welfare to work funds and should take into account the economic conditions in the state.
- **Effective work program for food stamp recipients.** The provisions providing additional funding for food stamp employment and training programs should be structured to encourage states to create the maximum number of effective work slots for food stamp recipients subject to work requirements, with a goal of creating 300,000 work slots over the next five years. In addition, the program should establish incentives that reward states the create slots that successfully move unemployment food stamp recipients into private sector employment.

- **Standards for Medicaid Managed Care** There should be strong financial and quality standards for Medicaid managed care programs. In general, we support the Medicaid managed care quality standards in the Senate bill, which are very similar to the quality standards that were included in the Coalition budget.
- **Efficient use of funds for children's health programs.** States should be required to use the increased funding to provide health insurance to low-income, uninsured children. In addition, there must be strong safeguards to ensure that increased federal funds for children's health are not used to supplant current state spending or shifted to other programs. The children's health care bill developed by the Democratic Caucus Task Force on Children's Health, which was co-chaired by Rep. Marion Berry, accomplishes all of these goals.

FAX

Date: July 16, 1997

Number of pages including cover sheet: 3

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REMARKS: Urgent For your review Reply ASAP Please comment



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

July 16, 1997

Memorandum to: Chris Jennings
Deputy Assistant to the President for Health Policy

From: Jonathan Gruber *JG*
Deputy Assistant Secretary of the Treasury (Economic Policy)

Re: Income Dynamics and Part B Premium Payments

As you know, the Senate proposal for administering the income-related Part B premium would have HCFA use IRS data to determine payment amounts. Individuals would be billed according to the income on their latest available tax return.

A key limitation of this approach is that tax returns are available only with a substantial lag, so that HCFA would use tax data that was three years old in determining premium payments. With the assistance of the Office of Tax Policy here at Treasury, we have computed the implications for income related Part B payments of using three year old tax data. Our findings are striking:

- **We estimate that twenty-two percent of households billed based on three year old tax data would in fact owe no income related premiums based on today's income.** Many individuals in the over-65 population have declining incomes, particularly upon retirement or death of a spouse. These individuals would be inappropriately billed by a system using previous tax data.
 - Although Part B enrollees are given an opportunity, under the legislation, to provide a revised estimate of income to HCFA, it is likely that many will fail to do so. Furthermore the process of entering and verifying revised data is likely to lead to additional errors.
- **Moreover, of those receiving bills, roughly one-half will be overbilled. One-half of this group will be overbilled by \$500 or more.**
- **We also estimate that four percent of households not billed based on three year old tax data would in fact owe income related premiums based on today's income.** Since the proposal calls for only billing those who are determined to owe premiums based on previous tax data, we would not send bills to this population whose income is increasing, and therefore should owe some income-related premium.
- **We find that total mis-payments of premiums would amount to over \$1.3 billion dollars.** This is comprised of approximately \$650 million in underpayments, and \$700 million in overpayments.

-- This is a very sizeable amount: these mis-payments amount to roughly one-third of the total five year revenues that CBO estimates we could raise through HCFA-administered Part B premiums.

-- The fact that overpayments and underpayments are roughly equal in no way implies that these are "harmless" errors: the underpayments are likely to be substantially unmet, while the overpayments are likely to lead to sizeable complaints among the billed population.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
 OFFICE OF HEALTH POLICY



PHONE: (202) 690-6870 FAX: (202) 401-7321

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Number of Pages (Including Cover): 20

Comments:

July 15, 1997 (3:00 p.m.)

MEMBER-LEVEL ISSUES

(Dark Shaded Areas = Resolved Provisions)

ISSUE	HOUSE OFFER	SENATE OFFER
MEDICARE+ CHOICE		
1) Types of Choices	House position, with language specifying that "coordinated care plans" may include point-of-service (POS), Preferred Provider Organization (PPO) and other types of private health plans included in the Senate bill.	Agreed [Senate accept House position]
2) Unrestricted fee-for-service plans	Senate position regarding "unrestricted fee-for-service" plans.	Agreed [Senate position]
3) Medical Savings Accounts	House position	Senate position on demonstration size of 100,000. Agree to House position on structure of MSA demonstration.
4) Enrollment and Disenrollment	House position that transitions to annual enrollment and disenrollment by 2001 (annual and 6-month disenrollment from MedicarePlus plans) with full implementation by 2002 (annual and 3-month disenrollment from MedicarePlus plans).	Senate position with amendment that annual open enrollment begins in 1999 instead of 1998.
5) Provider Discrimination	Senate provision prohibiting discrimination based on the license of a provider.	Agreed [Senate provision]
6) Disclosure of Information	House position, including Title IV provisions requiring 1) disclosure of MedicarePlus plan's grievance record, 2) types of providers covered under network, 3) utilization review procedures, etc.	Senate provision with amendment that disclosure of plan's grievance record be provided to beneficiary upon request.

ISSUE	HOUSE OFFER	SENATE OFFER
7) Access to services - general	<p>House provisions regarding access to all Medicare covered benefits guaranteed access to plans regardless of health status, 24-hour a day, 7-day a week provision of service, reimbursement for medically necessary out-of-network services, access to appropriate providers, etc.</p> <p>Excluded from these requirements would be Title IV provisions requiring that medical necessity determinations under MedicarePlus plans be made "in the opinion of the treating health care provider" and provisions allowing attending providers to determine length of hospital stays.</p>	Agreed (Senate accepts House offer).
8) Access to service - emergency	House position on "prudent layperson" standard, that does not include specific reference to "severe pain" or detailed definition of post-stabilization care.	Senate position on definition of prudent layperson standard, including severe pain. Agree to House provision on post-stabilization language.
9) Quality Assurance Program	Senate provision, with clarification that external review should not be duplicative of accreditation and that the Secretary has the authority to waive the requirement for external review when enhanced quality standards are met through private accreditation.	Senate provision, with clarification that external review should not be duplicative of accreditation, and that the Secretary has the authority to waive the requirement for external review on a plan-by-plan basis if the Secretary is satisfied that the plan has consistently maintained a good quality assurance record.
10) Patient Right to Know	House position prohibiting MedicarePlus plans from restricting provider communications with patients.	Senate position.
11) Appeals	House position, including provisions in Title IV requiring reconsideration by physician with expertise in the relevant field of medicine.	Senate position on coverage determinations and appeals and grievances with amendment that plans must provide notice of denial with statement of reasons, and physician with appropriate expertise must review reconsiderations. Report language to clarify "appropriate expertise".

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ISSUE	HOUSE OFFER	SENATE OFFER
<p>12) Provider-Sponsored Organizations</p>	<p>House position requiring initial State application, rather than federal certification.</p> <p>Include House Title IV provision allowing waiver of State licensing requirements after 90 days of "substantially complete" State license. Also include House Title IV provision regarding provider non-compete clauses, with modification to specify that provision is effective for only 3 years.</p> <p>Senate definition of PSO, specifically as such definition includes additional condition of affiliation that providers be participants in a lawful combination under which each provider shares substantial financial risk in connection with the organization's operation.</p>	<p>Senate position.</p> <p>Senate position.</p> <p>Senate position.</p>
<p>13) PSO: Preemption of State law</p>	<p>House Title IV provision, with modification clarifying that State laws that do not conflict with federal non-solvency requirements are not preempted if they: (1) apply uniformly to all plans, (2) provide more protection to consumers, and (3) do not relate to mandated benefits, provider participation, or coverage determinations.</p>	<p>Senate position.</p>
<p>14) Competitive Pricing Demonstration</p>	<p>House position, including express prohibition of current Denver demonstration, as included in Title IV.</p>	<p>Senate position with amendments: at least 7 sites, two of which must be in rural areas. HHS has discretion on payment methodology, however at least one site must demonstrate a payment methodology as outlined in the Senate bill. Denver demonstration will be terminated although Denver is not recused from being considered for demo under this section.</p>

ISSUE	HOUSE OFFER	SENATE OFFER
15) Medicare Supplemental Insurance Protections	House position guaranteeing issue to Medigap policies and providing limitations on preexisting conditions for seniors, as included in Title X of House bill.	Senate position
SUBTITLE B PREVENTION INITIATIVES		
16) Screening Mammography	House position waiving applicability of Part B deductible and guaranteeing annual mammograms for women age 40 and over.	Agreed (Senate accepts House provision).
17) Screening pap smears and pelvic exams	House position waiving applicability of Part B deductible for pap smears and pelvic exams.	Senate provision (no provision).
18) Prostate cancer screening	House position providing annual prostate cancer screening.	Senate position (no provision).
19) Colorectal cancer screening	House position providing immediate coverage of proven colorectal screening, and requiring the Secretary to make a determination about coverage for barium enema screening within 2 years.	Senate position, requiring coverage (like the House bill) beginning 1/1/98 and providing broad coverage authority without highly prescriptive language.
20) Vaccines outreach	House provision extending HCFA Influenza and Pneumococcal Vaccination Campaign through 2002 and authorizing additional funding.	Agreed (Senate accepts House provision).
21) Preventive Benefits Study	House provision authorizing broad study of a range of potential Medicare preventive benefits, as modified by Senate language on inclusion of registered dieticians in nutrition therapy study.	House offer, with technical changes to language (more general language as not all provisions are preventive).
SUBTITLE D ANTI-FRAUD AND ABUSE PROVISIONS		
22) Three Strikes, You're Out	House provision providing mandatory exclusion from Federal health care programs for persons convicted of 3 offenses.	Agreed (Senate accepts House provision).

ISSUE	HOUSE OFFER	SENATE OFFER
23) Liability for fiscal intermediaries and carriers	Senate provision.	Agreed (Senate provision)
24) Advisory Opinions	House provision requiring Secretary to issue binding advisory opinions on Stark II self-referral.	Senate provision (no provision).
25) Bankruptcy	House position.	Senate provision (i.e., not allowing excluded health care providers to remain in Medicare simply because they are in bankruptcy and allowing fines and payments due to Medicare fraud to survive bankruptcy).
26) New CMPs for anti-kickback	House position, which does not include CMPs for anti-kickback.	Senate provision on anti-kickback CMPs, but Senate agrees to House's two provisions that would levy CMPs for contracting with excluded providers and for furnishing services ordered by excluded providers.
27) Non-discrimination in Post-Hospital Referrals	House provision contained in Title IV of House bill requiring reporting by hospitals of financial interest in home health agencies. The provision would be expanded to require notification of financial interest in any post-hospital provider.	Agreed (Senate agrees to House offer regarding both provisions).
28) Inherent Reasonableness	House position which does not provide express authority for Secretary to modify payments for all Part B services, except physician services, where payment is either grossly excessive or grossly deficient.	Senate provision, providing Secretary with simplified authority to modify payments for all Part B services, except physician services, where payment is either grossly excessive or grossly deficient.

ISSUE	HOUSE OFFER	SENATE OFFER
<p>29) Competitive Acquisition Authority</p>	<p>Senate position, with amendment to provide authority for Secretary only to conduct several competitive acquisition demonstration projects</p>	<p>Senate provision, with modification that (1) within 1 year of enactment the Secretary shall initiate demonstration projects in no more than 8 sites, with no demonstration to exceed 3 years; (2) priority consideration given to oxygen, other DME, prescription drugs, and labs, or such other items as the Secretary determines might benefit from competitive bidding; (3) the Secretary may employ contractors; (4) the Secretary shall conduct an evaluation, and where competitive bidding is demonstrated to yield both savings and maintain or improve quality for a particular item or service, the Secretary shall be permitted to expand competitive bidding for that item or service nationwide; and (5) GAO shall study the effectiveness of these demonstration projects.</p>

ISSUE	HOUSE OFFER	SENATE OFFER
SUBTITLE E PROSPECTIVE PAYMENT SYSTEMS		
<p>30) Skilled Nursing Facilities</p>	<p>House provision regarding calculation of base facility specific and federal PPS rates, including using only free-standing facility data updated by the SNP market basket minus one percentage point.</p> <p>Senate provision to temporarily extend routine cost limits for FY 1998.</p> <p>House position regarding payment for Part B services delivered to custodial SNF patients (those beyond the 100 days) based on existing fee schedules or those established by the Secretary.</p> <p>Senate provision including low-volume SNFs in the immediate implementation of the PPS in July 1998.</p>	<p>Senate provision regarding calculation of base facility specific and federal PPS rates (which exclude exempted facilities and exceptions payments from the base calculation)</p> <p>Agreed. (Senate provision)</p> <p>Senate accepts House offer, with an amendment requiring that excluded professional services need to list the SNP provider number on their claims.</p> <p>Senate accepts House offer (Senate provision) with the inclusion of Senate language regarding SNFs enrolled in the RUGs III demonstration.</p>
<p>31) Rehabilitation Services</p>	<p>House provision that establishes prospective payment systems for outpatient therapy providers and comprehensive outpatient rehabilitation facilities (CORFs) and includes these services under the \$900 annual cap that is currently applied to independent therapists. The \$900 cap would be updated each year by GDP.</p> <p>House provision that requires therapy services that are incident to a physician's service meet the same standards that apply to therapy services provided in other settings.</p>	<p>House offer, with modification that cap is raised to \$1,500 (updated by each year by GDP) for services in all settings covered by this provision other than outpatient hospital and technical changes.</p> <p>Agreed (Senate accepts House provision)</p>

ISSUE	HOUSE OFFER	SENATE OFFER
SUBTITLE F PROVISIONS RELATING TO PART A		
32) PPS Hospitals	House position on PPS update. House amendment whereby certain non-teaching, non-disproportionate share, non-small rural dependent hospitals would receive 0.5 percent payment adjustment in FY 1998 and 0.3 percent payment adjustment in FY 1999 if they meet each of the following requirements: (1) located in a state with FY 1995 aggregate Medicare PPS payments that are less than aggregate costs for all non-teaching, non-disproportionate share hospitals that were also not classified as small rural dependent hospitals; (2) Medicare PPS operating payments in each FY 1997 and FY 1998 are less than their Medicare PPS operating costs; (3) do not receive disproportionate share hospital payments; (4) do not receive hospital teaching payments; and (5) do not receive small rural Medicare dependent hospital payments.	Senate position:

ISSUE	HOUSE OFFER	SENATE OFFER
	<p>House provision on PPS capital exceptions process for certain hospitals</p> <p>House transfer policy which makes the proposal applicable to all post acute settings, including home health care. House amendment which would extend transfer policy to swing beds.</p> <p>House agrees to freeze DSH payments for five years while maintaining the House position on the development of a new payment methodology which does not limit the Secretary to specified categories of care.</p> <p>House provision on indirect graduate medical education which gradually phases down payment adjustment to from 7.7 to 5.5 percent in FY 1999.</p>	<p>Senate provision</p> <p>Senate provision with amendment striking "immediate" and "discharge planning," and retaining Senate provision excluding home health care from the transfer policy.</p> <p>Senate provision with amendment that the Secretary must report to Congress on new formula in 12 months with impact analysis (Senate provisions on formula, excluding outpatient data). Senate retains provision on DSH spending constraints.</p> <p>Senate provision.</p>

ISSUE	HOUSE OFFER	SENATE OFFER
<p>33) PPS-Exempt Hospitals</p>	<p>Senate provision requiring the Secretary to collect data and prepare a report on establishing a Prospective payment system for long-term care hospitals.</p> <p>House operating payment provisions regarding payment update (between zero and market basket, depending on the relationship between costs and TEFRA limit), cap on TEFRA limits (90th percentile), new provider TEFRA limits, rebasing (including special long-term care hospital provision), and bonus payments.</p> <p>House recedes to Senate with amendment specifying capital reductions of 12.5 percent.</p>	<p>Senate position with modification that Secretary should study the feasibility of expanding the current DRGs.</p> <p>Senate provision.</p> <p>Senate provision (15% reduction in capital).</p>

ISSUE	HOUSE OFFER	SENATE OFFER
SUBTITLE G PROVISIONS RELATING TO PART B		
<p>34) Physician Services</p>	<p>Senate provision requiring the implementation of resource-based malpractice relative value units by FY 2000</p> <p>House provision requiring the Secretary to develop new resource-based practice expense value units as modified by combining Title IV and Title X provisions. The Secretary would be required to utilize, to the maximum extent practicable, generally accepted accounting principles and standards which recognize all staff, equipment, and supplies and expenses, not just those that can be tied to specific procedures. The Secretary would be required to examine actual data on equipment utilization. The Secretary would also be required to consult with organizations representing physicians regarding methodology and data and must develop a refinement process to be used during each of the four years of the transition period.</p> <p>Senate provision requiring the Comptroller General to report to the Committees within six months of enactment on the Secretary's recently released proposed rule for implementing resource-based practice expense values.</p> <p>House four year transition period for resource-based practice expense values.</p>	<p>Senate provision, with following modifications:</p> <ol style="list-style-type: none"> 1. Senate provision on one-year delay in implementation of HCFA June 1998 proposed rule on practice expense implementation (to 1/1/99). 2. Senate provision on special rule for 1998, with modification: <ol style="list-style-type: none"> a. Amount to be reallocated under special rule for 1998 shall not exceed \$390 million. b. No medical service that would have received an increase under the HCFA proposed rule shall be reduced under the 1998 special rule. 3. Senate provision on length of transition period. 4. Senate provision requiring the resource-based malpractice relative value units by FY 2000. 5. Senate provision on GAO study of HCFA proposed rule; and 6. Senate accepts to House provision on Secretarial direction, with following modification: The Secretary would be required to solicit the views of physician organizations and the individual views of physicians (in both surgical and nonsurgical areas, and in academic practices), accounting experts, and other relevant experts on (1) the need for additional data; (2) the adequacy of the methodology used by HCFA (including the use of generally accepted accounting principles and standards which recognize properly staff, equipment, and supplies and expenses), and (3) the refinement process used by HCFA for an extended transition period.

ISSUE	HOUSE OFFER	SENATE OFFER
35) Replacement of Reasonable Charge Methodology by Fee Schedule	House position.	Senate position.
36) Competitive bidding for Part B Services (excluding physician)	House position.	(Same as #29 above.)
37) X-Ray Requirement for chiropractic services	House position removing x-ray requirement for access to chiropractic services, including Title IV House provision requiring Secretary to promulgate guidelines on utilization.	Senate position.
38) Temporary reinstatement of portable EKG	House Title X provision reinstating separate transportation costs for portable EKGs for one year and requiring Secretary to make a coverage determination by July 1998.	Agreed (Senate accepts House provision).
39) Durable Medical Equipment Upgrade	House position, which includes no provision allowing upgrade of durable medical equipment	Agreed (Senate accepts House offer)
40) Reimbursement for Oxygen and Oxygen Equipment	House provision reducing oxygen payments by 20 percent through 2002.	Senate position.
41) Reimbursement for Drugs and Biologicals	House provision which reduces reimbursement to Average Wholesale Price (AWP) minus 5 percent	Senate position.

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ISSUE	HOUSE OFFER	SENATE OFFER
42) Coverage of oral anti-nausea drugs under Chemotherapeutic regimen	House provision, with modification to ensure provision is budget neutral.	Agreed (Senate accepts House offer).
SUBTITLE H PROVISIONS RELATING TO PART A AND B		
43) Home Health Transfer	House Title X position transferring non-post hospital home health care to Part B.	Senate position.
44) Medicare Secondary Payer	Senate provision clarifying time and filing limitations.	Agreed (Senate provision).
45) Direct Graduate Medical Education (GME)	House position on all direct GME policies except the following: (1) Senate position on payment policy to non-hospital providers; and (2) House agrees to eliminate non-payment for the initial five percent reduction (in both indirect and direct GME) in the residency count to existing GME demonstrations under Ways and Means Section 10734/ Commerce Section 4734, "Incentive Payments Under Plans for Voluntary Reduction in the Number of Residents."	Senate provisions on direct GME, with following modification: Senate accepts House provision for Incentive Payments Under Plans for Voluntary Reduction in the Number of Residents, with modification to eliminate the non-payment of the initial five percent reduction (in both indirect and direct GME) to existing demonstrations.
46) Coordinated Care Demonstration	Senate provision requiring the Secretary to implement a coordinated care demonstration project for fee-for-service beneficiaries with chronic conditions using case-management and other private sector tools.	Agreed (Senate provision).
47) Centers of Excellence	House provision to expand HCFA's demonstration project.	Senate position (no provision).

ISSUE	HOUSE OFFER	SENATE OFFER
48) Protection for Military Retirees - Waiver of Medicare Part B Late Enrollment Penalty and Medigap Special Enrollment	House position waiving Medicare Part B late enrollment penalty and providing guaranteed issue to Medigap policies during a special enrollment period for military retirees and dependents who did not enroll in Part B when first eligible.	Senate position.
49) National Bipartisan Commission on the Future of Medicare	House Provision	Senate provision with the following 3 modifications: add the House provisions regarding duties (with the exclusion of the study on the feasibility of establishing an enabling commission); House provision appointing Chairman by election of the members; and establish reporting date of January 15, 1999.
50) Limited reimbursement for non-medical services	Senate provision authorizing reimbursement for certain non-medical services.	Agreed (Senate provision).
<i>Moved from staff issue list</i> - 51) Reductions in Part A for Medicare Premium for Certain Public Retirees	House position which provides relief for certain retirees.	Senate position (no provision).

ISSUES THAT MAY BE RESOLVED BY STAFF
 (Dark Shaded Areas = Resolved Provisions)

ISSUE	HOUSE OFFER	SENATE OFFER
SUBTITLE A MEDICARE PLUS PROGRAM		
1) Local Price Indicators	Senate provision requiring the Secretary and the Medicare Payment Advisory Commission to study appropriate measures for adjusting annual capitation rates to reflect local prices.	Agreed (Senate provision).
2) Medicare Payment Advisory Commission (MedPAC)	Senate provision on the number of MedPAC commissioners at 15.	Senate provision.
3) Program of All-Inclusive Care for the Elderly (PACE)	Senate position with amendment to ensure that states are not required to participate under the PACE program.	Agreed (Senate accepts House offer).
SUBTITLE C RURAL INITIATIVES		
4) Rural Hospital Flexibility Program /Rural Primary Care Hospital Program	House position which provides more flexibility in the definition of distance criteria for designation and clarifies that swing beds (up to the limit) could be included in bed count.	Senate position.
5) Hospital Reclassification for Purposes of Disproportionate Share Hospital (DSH) Payments	House position that restores opportunity for rural hospitals to apply for reclassification for purposes of higher DSH payments. House position. Current HCFA methodology not yet available.	Senate position. Senate methodology with the exclusion of outpatient criteria in the formula. Secretary is instructed to develop a new DSH formula in 12 months.

ISSUE	HOUSE OFFER	SENATE OFFER
6) Geographic Reclassification for Disproportionately Large Hospitals	House position that allows certain large hospitals to be reclassified if they materially influence the average hourly wage in the area.	Senate position: (no provision)
7) Medicare Reimbursement for Telehealth Services	House position: Current HCFA methodology not yet available on telemedicine reimbursement.	Senate position.
8) Telemedicine, Informatics and Education Project	House position that evaluates the use of telemedicine from inner-city to rural areas as it relates to diabetes.	Agreed [Senate accepts House offer].
9) Sole Community Hospitals	House position.	Senate position.
10) Inclusion of Stanly County, N.C. in a large urban area	House position.	Senate position.
SUBTITLE D ANTI-FRAUD AND ABUSE PROVISIONS		
11) Improvements in program integrity	Senate provisions designed to improve program integrity, including providing additional information to Medicare beneficiaries and providing contractors additional authority to reduce excessive billing and utilization.	Agreed (Senate provisions, i.e., disclosure of information, surety bonds, and accreditation; identification numbers; furnishing of diagnostic information; GAO report; information to Medicare beneficiaries; prohibiting unnecessary payments; reducing excessive billings; with modification on certain clarifications and technical changes.)

ISSUE	HOUSE OFFER	SENATE OFFER
SUBTITLE E PROSPECTIVE PAYMENT SYSTEMS		
12) PPS-exempt hospitals	House version of special provision for excluded long-term cancer hospitals do not include Senate provision which could dramatically increase the number of PPS-exempt cancer hospitals.	Senate accepts House provision regarding PPS-exempt long-term cancer hospital, and Senate insists on its provision regarding research PPS-excluded cancer hospital with technical clarification that will assure the number of PPS-excluded hospitals is not dramatically increased and clarification that payments are prospective only.
13) Hospital Outpatient	House provision granting a one-year delay on implementation of the prospective rates for eight Cancer hospitals. House provision limiting Judicial Review.	Agreed (Senate accepts House provision). Agreed (Senate accepts House offer).
14) Ambulance Services	Both House and Senate bills establish a fee schedule for ambulance services. Senate provision which would limit updates under the fee schedule to CPI minus 1, with an amendment clarifying that such limitations are effective only through 2002. House provision beginning fee schedule in 2000 rather than 1999. House provision demonstrating coverage of ambulance services under contract with units of local government.	Agreed (Senate accepts House offer). Agreed (Senate accepts House offer). Agreed (Senate accepts House provision). Agreed (Senate accepts House provision).
SUBTITLE F PROVISIONS RELATING TO PART A		
15) Hospice Policies	House position on payment update of market basket minus one percent FY 1998-2002.	Senate position with one modification, accept the House provision on waiver of liability.

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ISSUE	HOUSE OFFER	SENATE OFFER
16) Reductions in Part A for Medicare Premium for Certain Public Retirees	[See #51 Member Issues]	[See #51 Member Issues]
SUBTITLE G PROVISIONS RELATING TO PART B		
17) Renal Dialysis Services	House provision requiring that the Secretary audit a sample of dialysis facility cost reports. House provision requiring the Secretary to develop and implement a method to measure and report on the quality of Medicare renal dialysis services.	Agreed [Senate accepts House provision]. Agreed [Senate accepts House provision].
18) Payments for durable medical equipment	House position instituting payment freeze on all DME. House position including 1 percent update for prosthetics and orthotics.	Agreed [Senate accepts House provision]. Agreed [Senate accepts House provision].
19) Laboratory Payments	Senate position which lowers payment ceiling from 76% to 74%, but maintain House provision freezing updates in laboratory payments. Senate IOM study on laboratory payments.	Agreed [Senate accepts House offer]. Agreed [Senate accepts House offer].
20) Laboratory Simplification	Senate position, with amendment which would not exclude all independent physician office laboratories, but would provide Secretary the authority to exclude independent physician offices and similar providers, where they would be unduly burdened by filing claims under the new system of regional carriers.	Agreed [Senate accepts House offer].
21) Rural Health Clinics	error [Senate position which lowers payment ceiling from 76% to 74%, but maintain House provision freezing updates in laboratory payments.]	Senate provision with one modification that the limited grandfathering of physician assistant owned and operated RHCs applies to those owned and operated by nurse practitioners.

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ISSUE	HOUSE OFFER	SENATE OFFER
SUBTITLE H PROVISIONS RELATING TO PARTS A & B		
<p>22) Home Health Care - Interim Payments</p>	<p>House provision that uses 75% agency-specific/25% regional data in calculating per beneficiary caps.</p> <p>Senate provision requiring that Medicare Part B Explanation of benefits forms include home health care benefits provided and billed. House amendment to this provision requiring similar information for Part A home health services.</p> <p>House provision that a patient cannot qualify for home health care services on the basis of needing skilled nursing care for drawing a blood sample.</p> <p>House position which provides for the Secretary to submit a report to Congress on the impact of home health utilization and admissions to hospitals and skilled nursing facilities stemming from new Part B payment for certain home health services.</p>	<p>Senate position:</p> <p>Agreed (Senate accepts House offer. (technical issues still need to be worked out)).</p> <p>Senate position:</p> <p>Agreed (Senate accepts House provision).</p>
<p>23) Protections for disabled workers who lose group health benefits</p>	<p>House position:</p>	<p>Senate position:</p>
<p>24) Placement of Advanced Directives in Medical Record</p>	<p>House position:</p>	<p>Agreed (Senate accepts House provision).</p>
<p>25) Organ Procurement Organizations</p>	<p>Senate provision increasing the certification period for certain organ procurement organizations.</p>	<p>Senate provision with the following modification: certification will be every 4 years (instead of every 3 years).</p>

PROGRESS ON HEALTH ISSUES IN CONFERENCE

MEDICARE

- Preliminary staff discussions but focused on Medicaid in anticipation of Governors' meetings on Tuesday.
- Appears that most issues will be resolved at the Members' level.

MEDICAID

- Staff discussions are mostly over. Draft bill including resolved issues will probably be ready for Tuesday's governors' meeting.

- **MEMBERS' ISSUES:**

- Premium assistance for low-income Medicare beneficiaries (Budget Agreement)
- DC, Territories (Budget Agreement)
- Coverage of certain disabled children (Budget Agreement)
- Disproportionate Share Hospital allotment [working group established]
- Cost-based reimbursement for certain clinics (FQHCs, RHCs)
- Return to work demonstration
- Coverage of certain people with breast cancer
- State-specific provisions (Alaska matching rate, New York provider tax exemption, Arizona demonstration expansion)

- **SELECTED RESOLVED ISSUES**

- Cost sharing for optional coverage included (with some protections)
- Medicaid payment for Medicare dual eligibles included (with protections),
- Privatization / Texas TIES included

CHILDREN'S HEALTH

- Preliminary staff discussions occurred but few issues resolved.

July 13, 1997

cc: Diana Fortuna

Debbie Chang
 James Lambrew
~~BRUCE~~

Consortium for Citizens with Disabilities

Jeff Crowley 202-898-0414
 Kathy McGinley 202-785-338

July 10, 1997

Dear President Clinton:

The undersigned are co-chairs of the Consortium for Citizens with Disabilities (CCD) Health Task Force, which represent over 50 national disability organizations. The issues raised in this letter represent the concerns of millions of children and adults with physical and mental disabilities and their families. We urge you to very carefully consider the impact of various provisions of the balanced budget act on programs of critical importance to children and adults with disabilities. In your work with House and Senate Conferees, we strongly urge you to take the following actions.

Medicaid

<u>Issue</u>	<u>House Bill</u>	<u>Senate Bill</u>	<u>CCD Recommendation</u>
Medicaid Managed Care Exemption for Children with Special Needs	Includes	Includes	Retain this exemption in final bill

- Members of both the House and Senate have recognized that children with special needs have numerous health and long term support needs. Because of these needs and because of the inexperience of managed care organizations (MCOs) in dealing with this population, both chambers have agreed to exempt these children from mandated Medicaid Managed care. This is a critically important protection for these children which should be maintained in the final bill.

<u>Issue</u>	<u>House Bill</u>	<u>Senate Bill</u>	<u>CCD Recommendation</u>
Medicaid Managed Care Guidelines for Individuals with Special Health Care Needs	Does not Include	Includes study and guideline requirements added by Sen. Grassley	Recede to Senate

- The CCD Health Task Force supports the exemption from mandatory Medicaid managed care of adults with disabilities. Although neither the House nor Senate bills exempt adults with special health care needs from mandatory Medicaid managed care as they do children, with the Grassley amendment the Senate bill

for using non-participating providers. These are particularly important protections for individuals with special health care needs and should be retained in the final bill.

<u>Issue</u>	<u>House Bill</u>	<u>Senate Bill</u>	<u>CCD Recommendation</u>
Guarantee of Continuing Medicaid Coverage for Children who Lose SSI	Includes "state option" language. Does not include a guarantee of coverage.	Does not include. Leadership assumes coverage in "child health block grant; but there is no guarantee	Include budget agreement language which would guarantee continued Medicaid coverage for these children.

<u>Issue</u>	<u>House Bill</u>	<u>Senate Bill</u>	<u>CCD Recommendation</u>
Improvements to Default Enrollment Provisions	Does not Include	Includes	Recede to Senate

- A major problem faced by Medicaid beneficiaries enrolling in managed care is related to enrollment. Choice of plans is intended to provide consumers with the opportunity to select the most appropriate plan. However, in many cases, beneficiaries have been fraudently enrolled in plans; given insufficient time and information to make an informed decision; and default enrollment processes have not taken into consideration issues such as the need for specialists or the need to keep all family members enrolled in one MCO. The Senate improvements to the Medicaid managed care default enrollment provisions should be retained in the final bill.

<u>Issue</u>	<u>House Bill</u>	<u>Senate Bill</u>	<u>CCD Recommendation</u>
Improvements to Grievance Procedures	Includes detailed grievance procedure requirements.	Includes vague provision.	Recede to House

- Grievance procedures that enable consumers to file complaints and resolve problems when they are faced with substandard care or the denial of health care services are essential to holding MCOs accountable. Too frequently, MCOs have developed internal grievance processes that do not work for beneficiaries and allow plans to delay the prompt resolution of grievances. The CCD believes that the House provisions related to grievance procedures are necessary in order to ensure a "meaningful and expedited"

procedure with notice and hearing requirements. The 30 day time limit for the resolution of complaints in the House bill is an essential consumer protection. The House provisions should be maintained in the final bill.

<u>Issue</u>	<u>House Bill</u>	<u>Senate Bill</u>	<u>CCD Recommendation</u>
Cost-Sharing Requirements for "Optionally Eligible" People	Does not Include	Includes	Recede to the House

- The CCD is deeply concerned by the effort to repeal existing cost-sharing protections in the Medicaid program. The Senate bill would allow premiums, co-payments, and deductibles of up to three percent of an individual's income for consumers who are optionally-eligible for Medicaid. Currently, many children and adults with disabilities, who are receiving a broad range of Medicaid services and supports, are optionally-eligible. This includes children covered by the Katie Beckett waiver, children under certain adoption agreements, and hospice beneficiaries. For people with low incomes, a cost sharing requirement because an major disincentive to accessing needed preventive and health care services. The Senate cost sharing requirements should not be included in the final bill.

Children's Health

<u>Issue</u>	<u>House bill</u>	<u>Senate bill</u>	<u>CCD Recommendation</u>
Funding Level for Children's Health Program	\$16 billion	\$24 billion	Recede to Senate

<u>Issue</u>	<u>House Bill</u>	<u>Senate Bill</u>	<u>CCD Recommendation</u>
Guarantee of Coverage for Children	Does not Guarantee health care coverage. Structure would allow funds to be spent on non-health items.	Guarantees that funds will be spent on health care coverage.	Recede to Senate

<u>Issue</u>	<u>House Bill</u>	<u>Senate Bill</u>	<u>CCD Recommendation</u>
Decreases Number of Uninsured Children	CBO estimates only 580,000 new children would be covered.	CBO estimates up to 2 million new children would be covered.	Recede to Senate

<u>Issue</u>	<u>House Bill</u>	<u>Senate Bill</u>	<u>CCD Recommendation</u>
Ensure Access to Specific Benefit Package	Not included	Includes standard Blue Cross/Blue Shield package plus vision and hearing.	Recede to Senate

- While both the House and Senate bills include children's health provisions, the Senate version would cover more children; would ensure that dollars are spent on children's health and not on other state priorities; and would provide access to a standard benefits package. While this package still is deficient in regards to the needs of children with disabilities, it is better than the House bill which has no minimum benefits requirements. There are critical differences between the House and Senate proposals that will have a major impact not only in the number of uninsured children served but in the types services that they receive. The Senate provisions should be included in the final bill.

Medicare

<u>Issue</u>	<u>House bill</u>	<u>Senate bill</u>	<u>CCD Recommendation</u>
Medical Savings Accounts	Includes a 500,000 person demonstration program. Caps maximum deductible at \$6,000 and caps out-of-pocket expenses at \$6,000.	Limits demonstration to 100,000 people. Caps deductible at \$2,250 and caps out-of-pocket expenses at \$3,000.	Recede to Senate

- Medical Savings Accounts are particularly problematic for individuals with high health care costs, such as many individuals with disabilities and chronic health care conditions. The CCD strongly opposes Medical Savings Accounts for this and many other reasons. Since the Congress has decided to pursue a demonstration of MSAs in Medicare, we believe that the scope of the demonstration must be as narrow as possible. We also believe that beneficiaries need reasonable protections from deductibles and out-of-pocket expenses that would place all but upper income individuals in financial jeopardy. The Senate provisions should be included in the final bill.

<u>Issue</u>	<u>House Bill</u>	<u>Senate Bill</u>	<u>CCD Recommendation</u>
Medigap Portability for People with Disabilities	Does not Include	Includes	Recede to Senate

- Access to Medigap policies has historically been an imprint supplemental insurance option available to elderly Medicare beneficiaries to protect them from unreasonable out-of-pocket expenses. People with disabilities in Medicare who are under age 65 need to access a broad range and large number of services. This need makes access to this type of insurance option particularly important to these individuals. It is also important to note, that the cost of treating the under 65 Medicare population is in line with the cost

for treating people who are elderly. Therefore, Congress should eliminate this discriminatory practice against non-elderly people in Medicare. The Senate provisions should be included in the final bill.

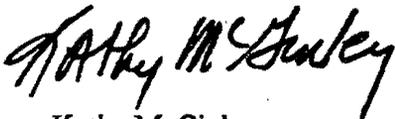
MEWAs

<u>Issue</u>	<u>House bill</u>	<u>Senate bill</u>	<u>CCD Recommendation</u>
Multiple Employer Welfare Arrangements	Includes	Does not Include	Recede to Senate

- MEWAs are strongly opposed by the CCD. These arrangements, which would allow small employers and associations to pool together to buy health insurance are not in the best interest of consumers, especially consumers with disabilities. The plans developed under these provisions would be exempt from state insurance mandates and protections -- most of which are much stronger than what is available at the federal level. These plans would be placed on the same level as current ERISA covered plans which have proved extremely problematic for individuals with disabilities and their families. These arrangements should not be included in the final bill.

We strongly urge you to consider these recommendations. If you have any questions, please contact one of the co-chairs listed at the top of this document.

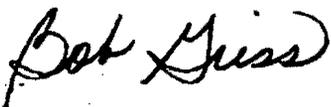
Sincerely,



Kathy McGinley
The Arc



Jeff Crowley
National Association of People with AIDS



Bob Griss
Center on Disability and Health



Peter Thomas
Brain Injury Association



THE DIRECTOR

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

Medicare File

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,



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.

CHRIS - WE WERE
CLEARLY ON RECORD
DURING BBA IN
SUPPORT OF MEDIGAP
REFORM FOR THE
DISABLED - WE
SHOULD BE MORE
AGGRESSIVE ABOUT
THIS - JMC

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. If extraneous to the budget agreement we find these provisions objectionable.

Provider Sponsored Organization. The inclusion of provider sponsored organizations is concerning, however, about the definition of the PSO, and we look forward to discussing these issues.

Managed Care Payments. 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

CHRIS - WE WERE CLEARLY ON RECORD DURING BBA IN SUPPORT OF MEDIGAP REFORM FOR THE DISABLED - WE SHOULD BE MORE AGGRESSIVE ABOUT THIS. THE PROVISIONS THAT ARE MADE IT CLEAR THAT IS THEIR POINTS AND ASPECTS THESE ISSUES. GRAPHIC VARIATION BILL. WE WANT AND INVERSE SELECTION.

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.

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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

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 work slots 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.

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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.