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CQ's WASHINGTON ALERT

Disability -
Kennedy-Jeffords -

11/30/98

Breaking Down Barriers For the Working Disabled
Health/Education/Welfare
(HR3433, HR2020; WR 11/28/98 p. 3209; 410 lines)
Item Key: 4250

press

SOCIAL POLICY

Breaking Down Barriers For the Working Disabled

>> Government rethinks health care eligibility rules that discourage self-sufficiency

By Sue Kirchhoff, CQ Staff Writer

PORTLAND, Ore. -- Maneuvering his wheelchair across a rain-drenched campus, Michael Goldhammer looks as if he has beaten some long odds. Born without use of his arms or legs, the 52-year-old works at Portland Community College as an "adaptive computer specialist," revamping equipment to meet the special needs of disabled students. He also runs a consulting business, providing similar advice to private customers.

The success is not as complete as it appears, however. Along with the daily challenges of navigating a world designed for the able-bodied, Goldhammer must steer through a maze of federal and state regulations that limit the amount he can earn.

If he makes too much money, the government will cut off Medicaid health benefits, including attendant care to help him dress, bathe and get to his job. Commercial insurance does not cover such services, which in his case cost about \$15,000 a year.

Goldhammer laments that many people with disabilities have chosen not to seek employment rather than risk the loss of health care or other aid. *

"These people are not criminals. They are people who would like to go to work, who would like to have the skills to do so. But [federal programs] have a poverty mentality," he said.

The disabled face a Catch-22. To qualify for federal assistance, they must prove they are unable to work. Once enrolled in government disability programs, they become eligible for Medicaid or Medicare.

Advances in technology, tougher civil rights laws and mandatory public education have made it possible for more people with physical and mental impairments to enter the job market. Those who choose to do so, and give up government aid, may be able to make up for lost cash benefits, but they are far less likely to find health care coverage.

Faced with soaring costs, the increasing clout of activists and a widening belief that the current system is outdated, Congress, states and the Clinton administration have begun a bipartisan effort to expand health care and job training.

"This is a very genuine problem. People who need personal assistance in order to live and work, and in addition have talents that can be used in the workplace, need some way to pay for the care," said Virginia P. Reno, director of research at the National Academy of Social Insurance, a nonprofit organization in Washington, D.C., that researches welfare and health care programs. "Private employers are not keen on picking up the costs."

While lawmakers have made some progress, they face major obstacles -- primarily the fact that expanding health care and other support services is a multibillion-dollar proposition. As Congress learned with ~~the 1996 welfare overhaul~~ (PL 104-193), helping move people off federal assistance and into jobs requires up-front investments to reap long-term gains. (1996 Almanac, p. 6-3)

Disability advocates, who have gained political sophistication and clout over the past several decades, argue that Democrats should have no qualms about supporting a voluntary effort to move the disabled into work. And the Republican campaign for self-sufficiency, they argue, should not end at the welfare office.

"What could be more in the interests of Republicans than getting people off the rolls and back into the work force?" said Peter W. Thomas, a Washington attorney with Powers, Pyles, Sutter & Verville who represents the National Organization on Disability, an advocacy group.

Nearly 5 million disabled workers, along with 1.6 million spouses and dependent children, received benefits under Social Security Disability Insurance (SSDI) in fiscal 1998. Payments are based on the length of time a worker paid Social Security payroll taxes.

The second major program is Supplemental Security Income (SSI), which is based on income. Originally envisioned as an income supplement

for the elderly poor, it is now primarily a disability program, serving more than 4 million disabled adults.

Nationally, fewer than 1 percent of those on SSDI leave the program for jobs. The unemployment rate for the severely disabled is estimated at nearly 70 percent.

Meanwhile, the number of working-age individuals receiving federal disability benefits has more than doubled over the past decade. Spending ballooned to more than \$75 billion in fiscal 1998 from \$25 billion in fiscal 1986.

Effective in October, Oregon was the first state in the nation to receive permission from the Health Care Financing Administration, which runs Medicare and Medicaid, to set up a new program to allow the working disabled to earn significantly more and still retain eligibility for Medicaid.

NEW DISCRETION FOR STATES

That plan, which will be up and running early next year, means that Goldhammer, unlike disabled individuals in other states, will be able to work as much as he wants without worrying about losing health insurance coverage.

The state will require recipients to make Medicaid copayments, which will rise as salary increases. For example, someone with gross earnings of \$30,000 would pay about \$20 a month in premiums. The expectation was that as individuals earn more, they would take advantage of tax deductions and private insurance to move off Medicaid.

The plan is designed to help not only those who now receive SSI and SSDI, but to enable working individuals with physical and mental impairments who are not in either program to purchase Medicaid.

The Medicaid buy-in was made possible by a little-noticed provision of the 1997 budget-reconciliation law (PL 105-33), proposed by the Clinton administration, which gave governors new discretion to expand coverage under the federal-state health program. (1997 Almanac, p. 2-18)

"We passed these people over for years. We invested in them through vocational education. . . . Then we didn't do anything on the other side, which was trying to put them to work," said Gary K. Weeks, director of the Oregon Department of Human Resources.

"We spend a lot of money [through government programs] on people who don't want to go to work, while we ignore people who are ready and willing to go to work," he said.

While the fine print of the Oregon initiative is still being developed, it is already having an effect. Right now, Goldhammer is able to hold his job under "self-support" provisions of the existing state Medicaid program that allow him, for a three-year period, to make a specified income, keep Medicaid and contribute to a special checking account to purchase a new van.

His three years are up in October 1999. Without the new Oregon proposal, he would either "have to make a big jump or quit."

One of the first to find work under the Oregon program was Scott A. Lay, a quadriplegic who had done only limited consulting and volunteer work in order to protect his benefits. An unpaid advocate who pushed for creation of the initiative, Lay was hired by the state to implement it.

"It's costing the state now to keep us not working, so why not get us working and collect the taxes?" said Lay, 47, in his home office, full of plaques from disability groups, pictures of Franklin D. Roosevelt and John F. Kennedy -- and science fiction movie posters.

"It's our belief that people who work are healthier than people who stay at home and watch TV. To us it's a no-brainer. Why didn't we do it a long time ago? The opportunity wasn't there," he said.

Vermont and Wisconsin are experimenting with smaller initiatives. It is unclear how many other states will follow unless Congress passes legislation to provide financial incentives, rather than just permission, to extend care.

For example, advocates said, about 30 states and the District of Columbia now offer attendant care under Medicaid, a key element in allowing many disabled to work. Without additional federal funds, those who do not offer the benefit may be unwilling to do so.

CONGRESS DEBATES CHANGES

The 105th Congress made several attempts to extend health care and training for those with chronic conditions.

The House on June 4, by a vote of 410-1, passed legislation (HR3433) that would have created a voucher system for the acquisition of training and rehabilitation services from state vocational offices or businesses. It would also have extended the time the working disabled could receive Medicare. (CQ Weekly, p. 1540)

The measure was designed to give rehabilitation agencies financial incentives to get the disabled into the workplace.

The bill, sponsored by House Ways and Means Social Security Subcommittee Chairman Jim Bunning, R-Ky., and ranking Democrat Barbara B. Kennelly of Connecticut, was based partly on the Clinton administration's 1997 "Ticket to Independence" training plan.

"The disability program is like a big, black hole. Once people fall into the program they never seem to make their way out," Bunning said when introducing the bill in March.

The legislation did not clear the Senate. The problem was not lack of support, but rather efforts to expand the bill.

Senate Labor Committee Chairman James M. Jeffords, R-Vt., and Edward M. Kennedy, D-Mass., drafted a measure that included the House training provisions, but took the next step in allowing the working disabled to buy into Medicaid and providing grants to states to help cover the cost.

To win support, the senators scaled their initial bill back to a plan estimated to cost \$1.5 billion to \$2 billion over five years. They pushed it during last-minute negotiations on the fiscal 1999 omnibus spending law (PL 105-277). Although supported by the White House, it was not included because lawmakers were concerned about attaching such a comprehensive package to the spending bill. There was also controversy about proposed spending offsets.

"Despite endless rhetoric about wanting to help people with disabilities get back to work, the Republican leadership slammed the door on legislation that would have removed barriers preventing people living with HIV/AIDS and other disabilities from being active participants in the work force," Sandra L. Thurman, director of the Office of National AIDS policy, said in an Oct. 15 statement.

The senators will re-introduce the bill early next year. They are hopeful that Clinton will propose funding for it in his fiscal 2000 budget.

"The legislation that Sen. Jeffords and I will re-introduce next year is designed to encourage and support every disabled person's desire to work, to live independently and to be a contributing member of their community," Kennedy said.

House aides said that the issue could also arise again next session as part of a larger bill to enhance patients' rights under managed care health plans. (Managed care, CQ Weekly, p. 2074)

Even as Congress and the states concentrate on getting people to work, there are accusations that basic needs are unmet.

On Nov. 2, in a protest timed to the midterm elections, members of Americans Disabled for Attendant Programs Today used their wheelchairs to block the entrances of the Democratic and Republican Party headquarters. They were protesting the fact that many state Medicaid programs do not pay for in-home care, such as personal attendants, forcing many to remain in institutions.

House Speaker Newt Gingrich, R-Ga., last year introduced legislation (HR2020) that would have expanded Medicaid to cover such services. The bill went nowhere because it would have been too costly.

The Jeffords-Kennedy measure would have required states that elected to extend Medicaid for the working disabled under a grant program to also offer attendant care.

Some caution that while the emerging work initiatives are an important step, they are not a panacea. To qualify for federal benefits, individuals must meet a tight standard of disability and many simply have too many chronic problems to go to work.

"It's not going to create droves or millions of people going off the rolls, but there are significant numbers of people who, because of the security of health care . . . decide not to work," said Ken McGill, Social Security Administration director of employment and rehabilitation programs.

"There are young people and others with pretty productive potential, but if the system is against them they are not going to work," he said.

Oregon officials estimate that 174,000 of the state's citizens are out of the job market due to disabilities. Of those, 125,000 want to work.

The Medicaid buy-in is just part of an overall Oregon initiative to improve training and form partnerships with businesses that hire the disabled. Since the program started in 1996, the state has placed 500 people in jobs and volunteer work.

There are concerns that the system may favor people with some disabilities over others. Paula Blue, executive director of The Arc of Oregon, which advocates for the mentally retarded, said the Medicaid program was mainly designed for those with physical, not mental impairments. The group has started a campaign to draw attention to Oregon's waiting list for vocational and support services.

"We're just at the point where we're seeing people come out of the system under the 1975 [education of the disabled] law. What are we

doing? We're putting them on waiting lists," she said.

Supporters said expanding Medicaid prescription coverage would be a major help for those with mental conditions, whose drug costs can run hundreds of dollars each month.

The fate of work legislation is also tied to a broader debate over Social Security. Clinton has called on Congress to pass legislation next year to ensure the long-term solvency of the program, which provides retirement, disability and survivors' benefits to 44 million Americans.

Some proposals call for reducing SSDI, funded through the program's payroll tax, by as much as 30 percent, in line with possible reductions in retirement benefits.

Further, the General Accounting Office has placed SSI -- which the libertarian CATO Institute in 1995 labeled the "black hole of the welfare state" -- on its list of programs susceptible to fraud. The Jeffords-Kennedy bill would have been financed, in part, by cracking down on alleged abuse in the program.

Congress in the 1996 welfare law tightened SSI benefits to children and eliminated aid to legal immigrants. Lawmakers later rolled back many of those provisions.

COPING WITH ROUTINE

Tens of millions of Americans have physical and mental impairments serious enough to affect their ability to perform the regular routines of daily life. The effort to improve the legal status of the disabled has been described as the next step of the civil rights movement.

In 1975, responding to court decisions, Congress passed legislation (PL 94-192) guaranteeing a free and adequate public school education for children with physical and mental limitations. (1975 Almanac, p. 651)

The 1990 Americans with Disabilities Act (PL 101-336) barred discrimination in employment, public services and access to public buildings. Estimated to have an impact on 43 million Americans, the law also required businesses to make "reasonable accommodations" for workers. (1990 Almanac, p. 447)

Still, a Harris Survey conducted in July for the National Organization on Disability found just 29 percent of those with chronic health conditions worked full or part time, compared with 79 percent of the broader population. One-third lived in households with income of \$15,000 or less, more than double the proportion for the able-bodied.

"I've had a lot of people say that there are attitudinal barriers that make it not very likely that they're going to be accepted on the part of employers and others in companies," said Alan A. Reich, president of the organization. The work issue is not a new one for Congress, which in the past has tried to build employment incentives into federal programs.

SSDI provides average monthly aid of more than \$700. To qualify, a worker must have a medical impairment that is expected to last at least 12 months and prevents substantial gainful activity. After 24 months, individuals become eligible for Medicare, which covers hospital and physicians' bills -- but not prescriptions or attendant care.

SSDI beneficiaries lose cash benefits when they earn \$500 per month after a nine-month trial and a three-month grace period. They can receive Medicare for four years while working, but must pay the premium.

To receive SSI, adults must meet the Social Security disability criteria and have a low income. Once on the rolls, they are eligible for the state-federal Medicaid program, which covers prescription drugs, long-term care and often attendant care. About 1.6 million people qualify for both disability programs.

SSI has more liberal work rules. As income rises, cash benefits are reduced gradually until they reach zero. Individuals can still receive Medicaid until they reach state-specified caps of about \$20,000 annually. Experts warn that that income level is too low to meet both living expenses and health care. About 6 percent of working-age recipients were employed as of September.

Oregon is well-positioned to launch the Medicaid buy-in. The state in 1981 was the first to receive a federal waiver to provide attendant care and other services as an alternative to institutional care. Further, Oregon has one of the nation's most expansive Medicaid programs.

WATCHING OREGON

Lay said officials from other states have been calling him to get the details of Oregon's experiment. He added that they blanch when he tells them Oregon has no firm estimate of how much it will save -- or cost.

"They always ask the same question: How many people and how much is it going to cost? We always say we don't know, and that scares them," Lay said.

The 1997 budget law gave states authority to expand Medicaid under

the following criteria: an individual had to be working, have a condition that met the Social Security disability definition and have net income below 250 percent of the federal poverty level, or \$20,125 per year for an individual. Participants did not have to be on the federal rolls to qualify.

Lay said Oregon officials figured that under those guidelines, the program would still impose an effective income cutoff at about \$40,000 annually. Further, individuals on SSDI -- most in need of access to Medicaid's personal attendant care and prescription drug benefits -- might not qualify. So the state got federal permission to tailor the guidelines.

To ensure the maximum number of people will be eligible, Oregon will not count unearned income -- disability, veterans', black lung or other benefits.

Current SSI rules allow only \$2,000 in savings. Oregon will permit up to \$12,000 along with separate, special savings for major expenses such as a motorized wheelchair or a van. The state will also allow individuals to deduct expenses directly related to a disability, such as special adaptive cushions or medical equipment.

There is recognition in Congress as well that the 250 percent income limit is too tight. The Jeffords-Kennedy bill would have eliminated the ceiling.

Still, Roger Auerbach, assistant director of the Oregon Department of Human Services, said when he described the program to officials from other states at a recent meeting, some could not understand why Oregon had decided to implement the plan.

To follow, other states would have to expand Medicaid spending for attendant care. Increased work force participation could boost state tax revenues, but major savings from the program would likely accrue to the federal government. Many state administrators are closely watching the Jeffords-Kennedy bill and other initiatives.

Diana - Here's a draft of what we want last week -
Can we have a call at 3pm to discuss?

DRAFT: Health Options: Return To Work

- **Aggressively promote Medicaid buy-in option.** This new policy allows states to let people with disabilities, regardless of whether they receive SSI or SSDI, buy into Medicaid, subject to an earned income limit of 250 percent of poverty and unearned and assets limits. Participants would receive the full Medicaid benefits package offered in the state.

The Administration intends to put out additional guidance, to work with the Governors and state Medicaid directors to encourage them to take this option. [add specifics]

- **Make Medicaid buy-in option more accessible to people who work.** Several provisions of BBA limit its ability to help people with disabilities returning to work.
 - 250 percent cap on earned income
 - Lifting limit on unearned income
 - Lifting limit on assets

[Note: All of the above can be accomplished using 1902(r)(2) without any scoring implications. States can also limit the upper eligibility limit with 1902(r)(2), whereas they could not if done legislatively.]

- **Create incentives for states to take the Medicaid buy-in option.** Savings in SSI and SSDI resulting from people leaving these programs could be used to provide grants to states to encourage their participation in this Medicaid option. Depending on amount of funds available, three types of grants could be given:

- **Planning grants.** To provide an immediate incentive for states to take this option, states that submit a short description of their plans could receive a grant (the same amount for all states) to develop state plan amendments. States must consult with the disability community in this planning process. [\$100,000 - 200,000 / state]
- **Infrastructure and outreach grants.** States that submit a state plan amendment could receive a grant for infrastructure development and education about the new option. This grant could be based on the number of people with two or more limitations on ADLs. [Allocate up to \$5 to 100 million]
- **Performance grants.** States could receive an annual grant based on the number of people leaving SSI and SSDI for work. [HHS is working on the details] This grant would serve as a way to share with states the savings to SSA resulting from people leaving SSI and SSDI for work. [To be determined]

C10m

+ Cost indirect effect on MS

B-K - \$5m - on budget
- 1 for 2 - \$40m

MA/MC? - Cost alloc + MC buy-in (\$2b)

SSI Fraud - 170m/5

= auth for duals to automatically charge BT for SSI
- not prewall, but not in reconer? -

* Show + SSA package of SSI fraud -

- Chris can't raise

Best Summary

(along w/PCO15)

of original K-T

SISS

Done by OMB

health people

→ List policy issues to MB

→ HCBS waivers to mgd. care

Jeffords/Kennedy Return to Work Bill
Populations Covered

Who - current fed state or state decides

	NON BENEFICIARY (Not on SSI or SSDI)	OPTIONS SSDI (0 to 24 months)	OPTIONS SSDI (24+ months)	SSI	OTHER MEDICAID DISABLED (e.g. medically needy)
CURRENT LAW DISABLED INDIVIDUAL	WHAT ARE THEY GETTING NOW? If not working: No cash benefits No acute care No long-term care If working: No cash benefits No acute care No long-term care	WHAT ARE THEY GETTING NOW? If not working: Cash benefits under SSDI No acute care under Medicare until after 24 months No long-term care If working: No cash benefits under SSDI No acute care under Medicare	WHAT ARE THEY GETTING NOW? If not working: Cash benefits under SSDI Acute care under Medicare No long-term care If working: No cash benefits under SSDI Acute care under Medicare for 39 months	WHAT ARE THEY GETTING NOW? If not working: Cash benefits under SSI Acute and long-term care under Medicaid If working but earning b/ 1619(b) and 250% then: Acute and long-term care under Medicaid No cash benefit under SSI If working but earning above 250% then: No acute and long-term care under Medicaid No cash benefit under SSI	WHAT ARE THEY GETTING NOW? If not working or if working: No cash benefits Acute and long-term care under Medicaid
WORKING INDIVIDUAL UNDER J/K Eligible Worker with a Disability (EWID) State definition of work eligible	WHAT DO THEY GET UNDER J/K? <i>End of limit @ state option</i> 1) Work Incentive Services (SWOP) Reduced Medicaid benefit package for disabled only Enhanced CHIP FMAP States would amend Medicaid state plan State must provide at least PAS & drugs - <i>NO Min.</i> States could reduce benefit standards States would have to comply with statewidness and comparability of service Free below 150% Buy-in above 150% Premiums on sliding scale basis <i>MA Payer Last Resort</i> 2) Counseling	WHAT DO THEY GET UNDER J/K? <i>Non-SWOP state: any meaning?</i> MUST GIVE UP CASH IF GIVE UP CASH THEN: 1) Work Incentive Services (SWOP) Reduced Medicaid benefit package for disabled only Enhanced CHIP FMAP States would amend Medicaid state plan State must provide at least PAS & drugs States could reduce benefit standards States would have to comply with statewidness and comparability of service Free below 150% Buy-in above 150% Premiums on sliding scale basis 2) Counseling 3) Auxiliary benefit continues 4) Easy back on the rolls 5) No EPE or TWP	WHAT DO THEY GET UNDER J/K? MUST GIVE UP CASH IF GIVE UP CASH THEN: 1) Work Incentive Services (SWOP) Reduced Medicaid benefit package for disabled only Enhanced CHIP FMAP States would amend Medicaid state plan State must provide at least PAS & drugs States could reduce benefit standards States would have to comply with statewidness and comparability of service Free below 150% Buy-in above 150% Premiums on sliding scale basis 2) Counseling 3) Auxiliary benefit continues 4) Easy back on the rolls 5) No EPE or TWP	WHAT DO THEY GET UNDER J/K? 1) Work Incentive Services (SWOP) Reduced Medicaid benefit package for disabled only Enhanced CHIP FMAP <i>states can make it</i> States would amend Medicaid state plan State must provide at least PAS & drugs States could reduce benefit standards States would have to comply with statewidness and comparability of service Free below 150% Buy-in above 150% Premiums on sliding scale basis 2) Counseling	WHAT DO THEY GET UNDER J/K? 1) Work Incentive Services (SWOP) Reduced Medicaid benefit package for disabled only Enhanced CHIP FMAP States would amend Medicaid state plan State must provide at least PAS & drugs States could reduce benefit standards States would have to comply with statewidness and comparability of service Free below 150% Buy-in above 150% Premiums on sliding scale basis 2) Counseling
		IF DO NOT GIVE UP CASH THEN: Current law	IF DO NOT GIVE UP CASH THEN: Current law except IRWE Can buy car in some circumstances		

Big issue on AIDS - bad precedent

must be same for all (unless waiver for only some)

all move if keep wkg

VSQ DW1
Equity w/ over 65

Cost sharing w/ current elig? maybe?

Why would a state do? - can save on dual eligibles

**Jeffords/Kennedy Return to Work Bill
Populations Covered**

	NON BENEFICIARY (Not on SSI or SSDI)	OPTIONS SSDI (0 to 24 months)	OPTIONS SSDI (24+ months)	SSI	OTHER MEDICAID DISABLED (e.g. medically needy)
<p>NOT WORKING UNDER J/K Work Eligible Individual (WEI) State definition of work eligible</p> <p>MEDICAID WAIVER PROVISION States would be allowed to apply for an 1115 Medicaid waiver and compute budget neutrality across SSI, SSDI, and Medicaid</p>	<p>WHAT DO THEY GET UNDER J/K? Nothing</p>	<p>WHAT DO THEY GET UNDER J/K? MUST GIVE UP CASH (????) IF GIVE UP CASH THEN: 1) Work Incentive Services (SWOP) Reduced Medicaid benefit package for disabled only Enhanced CHIP FMAP States would amend Medicaid state plan State must provide at least PAS & drugs States could reduce benefit standards States would have to comply with statewideness and comparability of service Free below 150% Buy-in above 150% Premiums on sliding scale basis 2) Counseling</p>	<p>WHAT DO THEY GET UNDER J/K? MUST GIVE UP CASH (?????) IF GIVE UP CASH THEN: 1) Work Incentive Services (SWOP) Reduced Medicaid benefit package for disabled only Enhanced CHIP FMAP States would amend Medicaid state plan State must provide at least PAS & drugs States could reduce benefit standards States would have to comply with statewideness and comparability of service Free below 150% Buy-in above 150% Premiums on sliding scale basis 2) Counseling</p>	<p>WHAT DO THEY GET UNDER J/K? 1) Work Incentive Services (SWOP) Reduced Medicaid benefit package for disabled only Enhanced CHIP FMAP States would amend Medicaid state plan State must provide at least PAS & drugs States could reduce benefit standards States would have to comply with statewideness and comparability of service Free below 150% Buy-in above 150% Premiums on sliding scale basis 2) Counseling</p>	<p>WHAT DO THEY GET UNDER J/K? 1) Work Incentive Services (SWOP) Reduced Medicaid benefit package for disabled only Enhanced CHIP FMAP States would amend Medicaid state plan State must provide at least PAS & drugs States could reduce benefit standards States would have to comply with statewideness and comparability of service Free below 150% Buy-in above 150% Premiums on sliding scale basis 2) Counseling</p>

Kennedy + Jeff
staff did this
for a negotiating
meeting

① * DF: AHS on State def of disab: by Friday

SSA re estoppel fix + Paul Miller what we think of policy of state def alt defs. - Rehab

④ * QDWE FIX? / MC-Ned by Fri Outline for Meeting with White House/OMB/HCF A July 15, 1998

* Christ + Nexon agreement

limited # steps (= fix estoppel) effect on cost

Meeting Structure

* Vetting ticket des w/ SSA? Care Chesser

- 1). Share the things that are important
 - A. Keep the OPTIONS Program Infrastructure

Extended Medicare

- Medicaid buy-in using BBA mechanism *not in SSA*
- Work Incentives Assistance Program -- covers all work incentive programs
- Protection and Advocacy piece

- 2). Mechanisms for Medicaid buy-in *in ticket, esp.*

OPTION #1 see paper

- Lift the 250 percent cap on the 1997 BBA *assets/res.*
- Insurance is payor of first resort *(held in trust in AOD) (current law: don't have to take ins - indiv mandate)*
- State-determined cost-sharing provisions above 250 percent earned income *DF, WID wanted*

OPTION #2 see paper

- Lift the 250 percent cap of BBA
- Private Insurance is payor of first resort.
- States define cost sharing above 250 percent of earned income.

DF to run IDWIS process
Ji: Monday mtg - Howard to setup
Try to get cost est

- State determines the definition of working person with a disability based on OPTIONS criteria *(Lefty + Marie Stralio)*

** implications for the definition of disability

#3 see paper

Incentives for State participation

Incentive Grant Program

- Planning grant for all states in year one *20k*
- Infrastructure and outreach *\$1.2m/state, 725 states*
- Performance grants based on states ability to demonstrate state-wide PAS for OPTION-eligible participants either through their state plan or through a combination of the state plan and state-wide 1115 Waivers.

Rehab Act: def - Prob: or meet such as to work
CB: sd expensive - Provost

estoppel problem - big issue; AODS comm.

② Look @ outcomes 19 states don't offer PAS? Christy says all offer some @ least thru waivers
* Look @ current coverage in states

Medicare Option #1 — current J-K — buy in

see paper

Medicare Option #2

see paper (employer contribution)

— use em subsidy to pay for Part A ^{against wid}
if no private coverage, still J-K

→ Alt: (buy in to QDWE??)

Alt must be off EPE to get QDWE
— have to be w/o coverage
for a time

QDs: MC Earned benefit
Also better access to providers

* Worth fixing all on its own?

Jeanne — people troubled by uhhdmc
(what about MA?)

~~Q~~

- ① narrow fix to QDWE
- ② dual eligs (?) (a mandate?)
- ③ our position on MC
- ④ top credit

MEDICAID OPTION 1

1
2 **SEC. 201. ELIMINATION OF INCOME AND ASSET AND RE-**
3 **SOURCE LIMITATIONS ON STATE OPTION TO**
4 **PERMIT WORKERS WITH DISABILITIES TO**
5 **BUY INTO MEDICAID.**

6 (a) IN GENERAL.—Section 1902(a)(10)(A)(ii)(XIII)
7 of the Social Security Act (42 U.S.C.
8 1396a(a)(10)(A)(ii)(XIII)) is amended—

9 (1) by striking “are in families whose income is
10 less than 250 percent of the income official poverty
11 line (as defined by the Office of Management and
12 Budget, and revised annually in accordance with sec-
13 tion 673(2) of the Omnibus Budget Reconciliation
14 Act of 1981) applicable to a family of the size in-
15 volved, and who”;

16 (2) by inserting “(determined without regard to
17 any assets or resources of the individual)” after
18 “1905(q)(2)(B)”; and

19 (3) by inserting “and who, in the case of indi-
20 viduals who are in families whose income exceeds
21 250 percent of the income official poverty line (as
22 defined by the Office of Management and Budget,
23 and revised annually in accordance with section
24 673(2) of the Omnibus Budget Reconciliation Act of
25 1981) applicable to a family of the size involved, do

1 not have creditable coverage, as defined in section
2 2701(c) of the Public Health Service Act," after
3 "security income"

4 (b) EFFECTIVE DATE.—

5 (1) IN GENERAL.—The amendments made by
6 subsection (a) shall apply on and after October 1,
7 1998.

8 (2) EXTENSION OF EFFECTIVE DATE FOR
9 STATE LAW AMENDMENT.—In the case of a State
10 plan under title XIX of the Social Security Act
11 which the Secretary of Health and Human Services
12 determines requires State legislation in order for the
13 plan to meet the additional requirements imposed by
14 the amendments made by a provision of this section,
15 the State plan shall not be regarded as failing to
16 comply with the requirements of such section solely
17 on the basis of its failure to meet these additional
18 requirements before the first day of the first cal-
19 endar quarter beginning after the close of the first
20 regular session of the State legislature that begins
21 after the date of the enactment of this Act. For pur-
22 poses of the previous sentence, in the case of a State
23 that has a 2-year legislative session, each year of the
24 session is considered to be a separate regular session
25 of the State legislature.

MEDICAID OPTION 2

1 SEC. ____ . STATE OPTION TO PERMIT OPTIONS PROGRAM 2 3 PARTICIPANTS TO BUY INTO MEDICAID.

4 (a) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the
5 Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is
6 amended—

7 (1) in subclause (XIII), by striking “or” at the
8 end;

9 (2) in subclause (XIV), by adding “or” at the
10 end; and

11 (3) by adding at the end the following:

12 “(XV) who are SSDI OPTIONS
13 program participants, as defined in
14 section 1181(3) or are eligible work-
15 ing individuals with a disability, as de-
16 fined in section 1181(2), participating
17 in the OPTIONS program established
18 under part D of title XI and who, in
19 the case of individuals who are in
20 families whose income exceeds 250
21 percent of the income official poverty
22 line (as defined by the Office of Man-
23 agement and Budget, and revised an-
24 nually in accordance with section
25 673(2) of the Omnibus Budget Rec-

1 conciliation Act of 1981) applicable to
2 a family of the size involved, do not
3 have creditable coverage, as defined in
4 section 2701(c) of the Public Health
5 Service Act, (subject, notwithstanding
6 section 1916, to payment of premiums
7 or other cost-sharing charges (set on
8 a sliding scale based on income) that
9 the State may determine);”

10 (b) EFFECTIVE DATE.—

11 (1) IN GENERAL.—The amendment made by
12 subsection (a) shall apply on and after October 1,
13 1998.

14 (2) EXTENSION OF EFFECTIVE DATE FOR
15 STATE LAW AMENDMENT.—In the case of a State
16 plan under title XIX of the Social Security Act
17 which the Secretary of Health and Human Services
18 determines requires State legislation in order for the
19 plan to meet the additional requirements imposed by
20 the amendments made by a provision of this section,
21 the State plan shall not be regarded as failing to
22 comply with the requirements of such section solely
23 on the basis of its failure to meet these additional
24 requirements before the first day of the first cal-
25 endar quarter beginning after the close of the first

MA #3 S.L.C. option

1 regular session of the State legislature that begins
2 after the date of the enactment of this Act. For pur-
3 poses of the previous sentence, in the case of a State
4 that has a 2-year legislative session, each year of the
5 session is considered to be a separate regular session
6 of the State legislature.

7 **SEC. ____ . GRANT PROGRAM TO DEVELOP AND ESTABLISH**
8 **STATE INFRASTRUCTURES TO SUPPORT**
9 **WORKING DISABLED INDIVIDUALS.**

10 (a) **ESTABLISHMENT.**—The Secretary of Health and
11 Human Services (in this section referred to as the “Sec-
12 retary”) shall award grants described in subsections (c),
13 (d), (e) to States to support the design, establishment, and
14 operation of State infrastructures that provide items and
15 services to support working disabled individuals. A State
16 shall submit an application for a grant authorized under
17 this section at such time, in such manner, and containing
18 such information as the Secretary may determine.

19 (b) **GRANTS FOR PLANNING AND IMPLEMENTA-**
20 **TION.**—Out of funds appropriated for fiscal year 1999 the
21 Secretary shall award grants to States to support the
22 planning and design of the State infrastructures described
23 in subsection (a).

24 (c) **GRANTS FOR INFRASTRUCTURE AND OUT-**
25 **REACH.**—Out of funds appropriated for each of fiscal

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approved
spa

1 years 2000 through 2003, not less than ____ percent of
 2 the amount appropriated each fiscal year shall be used by
 3 the Secretary to award grants to States under this sub-
 4 section to—

5 (1) support the establishment, implementation,
 6 and operation of the State infrastructures described
 7 in subsection (a); and

8 (2) conduct outreach campaigns regarding the
 9 existence of such infrastructures.

10 (d) PERFORMANCE GRANTS.—

11 (1) IN GENERAL.—Out of funds appropriated
 12 for each of fiscal years 2000 through 2003, the Sec-
 13 retary shall reserve ____ percent for awarding per-
 14 formance grants to States that have established in-
 15 frastructures and met outcome standards that sup-
 16 port disabled individuals to obtain and retain em-
 17 ployment. Not less than ____ percent of the amount
 18 appropriated each fiscal year shall be used to award
 19 grants under this subsection.

20 (2) DEVELOPMENT OUTCOME STANDARDS.—

21 Performance grants shall be awarded to States
 22 under this subsection based on scores assigned from
 23 the application of outcome standards that meas-
 24 ure—

including but not limited to:
5

1 (A) the effectiveness of State infrastruc-
2 tures and service delivery systems that support
3 disabled individuals to obtain and retain em-
4 ployment; and

5 (B) the increase percentage in the number
6 of individuals receiving disability insurance ben-
7 efits under title II of the Social Security Act
8 and supplemental security income benefits
9 under title XVI of such Act return to work.

10 The outcome standards shall be developed by the
11 Secretary in consultation with the Secretary of
12 Labor, the Secretary of Education, and the Work
13 Incentives Advisory Panel established under section
14 411 of the Work Incentives Improvement Act of
15 1998.

+SEA

16 (e) GRANT REQUIREMENTS.—

17 (1) ELIGIBILITY.—

18 (A) IN GENERAL.—No State may receive a
19 grant under subsection (c) or (d) unless the
20 State demonstrates to the satisfaction of the
21 Secretary that the State makes personal assist-
22 ance services available to working disabled indi-
23 viduals either as an optional service available
24 under the State medicaid plan under title XIX
25 of the Social Security Act or under any other

}
}

1 provision of law, including through a Statewide
 2 waiver approved under section 1115 or 1915 of
 3 the Social Security Act (42 U.S.C. 42 U.S.C.
 4 1315, 1396n).

5 (B) DEFINITION OF PERSONAL ASSIST-
 6 ANCE SERVICES.—In this section, the term
 7 “personal assistance services” means a range of
 8 services, provided by 1 or more persons, de-
 9 signed to assist an individual with a disability
 10 to perform activities of daily living on or off the
 11 job that the individual would typically perform
 12 if the individual did not have a disability. Such
 13 services shall be designed to increase the indi-
 14 vidual’s control in life and ability to perform ac-
 15 tivities of daily living on or off the job.

16 (2) AMOUNT OF GRANTS.—No State shall re-
 17 ceive a grant under subsection (c) or (d) for a fiscal
 18 year that is less than \$1,000,000 or more than
 19 \$3,000,000. The amount of a grant under such sub-
 20 sections for a State for a fiscal year shall be deter-
 21 mined on the basis of the percentage of the popu-
 22 lation of the State that receives disability insurance
 23 benefits under title II of the Social Security Act and
 24 supplemental security income benefits under title
 25 XVI of such Act.

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1 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
2 authorized to be appropriated—

3 (1) \$25,000,000 for fiscal year 1999 to award
4 planning and implementation grants in accordance
5 with subsection (b); and

6 (2) \$75,000,000 for each of fiscal years 2000
7 through 2003 to award grants for the purposes de-
8 scribed in subsections (c) and (d).

9 [alternative mandatory appropriation](f) APPRO-
10 PRIATION.—Out of any funds in the Treasury not other-
11 wise appropriated, there is authorized to be appropriated
12 and there is appropriated—

13 (1) \$25,000,000 for fiscal year 1999 to award
14 planning and implementation grants in accordance
15 with subsection (b); and

16 (2) \$75,000,000 for each of fiscal years 2000
17 through 2003 to award grants for the purposes de-
18 scribed in subsections (c) and (d).

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500K ea.



ADAPT

action news bulletin

OMB

cc Chris Jennings
Jeanne Lambrew
Dan Meudelson
Anne Tomlinson
Bonnie Washington
Call 690 6726
for fax)
Bob Williams
(call 690.643
for fax)

The Honorable Bill Clinton
President of the United States
The White House
Washington, DC 20000

July 13, 1998

Dear President Clinton:

Two representatives from ADAPT met with you at the White House on September 10, 1997. The issue of home and community services was a major topic of discussion at this meeting.

During this meeting, you directed your staff to work on initiatives that would change the institutional bias of the long term service system. Almost one year has gone by since that meeting and the institutional bias of the long term care system continues virtually unchanged.

The workgroup established after the September 10th meeting co-chaired by Sally Richardson, Medicaid Director and Bob Williams, Deputy Assistant Secretary for Disability, Aging, and Long Term Care has been embarrassingly ineffective. The minor policy changes they have made do not begin to address the enormity of this problem.

Recently HCFA sent out a small grant proposal to the states that has absolutely no relation to what ADAPT had in mind when the "Date Certain" concept was discussed with staff. The concept of "Date Certain" was to select a date, when in 6-10 states, ALL individuals in Medicaid funded nursing homes and other institutions were to be given "the choice" of using that money for home and community services. The proposal sent out by HCFA has absolutely no resemblance to what we had agreed upon except for using the "Date Certain" rubric.

Does the problem lie in your commitment or your staff's unwillingness to execute that commitment?

Nancy Ann Min DeParle, HCFA Administrator has gone back on her commitment to continue the working relationship ADAPT had with the former Administrator and she refuses to answer our letters. Does Ms DeParle's lack of responsiveness represent your Administration's commitment to the issue?

FYI.
Diana

Delay tactics and paternalistic, token gestures are all the disability community has been fed since the September 10th meeting.

Our questions to you are simple: Will you make deinstitutionlizing people with disabilities, old and young , a priority for your Administration?
Will you make a major budget initiative for home and community services in your next budget? Will you initiate a REAL "date certain" project?

At the September 10th meeting you exhibited a knowledge of the political problems associated with tackling this issue. ADAPT also recognizes the complexity of the problem.

You, as President, need to show the same leadership in the area of long term services that you are showing in the areas of child care, race and Social Security. Until long term services is raised politically as an issue your Administration is committed to, Congress will not act and people with disabilities will continue to be warehoused in nursing homes and other institutions.

ADAPT wants to work with your Administration to change the institutional bias of the long term care system. However, our goal is attendant service not lip service. Please respond by August 13, 1998.

For an Institution Free America,


M.W. Auherger
Organizer


Stephanie Thomas
Organizer


Bob Kafka
Organizer


Mike Oxford
Organizer

ADAPT
P.O. Box 9598
Denver, Colorado 80209
303/333-6698
512/442-0252

Date 6/10/98

cc Jeanne

FAX



Health Division



Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

To: *Diana Fortuna*
Fax:
Phone:

From: *Rikki*

Number of Pages (not including cover): *13*

Subject: *Kennedy / Jeffords CBO scoring.*

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**PRELIMINARY CBO ANALYSIS OF S. 1858,
THE WORK INCENTIVES IMPROVEMENT ACT OF 1998**

S. 1858 would establish the Opportunity to Fully Integrate Through Occupations (OPTIONS) program for some working individuals with disabilities. OPTIONS would provide participants with extended Medicare benefits and work counseling services. The bill would also give states the option to provide certain Medicaid benefits to OPTIONS participants and to some other disabled individuals. Additionally, the bill would extend Disability Insurance (DI) program demonstration project authority, add requirements for consideration of Section 1115 waivers that reduce work disincentives, and establish a program of outreach to individuals with disabilities potentially eligible to participate in OPTIONS and other work incentive programs. The health and counseling provisions of the bill would be effective one year after enactment, and would sunset 10 years after enactment. For this analysis, CBO assumed that the bill would be enacted in September 1998 and this program would be implemented in fiscal year 2000.

CBO estimates that the bill would raise federal mandatory spending by \$1.2 billion in 2000 and by \$5.4 billion between 2000 and 2003. The largest component of this increase is in the Medicaid program, with five-year spending of \$5.2 billion. Discretionary costs would rise by \$0.5 billion in 2000 and by about \$0.3 billion a year thereafter, for a total of \$1.4 billion between 1999 and 2003; those costs would be paid from appropriated funds. Provisions affecting workers with disabilities under current law and S. 1858, and assumptions underlying this estimate, are discussed below and summarized in the attached tables.

Current Law. Under current law, both the DI program and the Supplemental Security Income (SSI) program offer incentives for disabled persons to work. In both programs, applicants must show that they are incapable of substantial work (labeled "substantial gainful activity" or SGA, currently defined in regulation as earnings of more than \$500 a month) in order to be awarded disability benefits. If DI recipients work after entitlement, however, the law permits them to earn unlimited amounts for a 9-month period (known as the trial work period, or TWP) and a subsequent 3-month grace period before their benefits are suspended. During the next 3 years—a period known as the extended period of eligibility, or EPE—those beneficiaries may automatically return to the DI rolls if their monthly earnings sink below \$500. Furthermore, Medicare benefits (for which DI beneficiaries qualify after two years of entitlement) also continue during the 3 years of the EPE. Beneficiaries pay no Medicare

Hospital Insurance (Part A) premium, but must pay the Supplementary Medical Insurance (Part B) premium. Once the EPE ends, earnings above SGA result in DI benefits being terminated. Moreover, beneficiaries cease to get Medicare benefits, unless they pay the full Part A premium (\$322 a month in 1999). Research suggests that only 10 to 20 percent of DI recipients ever work after they start collecting benefits, only 2 to 3 percent eventually have benefits suspended due to earnings (that is, start an EPE), only about 1 percent are terminated at the end of the EPE, and few purchase Medicare coverage thereafter.

SSI recipients who work get a reduced benefit, but do not give up their benefit entirely. Most SSI recipients receive full Medicaid benefits. If their monthly earnings exceed \$500 but they are still medically disabled, they move into section 1619(a) status and continue to collect a small cash benefit. The cash benefit is reduced by \$1 for every \$2 of earnings above \$85. If their earnings rise further, they enter 1619(b) status, where they collect no cash benefit, but still qualify for Medicaid until their earnings reach a point at which they are deemed to be able to afford medical care and living expenses. Income cutoff levels for the 1619(b) group differ among the states. About 20 percent to 25 percent of SSI beneficiaries work after entitlement, but typically do so sporadically (only one-third to one-half of the time) and at low earnings. Many disabled adults receive SSI and DI concurrently; concurrent beneficiaries constitute about 30 percent of the SSI adult disabled population.

Medicaid offers disabled beneficiaries several benefits that are unavailable in the Medicare program; two of these benefits—prescription drugs and personal care services—are included as work incentive services under S. 1858. Most states have exercised the option under current law to provide prescription drugs as a Medicaid benefit; about half of 1997 spending on this benefit was for disabled persons. All states provide some personal care services as a Medicaid optional benefit, as a benefit within a package of services in home- and community-based waiver demonstration programs for selected eligibility groups in selected areas, or as a service included with the home health benefit. The personal care benefit includes services performed by a personal attendant to assist an individual with eating, bathing, dressing, and other activities of daily living. States have latitude in determining how the benefit will be delivered and supervised and may require authorization by a physician or supervision by a registered nurse.

According to surveys conducted by the Bureau of the Census, approximately 17 million Americans between the ages of 18 and 64 describe themselves as having a disability that limits their ability to work. About 8 million receive cash benefits under either the DI or SSI programs. Of the remaining 9 million disabled people who do not receive benefits, about 5 million report some earnings, of whom 3 million have low earnings. Some of those low-

wage disabled workers receive employer-sponsored health insurance, either on their own or through a family member, or have an individual policy. Personal assistance services are generally not available through employer-sponsored insurance, however. For purposes of this estimate, CBO assumes that about one-quarter to one-half of the workers with disabilities go without health insurance entirely or are underinsured. Some disabled workers not eligible for cash benefits under the SSI program (and, hence, Medicaid) might be eligible for Medicaid benefits under other eligibility criteria. For example, states have the option of buying into Medicaid disabled workers whose incomes are under 250 percent of poverty.

S. 1858. The bill would establish the OPTIONS program for two categories of working people with disabilities: eligible working individuals with a disability (EWIDs) and SSDI OPTIONS program participants. EWIDs would be working individuals ages 18-64 requiring personal assistance services or prescription drugs and who do not receive disability benefits under Title II or Title XVI. Under the bill, states would perform eligibility determinations for EWIDs.

SSDI OPTIONS program participants would be individuals ages 18-64 eligible for disabled-worker cash benefits who work and elect to participate in the OPTIONS program. SSDI OPTIONS enrollees who have been entitled for less than 24 months would have to give up DI cash benefits in exchange for health benefits under the OPTIONS program. Participants entitled to DI cash benefits for more than 24 months could keep any cash benefits to which they are entitled under current law and still receive enhanced health benefits, provided they remain employed. (That means that they could continue to take advantage of the 9-month TWP and 3-month grace period of unlimited earnings, but would still be subject to suspensions of cash benefits thereafter.) However, more impairment-related work expenses (IRWEs), notably costs of a vehicle in rural areas and commuting costs in other areas, could be excluded from earnings in the determination of SGA than under current law; that provision might enable some beneficiaries to remain eligible for DI cash benefits for longer than they would under current law.

All OPTIONS participants would receive Medicaid work incentive services (personal assistance services and prescription drugs), if the state plan offers these benefits and work counseling and assistance services proposed under Title XI of the Social Security Act. Work counseling and assistance services would be financed from SSA's discretionary appropriation.

SSDI OPTIONS program participants would have the opportunity to buy into Medicare after two years of DI or OPTIONS participation. SSDI OPTIONS participants earning under 250

percent of poverty could receive Medicare benefits indefinitely (not just during the 3-year EPE) without having to pay any Part A premium, provided they continue working. SSDI OPTIONS participants earning more than 250 percent of poverty could receive Medicare benefits indefinitely by paying the Medicare Part A premium on a modest sliding scale basis. All SSDI OPTIONS participants would pay the Part B premium in full, as under current law. SSDI OPTIONS participants who stop working and revert to cash status could count any time spent in the OPTIONS program toward the 24-month wait for Medicare.

This bill would also amend Title XIX of the Social Security Act to allow states the option to provide Medicaid work incentive services to Qualified Eligible Working Individuals with a Disability (QEWIDs), which include OPTIONS program participants and SSI individuals under 1619(a) and 1619(b), and to Work Eligible Individuals (WEIs, current recipients of SSI or SSDI defined by states as being in transition to work).

If a state Medicaid program offers work incentive services, it must offer them to all QEWIDs and WEIs. The package of work incentive services must include at least pharmaceutical benefits and personal assistance services. Work incentive services that are not already provided under current law or under existing state programs (as described in the bill's maintenance of effort language) would be reimbursed under an enhanced match rate that is equal to an increase of 30 percent of the difference between the current federal match and 100 percent ($FMAP + .30 * (1 - FMAP)$), with a ceiling of 85 percent. States would not be allowed to impose cost-sharing on enrollees with incomes below 150 percent of poverty, but would be permitted to impose cost-sharing above that threshold. States could not require that personal assistance services be ordered by a physician.

The bill would add new waiver requirements on section 1115 demonstrations designed to reduce work disincentives affecting 5,000 or more persons. In determining cost neutrality of waiver demonstrations, HCFA would have to incorporate savings achieved in the SSDI and SSI programs into the calculation of budget neutrality. The bill would also extend through June 1999 the authority of the Social Security Administration to conduct research and demonstration projects that require waivers of current law. Additionally, the bill would require the Commissioner of Social Security to establish an outreach program for work incentive programs under OPTIONS or 1619(a) or 1619(b).

Cost of S. 1858. Enactment of this proposal would increase mandatory spending by \$5.4 billion and discretionary spending by \$1.4 billion over the 1999-2003 period. The largest component of spending under S. 1858 is in the Medicaid program, with additional five-year spending of \$5.2 billion, compared to current law. CBO's estimates of the number of

participants, cost per participant and total cost of the bill are described below.

Number of Participants. CBO estimates that approximately 440,000 individuals would be eligible for benefits under the OPTIONS program in 2000. Of that number, 325,000 would be SSDI OPTIONS program participants and another 115,000 would be EWIDs (that is, workers with serious impairments who are nevertheless not collecting cash benefits). CBO estimates that an additional 540,000 individuals could be eligible for work incentive services if all states provided these benefits. Although all of these individuals could potentially be eligible for Medicaid work incentive services, not all would receive them because only a portion of states would offer this benefit and maintenance of effort requirements would prevent states that do offer the benefit from providing these services to all eligibles. CBO assumes that states with one-third of eligibles participate, and that maintenance of effort requirements are partially effective, resulting in 200,000 persons receiving work incentive services under the bill.

Eligible Working Individuals with a Disability (EWIDs). CBO assumes that about half of the 3 million low-income disabled workers without DI or SSI benefits are uninsured or underinsured, and would be interested in participating in the OPTIONS program as eligible working individuals. Since states would have discretion in screening these individuals for OPTIONS benefits, CBO assumes that only a small fraction of this group would meet the eligibility criteria. Therefore, approximately 115,000 individuals could be eligible for benefits if all states provided them in 2000; about 40,000 would receive services under the bill. A few of those people are assumed to have Medicaid coverage already.

SSDI OPTIONS Program Participants. It is unlikely that current recipients of DI who have been entitled for less than 24 months would give up cash benefits (which average more than \$700 per month) to secure work incentive services and extended Medicare benefits under the OPTIONS program. First, many such DI recipients are concurrent SSI recipients, and thus are already eligible for full Medicaid benefits, which in most states include some personal assistance services and prescription drugs. Second, if the enrollee signed up for OPTIONS during his or her first 24 months on the rolls, he or she would forfeit the right to a TWP and grace period while working.

Third, although some short-term DI-only recipients would have an incentive to trade cash for work incentive services immediately, they are likely to qualify for these benefits outside of the OPTIONS program. If a state offers these services, it must offer them to DI "work-ready" individuals. A short-term DI-only recipient would therefore seek the work incentive services outside of the OPTIONS program so as to not give up his or her cash benefit.

Finally, the remaining advantage of enrollment--the indefinite extension of Medicare coverage beyond the current-law EPE, at a zero or modest Part A premium--would remain available to the beneficiary if he or she chose to defer enrollment until after 24 months.

CBO assumes that DI recipients who have been entitled for more than 24 months would join OPTIONS since they would not give up cash or other benefits that they can get under current law. CBO assumes that 235,000 DI-only beneficiaries and 90,000 concurrent beneficiaries would enroll in SSDI OPTIONS in 2000. CBO assumes that few would earn significantly more than 250 percent of poverty (about \$20,000 for a single individual, or \$41,000 for a family of four, in 1998), the threshold at which the enrollee would begin to owe a premium for Part A coverage. For most of those enrollees, OPTIONS would be indistinguishable from current-law Medicare benefits; only a minority would leave the DI rolls and benefit from the indefinite extension of the EPE. Only about 85,000 of these beneficiaries actually would receive work incentive services due to the state participation and maintenance of effort requirements.

1619(a) and 1619(b) SSI beneficiaries: CBO projects that in 2000, there will be about 110,000 working SSI recipients in the 1619(a) or 1619(b) program, all of whom would be eligible for Medicaid benefits under current law. Only 10,000 of these beneficiaries would receive work incentive services due to the state participation and maintenance of effort requirements.

"Work ready" Individuals: CBO assumes that another 430,000 individuals would be considered "work ready" under the bill and would be eligible for work incentive services, if offered by the state of residence and not provided under current law. Those include approximately 250,000 SSI-only recipients who are working but earning less than SGA (and who are, therefore, in the regular SSI program rather than in one of the section 1619 programs). Many already receive prescription drug and personal assistance services under the Medicaid program. Depending upon the state definition of "work ready", some SSI individuals who are not working, but are deemed to have the potential to work, could also qualify. CBO assumes that about 70,000 such individuals could be eligible for work incentive services. Of SSDI recipients who are not working, but might be deemed to have potential to work, CBO assumes that about 110,000 could be eligible for work incentive services. In summary, only about 65,000 of individuals eligible under the "work ready" category would receive work incentive services due to the state participation and maintenance of effort requirements.

Cost of Benefits Per Participant: CBO estimates that Medicare spending for DI recipients

B-

who work would average about \$2,900 per year in 2000. CBO projects that this amount would rise to \$4,400 per year by 2008. Those per capita rates are about two-thirds of the per capita rates for the average disabled recipient, since it is likely that disabled people who work are healthier than others on the rolls.

Under current law, the combined federal Medicaid per capita costs for prescription drugs and personal assistance services for the disabled are approximately \$5,800 per year. With the match rate enhancement available under the bill, CBO estimates that the combined federal spending for prescription drugs and personal assistance services under this program would be approximately \$7,000 per disabled beneficiary per year in 2000.

Work counseling and assistance services would include client evaluations and health insurance counseling. Counselors would be paid out of SSA's appropriation and would refer clients to vocational rehabilitation providers or to prospective employers. CBO assumes those costs would average about \$500 per year per enrollee.

Total Cost of S. 1858. CBO estimates that S. 1858 would increase federal Medicaid costs by \$1.2 billion in 2000, with five-year costs of approximately \$5.2 billion. CBO assumed that about one-third of states would take up the option to provide work incentive services to eligible individuals. Some of these individuals would already be eligible for Medicaid benefits (which generally include personal assistance services and prescription drugs) because of their SSI status or other Medicaid eligibility criteria and would be barred from getting work incentive services under S. 1858's maintenance of effort requirements. However, CBO assumes that these requirements would not be fully effective, and that states would be able to federalize some state-only programs and convert some current Medicaid beneficiaries' optional benefits to the enhanced match available under S. 1858. Getting an enhanced match on services states otherwise would have provided would protect states from financial loss associated with newly covered individuals.

CBO's Medicaid estimate accounts for the full cost of work incentive services for those not currently receiving those benefits under the Medicaid program. It also accounts for the marginal increase in federal costs attributable to states converting some optional prescription drug and personal assistance services for eligible persons from Medicaid to the enhanced match program. Although the bill gives states the ability to impose cost-sharing requirements on individuals earning more than 150 percent of poverty, CBO assumes that few newly-enrolled individuals would be affected by any requirements that states would impose, and would likely pay less than 5 percent of the cost of benefits. The estimate also takes into account increases in Medicaid administrative spending associated with new

eligibility determinations. (Under current law, when SSA does disability determinations at the behest of a state solely for the purpose of establishing Medicaid eligibility, SSA absorbs half the cost and the rest is split evenly between federal and state Medicaid outlays.)

CBO estimates that federal spending on Medicare would increase by approximately \$10 million in 2000, compared to current law, and by \$200 million over five years. CBO assumed that working SSDI recipients entitled for more than 24 months would join OPTIONS and qualify for extended Medicare benefits once they exhaust their regular coverage. For most SSDI OPTIONS participants, who would not earn enough to jeopardize their DI benefit, there would be no cost to the policy compared with current law, as they would have gotten Medicare coverage (including free part A coverage) in any case. For those few SSDI OPTIONS participants who will graduate from an EPE, there are Medicare costs compared with current law. Since very few of them would otherwise have bought into Medicare by paying the full actuarial premium for part A coverage, and since relatively few would pay a significant premium under S. 1858's proposed sliding scale based on income, those premiums are largely immaterial to CBO's estimate. Since CBO assumed that hardly any OPTIONS participants would waive their cash benefits, it estimates no DI savings.

The bill would direct that SSA conduct certain demonstration programs to test the effects of various work incentives. The bill would extend SSA's waiver authority, however, only through June 1999--not long enough to get any major projects off the ground. Therefore CBO has not included costs of demonstration projects in its estimate.

CBO estimates that S. 1858 would result in increases in SSA's discretionary spending. Costs for counseling about 440,000 OPTIONS participants at about \$500 per year each would be about \$0.2 billion a year. On the assumption that participating states request SSA to perform disability determinations for EWIDs, SSA's share of costs for those determinations would be about \$0.3 billion in 2000, when the program would first get under way, and subside to about \$50 million a year thereafter. In total, SSA's discretionary costs would rise about \$0.5 billion in 2000 and \$0.3 billion a year thereafter, for a five-year total of \$1.4 billion.

Uncertainties in CBO's estimate. There are several factors that could make the costs of S. 1858 significantly higher or lower than CBO's estimate. Primarily, states' participation in this new, optional Medicaid program is uncertain. CBO's judgment that states with one-third of the eligible population would participate is based on an analysis of how many states would be fiscally no worse off if they offered the new benefits to more people but also enjoyed the enhanced match rate and shifted some current costs. The extent of that behavior could be larger or smaller than CBO assumed. Many more states might participate if they were

willing to incur higher state costs. On the other hand, some states might balk at the program's complexity, especially in the early years.

Another source of uncertainty is the size of the working disabled population. As discussed above, about 8 million people between the ages of 18 and 64 collect Social Security disability or SSI benefits, but 17 million in that age group report a work disability. That would imply 9 million potential applicants for S. 1858's enhanced Medicaid and other benefits. Those figures reflect one particular definition of disability used by the Bureau of the Census--namely, "work disability," defined as an impairment that prevents the respondent from working or limits the kind or amount of work he or she can do. In those same surveys, only 11 million, not 17 million, people describe themselves as meeting a narrower definition ("severe" work disability). But when a broader definition of disability--one resembling the definition in the Americans with Disabilities Act--is used, nearly 30 million people age 21 to 64 describe themselves as disabled.¹ These figures imply that the potential demand for benefits under S. 1858 among disabled people who are not collecting cash benefits could fall in a very wide range.

That uncertainty is magnified by the fact that S. 1858 contains no definition of disability, and would instead leave it to the states to determine eligibility. CBO's estimate assumes that states would delegate responsibility for determining initial eligibility to the Disability Determination Services (DDSs), which already do that task for the Social Security and SSI disability programs. The advantage, from the states' standpoint, is that they would then pay only a fraction of the cost of the disability determinations (whose cost runs about \$500 to \$700 each). The DDSs use the definition of disability that is contained in the Social Security Act. But states that chose to make their own determinations could use a much broader definition, potentially adding hundreds of thousands of people to enrollment. Also, the bill contains no direction regarding appeals processes.

States would not have to make a determination of disability for people already receiving DI or SSI benefits, of course. But states would decide whether those beneficiaries, if not already working, are "in a transition to work readiness or otherwise work eligible"--the definition of a WEI. That would afford states another tool to control enrollment.

CBO's estimate of S. 1858 include no effects on the SSI and DI programs. Potential effects

¹ The oft-cited figure of 40 million, or more, Americans with disabilities includes children and the elderly, whereas S. 1858 is targeted at those between the ages of 18 and 64.

Jeanne

FY1 -

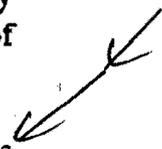
Diana

No SSA

savings

in Kennedy

Jeffords



are highly mixed. It is possible, for example, that giving people with severe impairments better access to personal care services and prescription drugs could enable them to avoid or delay going on SSI or DI. And it is possible that extending Medicare, for the handful of DI recipients who go back to work, would remove a source of anxiety and encourage them to stay at their new jobs longer. Therefore, S. 1858 could lead to some savings in the SSI and DI programs. On the other hand, S. 1858 would expand the definition of impairment-related work expenses (IRWEs), making it possible for some DI recipients to keep benefits that they would otherwise lose. And both SSI and DI benefits would be costlier if the outreach and counseling efforts required by S. 1858 led to more applications for benefits. Because these effects are highly uncertain, and work in opposite directions, CBO displays no SSI or DI effects in its estimate.

CBO makes no judgment regarding the requirement that the Secretary take into account savings in DI and SSI in considering requests for Section 1115 waivers. Uncertain effects on DI and SSI from S. 1858 notwithstanding, interagency implementation of this provision is likely to be ineffective. Additionally, spending under Section 1115 Medicaid demonstrations could expand more rapidly than under current law if savings from non-Medicaid programs could be used in budget neutrality determinations.

Summary of S. 1858 as introduced by Senators Jeffords, Kennedy, and Harkin			
Group	Get (current law)	Eligible for under S. 1858	Budgetary effects?
1--"eligible working individuals with a disability" (nonrecipients of Title II disability benefits or SSI disability benefits who are working," as certified by states)	No OASDI or SSI cash. No Medicare or Medicaid, unless they happen to fall into some other program category.	No OASDI or SSI cash. No Medicare. Medicaid under sec. 1929A, if offered as a state option (technically, just "extra" services, i.e., personal care services plus prescription drugs, but not "core" Medicaid). Work counseling under sec. 1183 (discretionary)	Medicaid costs for sec. 1929A benefits less any premium contribution. Discretionary SSA costs for sec. 1183 counseling. HCFA and SSA costs for doing disability determinations, if done in accordance with sec. 1634 of S.S. Act. Possible DI or SSI savings. If enhanced health benefits forestall people from going on rolls; speculative.
2--SSDI OPTIONS participants (SSDI recipients who choose to enroll in OPTIONS; must be employed)	Cash benefits under DI; Medicare after 24 months on DI. If working: unlimited earnings for 9-month TWP, plus 3 months grace; then no cash benefits so long as earnings above SGA, though Medicare continues for 3 years (during the "extended period of eligibility," or EPB).	Medicaid under sec. 1929A, if offered as state option. Work counseling under sec. 1183. Indefinite Medicare (for as long as employment continues) under sec. 1818B. Must have been on DI (or OPTIONS) for 24 months for Medicare eligibility. May owe premium if income >250% of poverty. If enrolled in OPTIONS during first 24 months of entitlement, must waive DI cash; appears likely to be rare. If enrolled in OPTIONS after more than 24 months on rolls, no waiver required. Can exclude mere IRWEs, notably those for preparing for work and traveling to work, in computing whether earnings < SGA.	Medicaid costs for sec. 1929A benefits less any premium contribution. Discretionary SSA costs for sec. 1183 counseling. Medicare costs (possibly offset by small premium receipts, and by "secondary payer" savings if beneficiary covered by employer plan) for extending coverage indefinitely (not just for 3 years) for DI recipients who return to work. Possible small DI savings from voluntary waivers of cash (unlikely) and induced returns to work. Small DI gains from expanding definition of IRWEs.
3--SSI 1619(a) and 1619(b) recipients (i.e., those with earnings > SGA)	Cash benefits under 1619(a). Ordinary Medicaid under both 1619(a) and 1619(b).	Medicaid (sec. 1929A).	Medicaid costs for sec. 1929A benefits less any premium contribution.
4--"work eligible individuals" (SSI and DI recipients who are not working, but are deemed "work-ready" by states)	Ordinary DI and SSI program rules apply.	Medicaid (sec. 1929A).	Medicaid costs for sec. 1929A benefits less any premium contribution.

NOTES:

Groups 1 and 2 are called "OPTIONS" participants. Groups 1, 2, and 3 are called "qualified eligible working individuals with a disability."

Sec. 1929A (enhanced Medicaid) services would cover attendant care and prescription drugs. They would be optional for states; however, a state that covered any of the four groups above would have to cover all. Sec. 1929A services would be financed at an enhanced FMAP.

Sec. 1818B (enhanced Medicare) would extend Medicare coverage indefinitely so long as recipients remained employed (instead of ending it after the 36-month extended period of eligibility as under current law); the ordinary part B premium, and a modest income-related premium for part A, would be charged.

Sec. 1183 (work incentive counseling and assistance) would offer client evaluations and health-insurance counseling to eligible individuals; counselors would be paid, under contract, out of SSA's appropriation. Counselors would refer clients to vocational rehabilitation providers or employment prospects, but would not deliver or pay for such services directly (except to the extent already provided under current law).

"Title II disability benefits" encompass benefits for disabled workers (paid from the DI trust fund) and for disabled widow(er)s and disabled adult children (mostly paid from the OASI trust fund).

DI = disability insurance, TWP = trial work period, SGA = substantial gainful activity, IRWEs = impairment-related work expenses.

S 1988 Work Incentives Improvement Act of 1988

As introduced on March 25, 1988

By Fiscal year, in billions of dollars	1989	1990	1991	1992	1993	1994	1995	1997	2000	1999-2003
Mandatory										
Federal share of Medicaid										
Costs	1.3	1.2	1.3	1.3	1.5	1.7	1.9	2.3	2.6	6.1
- Copayments	-0.6	-0.0	-0.6	-0.6	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
Medical share of equality of beneficiaries	0.1	0.9	0.6	0.6	0.0	0.0	0.0	0.0	0.0	0.2
Subtotal Medicaid	1.2	1.3	1.5	1.5	1.5	1.7	1.9	2.3	2.6	5.3
Medicare costs	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.2
Total mandatory	1.2	1.3	1.5	1.5	1.6	1.8	2.0	2.5	2.8	5.4
Discretionary										
Additional SSA costs	0.5	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	1.4

NOTE: "-" denotes "zero," "0.0" denotes "less than \$50 million."

PRELIMINARY AND UNOFFICIAL

JEFF1056.WK4

03:56 PM

05/29/98

July 2, 1998

TO: Barbara Chow
Chris Jennings
Diana Fortuna

FR: Judy Chesser

RE: Kennedy-Jeffords Budget Issue

Brian Coyne asked that I send you the attached which shows that the Bunning-Kennelly Ticket does not produce savings. Thus, no opportunity there for an offset for health expansion.

TO: Brian Coyne
THRU: Judy Chesser
FROM: *Juo* Jim O'Donnell
DATE: June 30, 1998
SUBJECT: Why we can not use "savings" from the Ticket to pay for health care

Attached is the relevant table from the Congressional Budget Office scoring of the Bunning/Kennelly return to work legislation that shows they do not believe there will be any savings from benefit cessation under the ticket program. In fact, their analysis shows more costs than savings.

As you can see from my added column in the margins, the costs over the period 2000-2008 for DI are \$516 million, while the savings from benefits avoided is \$492 million for a loss of \$24 million. The corresponding SSI figures are \$173 million in costs, with a savings of \$126 million and a loss of \$47 million.

The reason there are no savings is the way in which CBO estimates "benefits avoided" or savings. CBO subtracts out as costs rather than savings those beneficiaries who return to work who would have returned to work anyway without provider payments but for whom we will now pay providers. In addition CBO assumes a recidivism rate of people who will return to our rolls. CBO estimates that for every 1,000 ticket holders only 400 are real savings and 600 are people who would have gone off the rolls without a provider payment. In addition, they assume that 40% will return to our rolls.

Even if we ignore CBO's scoring of the ticket and assume savings, the savings are not big enough to pay for the estimated \$1 billion annual Medicaid cost in the Jeffords/ Kennedy bill. (For example, assume: 6,000 people go off the rolls at an average benefit rate of \$800 a month. We pay providers 40% or \$320 leaving a "savings" of \$580 a month per beneficiary or about \$41.7 million a year in savings).

Table 2. Estimated Budgetary Effects of Provisions of H.R. 3433

	By Fiscal Year, in Millions of Dollars										
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	
Section 2											
Tickets Program for Vocational Rehabilitation Clients-DI											
Payments to Program Manager	1	2	1	1	2	3	3	4	4	4	24
Milestone Payments to Providers	0	a	1	5	11	17	21	24	28	33	140
Incentive Payments to Providers	0	a	a	3	12	27	48	66	87	109	352
Gradual Phase-out of Current VR System	0	a	a	-3	-8	-14	-21	-32	-44	-58	516
Benefits Avoided	0	a	a	-4	-20	-48	-84	-98	-112	-126	←492
Extra Benefits Paid	0	a	1	2	3	5	7	10	13	16	
Subtotal, DI	1	2	3	5	1	-10	-26	-27	-24	-22	
Resulting Medicare Savings ^b	0	0	a	a	1	1	1	-2	-9	-20	
Total, Provision	1	2	3	5	1	-9	-25	-29	-33	-41	
Tickets Program for Vocational Rehabilitation Clients-SSI											
Payments to Program Manager	a	1	a	1	1	1	2	2	2	2	212
Milestone Payments to Providers	0	a	1	3	6	9	10	12	14	16	71
Incentive Payments to Providers	0	a	a	1	3	7	12	17	22	28	90
Gradual Phase-out of Current VR System	0	a	a	-1	-4	-7	-11	-16	-22	-29	173
Benefits Avoided	0	a	a	-1	-5	-12	-22	-25	-29	-32	126
Extra Benefits Paid	0	0	0	0	0	0	0	0	0	0	
Subtotal, SSI	a	1	1	2	a	-3	-8	-11	-13	-15	
Resulting Medicaid Savings	c	c	c	c	c	c	c	c	c	c	
Total, Provision	a	1	1	2	a	-3	-8	-11	-13	-15	
"\$1-for-\$2" Demonstration Projects^c											
Contractor Costs	0	a	4	5	6	6	4	4	4	4	
DI Benefit Costs	0	0	3	8	13	18	19	18	18	18	
Medicare Costs	0	0	0	0	2	4	7	9	9	9	
Total, Provision	0	0	7	13	20	28	29	31	31	31	
Section 3											
Extension of Medicare from 3 years to 5 years for clients suspended from DI who have used a ticket ^d	0	0	0	0	a	a	1	0	0	0	
Section 5											
Extension of DI Demonstration Project Authority until June 10, 2001	3	5	5	3	a	0	0	0	0	0	

Continued

National

The New York Times
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June 14, 1998

Benefits Dwindle for the Unskilled Along With Wages

Related Articles

- [Self-Employed Get a Few More Breaks \(March 1\)](#)
- [For Many Small Businesses, the Labor Pool Is Shallow \(Aug. 24, 1997\)](#)
- [New Health Insurance Rules Spell Out Workers' Rights \(April 2, 1997\)](#)

By PETER PASSELL

Since the 1970s, the gap in wages between skilled and unskilled workers has widened sharply. But new research shows the inequality doesn't stop there.

Discrepancies in job benefits and the quality of work life have also grown, pointing to a bigger chasm than previously recognized.

"Unskilled workers get the short end of the stick — and it's getting shorter," said James Heckman, an economist at the University of Chicago.

Study after study has shown that the gains from post-1970s economic growth have eluded unskilled workers. The median wage of those with only a high school diploma fell by 6 percent, adjusted for inflation, from 1980 to 1996, while the earnings of college graduates rose by 12 percent. Though there have been indications in recent months that a scarcity of workers in the surging American economy has begun raising wages for those on the low end, the gain has been modest so far and not enough to counter the decades-long trend.

Besides, wages alone provide an incomplete picture of a worker's standing. Though economists have long recognized the need to incorporate working conditions and fringe benefits in any comprehensive analysis, they have been stymied by a lack of detailed data.

Until now, Brooks Pierce, an economist at the U.S. Department of Labor, used confidential data regularly collected by the Bureau of Labor Statistics from businesses to measure trends in total compensation. The results are striking: While specialists had long assumed that benefits acted as a leveling influence, particularly because of government-required benefits like Social Security and unemployment insurance, the opposite is true.

In 1982, people in the top one-tenth of the work force made \$24.80 an hour, 3.95 times the \$6.28 an hour for workers in the bottom one-tenth. By 1996, the wage gap had widened, with the high-end workers averaging \$25.74 an hour, or 4.72 times the \$5.46 an hour of those at the bottom. Wages for the purposes of Pierce's study are all expressed in 1997 dollars to account for inflation.

The decline among unskilled workers is hardly surprising given the increasing demands of an information-driven economy. But to understand it requires a look at total compensation, which places a value on benefits like health insurance, vacation time and pension plans.

By Pierce's calculation, the total compensation in 1982 of workers in the top 10 percent — \$35.16 an hour — was 4.56 times that of workers in the bottom 10 percent — \$7.72 an hour. Fourteen years later, the ratio had increased to 5.43 to 1, with highly paid workers having gained \$1.73 an hour and low-end workers having lost 93 cents an hour.

Benefits led to a greater discrepancy in earnings between high- and low-wage workers in both 1982

and 1996. Moreover, they were responsible for one-tenth of the increasing disparity between the working elite and the working poor over the 14 years.

Benefits have long been perceived as a great equalizer. In percentage terms, after all, a bare-bones \$3,000 medical insurance package adds more to the compensation of a worker making \$20,000 than a full-frills \$10,000 package for an executive earning \$200,000.

The catch, according to Pierce, is that a growing number of workers at the bottom of the pay scale have lost access to key employer-provided benefits.

More than 80 percent of workers received paid holidays and vacations in 1996, but less than 10 percent of those in the bottom tenth received paid leave of any kind. Similarly, about 70 percent of workers have pension plans, while less than 10 percent of those in the bottom can count on any employer-financed retirement benefits. Access to health insurance follows a similar pattern.

Employers generally cannot deny benefits to lower-wage workers without putting the tax-exempt status of those benefits at risk. So how is this disparity in benefits possible?

Henry Farber, an economist at Princeton University whose own research on medical benefits confirms Pierce's findings, points to loopholes that allow companies to deny benefits to workers just starting out and to workers not classified as full time. "Employers are figuring out all sort of ways to discriminate between employees they wish to keep and those who come and go," he said.

None of this would come as news to Mary Mendez, a 40-year-old single mother who sorts apples in a packing plant in Wenatchee, Wash., for \$7.71 an hour. Her employer takes such a strict view toward paid absences that she was docked for the hours she missed while recovering from a minor accident at the plant. And while the company does offer health insurance in an industry where fringes are rare, she must contribute \$21 a month to cover her child.

In other cases, employers have turned to temporary and contract workers, whose pay packages do not include time off and other benefits. United Parcel Service even endured a strike in which a big issue was the company's desire to use more part-time workers to hold down costs.

Perhaps an even bigger surprise than the lack of benefits is how little people with especially demanding or unpleasant jobs are compensated for difficult working conditions.

Job hazards, everything from working in extreme temperatures to working a dangerous, lonely night shift at a highway convenience store, would seem to command higher wages than similar work under less taxing circumstances.

Lillie Reed says her job as an aide in a nursing home in Stamford, Conn., is dirty, sometimes dangerous — and getting harder.

A few years ago, each nursing assistant cared for seven patients. Today, it could be as many 16 on weekends. "The people coming to the home are older, sicker and angrier," she adds. "It's really tough lifting them, dressing them and keeping them clean."

By looking at arguably the best measure of job conditions, the risk of injury, a new study by Daniel Hamermesh, an economist at the University of Texas, found that workers on the low end of the wage scale were falling ever further behind.

In 1979, workers in the top quarter of wage earners lost 38 percent more days to on-the-job injuries than workers in the bottom quarter, Hamermesh found. By 1995, the pattern had reversed. High-wage earners lost 32 percent less days than low-wage earners.

It is hard to believe that only workers at the top end of the wage scale are interested in their own health and safety. One possible explanation for the failure to reduce injuries among low earners, suggests Alan Krueger, an economist at Princeton University, is the declining power of labor unions. While employers may know how dangerous a job is and how much it would cost to make it safer, individual workers rarely do. A union may be able to even the playing field by tracking health and safety issues and negotiating improvements.

Another explanation, favored by Hamermesh, is that all unskilled workers — union and nonunion — have lost much ground over the last two decades as skilled workers added so much more to corporate productivity. "Overall, workplace safety hasn't changed much," Hamermesh said.

ODCLCA QUICK FAX

(202)358-6030- Voice/(202 358-6074/6075- Fax)

Date: 7/2/98

TO: Barbara Chow

FROM: Judy Chesser

COVER + 3 pages

COMMENTS:

Record Type: Record

To: Jeanne Lambrew/OPD/EOP, Anne E. Tumlinson/OMB/EOP, Joanne Cianci/OMB/EOP, Bwilliam @ osaspe.dhhs.gov @ inet

cc:

Subject: summary of conversation with another disability advocate

I spoke this morning with Tony Young of United Cerebral Palsy on Kennedy-Jeffords. He has been particularly committed to return-to-work over the past few years, building support for the ticket beginning a few years ago. In my experience, he tends to be optimistic, but he also is more engaged in the process and constructive than many in that community.

- He said those working on K-J were forced into a different mode when they got word that Senate Finance would just sit on the bill, leading Kennedy to do the hold on B-K. So they started a big grass roots push to call member offices to keep K-J alive.
- The current effort between Kennedy and the advocates is to integrate the best of B-K with the best of K-J. He says they are in the last throes of doing this.
- He minimized the current price tag of K-J, but acknowledged it must be paid for with offsets. But he said he can't tell me what the offsets are that they are working on. He was definite that they would find offsets, and didn't respond to my observation that \$5b is hard to find.
- He said Kennedy & Jeffords are calling members, particularly on Finance, and that members are coming around to see this as important. But he described Roth and Moynihan as cautious and not focused on this, and said they have no commitment from Lott.
- He has heard that HCFA is working on something, and mentioned the meeting that was cancelled. He said they are open to talking, but they have bottom line parameters like the fact that DI people shouldn't have to impoverish themselves to go to work.
- When I said we thought BBA was good, he said that this effort is a "different ballgame": an effort to preserve the SSI/SSDI entitlement and forestall Congress from changing eligibility rules for SSI/DI. (This is a longtime concern of certain members of the community -- that SSI/SSDI will be the next big target for cuts by Congress, a la children's SSI and welfare.) When I mentioned that none of these programs have managed to score more than minimal savings in DI from CBO, he said that they met repeatedly with CBO and it's like talking to a rock, and so they don't expect to persuade them prior to passing a bill.
- He implied that Medicaid is not a major source of offsets, and said the firewall makes it difficult to get offsets from DI.

Diana Fortuna

06/26/98 11:29:04
AM

Record Type: Record

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

cc:

Subject: Some intelligence on B-K vs. K-J

I spoke to Marty Ford of the Arc; she's a good, plugged-in advocate who is very involved in the return to work legislation. Bob, feel free to forward within HHS. Here's what she told me:

- Kennedy is continuing to try to pull together a substitute bill that includes the ticket and health care. Now Connie is trying to set up a "bipartisan, bicameral working group" to develop this substitute, with people like Bunning and Dingell. Not clear if that will come together. Marty said she has spent innumerable hours on this recently.
- The disability community's position is that the ticket and health care must go together -- not one without the other (although Bunning's person, Kim Hildred, is very worried about deep-sixing the ticket through this strategy).
- When I asked about the \$5b price tag, she said Connie is working on offsets and on "slimming it down" -- unfortunately with more emphasis on the former than the latter. She doesn't know (or wouldn't tell me) what offsets Connie is considering. She didn't hint at any major restructuring of the elements of K-J, and spoke of all the elements (SWOP, Medicare buy-in) as if they are alive and well. When I asked if the goal is to make the bill budget-neutral, she said either that or at least "sellable" (meaning cheaper, I assume).
- When I told her we thought the BBA was pretty cool but we recognize the problem of whether states will adopt the option, she said yes, but another problem is the assets/resources forcing a person to still be poor -- confirming Bob's sense that this issue really does matter to the community.
- She downplayed the jurisdictional battle with Finance, saying staff members may have their noses out of joint, but that Kennedy regards this as a member-to-member issue and will try to sell it that way. She said the overwhelming lovefest for Bunning-Kennelly in the House is partly a result of the election year driving members to give out goodies, and they hope that same dynamic will help the health provisions prevail as well.
- When I referred to the K-J Medicare feature as means-testing, she made an argument that the community doesn't see this as means-testing, because you get the same Medicare benefit no matter what, and that the real means-testing occurs when people are kept out of the program altogether.
- They are thinking how to rejigger the ticket to fit with the health piece -- things like shouldn't the ticket's advisory committee also have a role in the health care SWOP piece.

She sounded pretty optimistic and didn't seem desperate for slim-down options. I didn't present any outlines of our alternative thinking, beyond saying we still think the BBA is underrated. I did mention we had issues with K-J's cost, partial Medicaid benefits, enhanced match, and Medicare income-related premium. I'll make some more calls.

Message Sent To:

FAX

CONGRESSIONAL BUDGET OFFICE
Human Resources Cost Estimates Unit
Room 431
Forc House Office Building
Second and D Streets, S.W.
Washington, D.C. 20515
Phone: (202) 226-2820
Fax: (202) 226-2822 (preferred) or -2963

RTW
JML
Jacoby

FROM: Kathy Ruffing, CBO
e-mail: kathy@cbo.gov

TO: Pam Mazur

Phone: _____

Fax: 358-6074

PAGES TO FOLLOW: 3 + 13

COMMENTS: CBO's informal analysis of Jeffords et al. bill -- it was written chiefly by our health staff, so I've also included my notes on how it relates to SSI / DI caseloads. Looking forward to working with you in your new post!

- o **SSA-financed counseling program**--Would cover all 0.3 million SSDI OPTIONS participants (SSA-certified) plus the estimated 0.1 million EWIDs (state-certified).
- o **Extended Medicare**--Would cover SSDI OPTIONS enrollees who otherwise exhaust their coverage. As suggested above, CBO assumes that would encompass the roughly 6,000 people who now complete an EPE each year and lose their Medicare (or are eligible to purchase it only at a steep price). Note that, for the bulk of the 0.3 million SSDI OPTIONS participants--most of whom never work enough to trigger an earnings-related suspension or termination--the Medicare coverage proposed by S. 1858 differs little from current law; the changes proposed by S. 1858 would chiefly affect the minority who complete an EPE.

Resulting costs

- o Most provisions would take effect one year after enactment, i.e., in fiscal year 2000.
- o **Medicaid WIS costs**--About 50,000 current Medicaid recipients would receive additional services (or, states would engage in cost-shifting or match-enhancement in their cases) averaging about \$1,000 each. Another 140,000 would become newly entitled to services averaging nearly \$7,000 a year each. Total costs of about \$1 billion in first year, climbing with caseloads and per-capita cost increases thereafter. Roughly 5 percent recouped through co-payments.
- o **SSA counseling costs (discretionary)**--About 0.4 million recipients costing about \$500 a year each, for a total of \$0.2 billion.
- o **Medicare costs**--Extra costs, ranging from about \$10 million in 2000 to \$0.2 billion in 2008, for the relatively few SSDI options participants (6,000 by end of 2000, 50,000 by end of 2008) who exhaust their current-law EPE and who could keep coverage under S. 1858.
- o **Eligibility determination costs**--CBO assumes that states would delegate this task to the disability determination services, using the procedure in section 1634 of the Social Security Act. Total costs would be about \$0.6 billion in the first year and \$0.1 billion a year thereafter. One-half would be borne by SSA (discretionary), one-fourth by federal Medicaid (mandatory), and one-fourth by states.

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7 *

TO: Cris Crowley, Senator Jeffords' Office
Connie Garner, Senator Kennedy's Office

From: Jeanne De Sa, CBO
Kathy Ruffing, CBO

Re: Preliminary Estimate of S. 1858: The Work Incentives Improvement Act of 1998

Date: June 1, 1998

At your request, we have reviewed S. 1858, the Work Incentives Improvement Act of 1998, as introduced on March 25, 1998. Our detailed comments and analysis are included in the attached paper. Our preliminary estimate is that enactment of this proposal would increase mandatory spending on Medicaid and Medicare by \$1.2 billion in 2000 and by \$5.4 billion over the 2000-2003 period. Because the proposal would affect direct spending, pay-as-you-go procedures would apply. The largest component of this increase is in the Medicaid program, with additional five-year spending of \$5.2 billion. Discretionary costs would rise by \$0.5 billion in 2000 and by about \$0.3 billion a year thereafter, for a total of \$1.4 billion between 1999 and 2003; those costs would be paid from appropriated funds. This estimate assumes enactment in September 1998, and implementation of Medicaid and Medicare provisions in 2000.

We would be happy to discuss any questions or comments you may have.

**PRELIMINARY CBO ANALYSIS OF S. 1858,
THE WORK INCENTIVES IMPROVEMENT ACT OF 1998**

S. 1858 would establish the Opportunity to Fully Integrate Through Occupations (OPTIONS) program for some working individuals with disabilities. OPTIONS would provide participants with extended Medicare benefits and work counseling services. The bill would also give states the option to provide certain Medicaid benefits to OPTIONS participants and to some other disabled individuals. Additionally, the bill would extend Disability Insurance (DI) program demonstration project authority, add requirements for consideration of Section 1115 waivers that reduce work disincentives, and establish a program of outreach to individuals with disabilities potentially eligible to participate in OPTIONS and other work incentive programs. The health and counseling provisions of the bill would be effective one year after enactment, and would sunset 10 years after enactment. For this analysis, CBO assumed that the bill would be enacted in September 1998 and this program would be implemented in fiscal year 2000.

CBO estimates that the bill would raise federal mandatory spending by \$1.2 billion in 2000 and by \$5.4 billion between 2000 and 2003. The largest component of this increase is in the Medicaid program, with five-year spending of \$5.2 billion. Discretionary costs would rise by \$0.5 billion in 2000 and by about \$0.3 billion a year thereafter, for a total of \$1.4 billion between 1999 and 2003; those costs would be paid from appropriated funds. Provisions affecting workers with disabilities under current law and S. 1858, and assumptions underlying this estimate, are discussed below and summarized in the attached tables.

Current Law. Under current law, both the DI program and the Supplemental Security Income (SSI) program offer incentives for disabled persons to work. In both programs, applicants must show that they are incapable of substantial work (labeled "substantial gainful activity" or SGA, currently defined in regulation as earnings of more than \$500 a month) in order to be awarded disability benefits. If DI recipients work after entitlement, however, the law permits them to earn unlimited amounts for a 9-month period (known as the trial work period, or TWP) and a subsequent 3-month grace period before their benefits are suspended. During the next 3 years--a period known as the extended period of eligibility, or EPE--those beneficiaries may automatically return to the DI rolls if their monthly earnings sink below \$500. Furthermore, Medicare benefits (for which DI beneficiaries qualify after two years of entitlement) also continue during the 3 years of the EPE. Beneficiaries pay no Medicare

Hospital Insurance (Part A) premium, but must pay the Supplementary Medical Insurance (Part B) premium. Once the EPE ends, earnings above SGA result in DI benefits being terminated. Moreover, beneficiaries cease to get Medicare benefits, unless they pay the full Part A premium (\$322 a month in 1999). Research suggests that only 10 to 20 percent of DI recipients ever work after they start collecting benefits, only 2 to 3 percent eventually have benefits suspended due to earnings (that is, start an EPE), only about 1 percent are terminated at the end of the EPE, and few purchase Medicare coverage thereafter.

SSI recipients who work get a reduced benefit, but do not give up their benefit entirely. Most SSI recipients receive full Medicaid benefits. If their monthly earnings exceed \$500 but they are still medically disabled, they move into section 1619(a) status and continue to collect a small cash benefit. The cash benefit is reduced by \$1 for every \$2 of earnings above \$85. If their earnings rise further, they enter 1619(b) status, where they collect no cash benefit, but still qualify for Medicaid until their earnings reach a point at which they are deemed to be able to afford medical care and living expenses. Income cutoff levels for the 1619(b) group differ among the states. About 20 percent to 25 percent of SSI beneficiaries work after entitlement, but typically do so sporadically (only one-third to one-half of the time) and at low earnings. Many disabled adults receive SSI and DI concurrently; concurrent beneficiaries constitute about 30 percent of the SSI adult disabled population.

Medicaid offers disabled beneficiaries several benefits that are unavailable in the Medicare program; two of these benefits--prescription drugs and personal care services--are included as work incentive services under §. 1858. Most states have exercised the option under current law to provide prescription drugs as a Medicaid benefit; about half of 1997 spending on this benefit was for disabled persons. All states provide some personal care services as a Medicaid optional benefit, as a benefit within a package of services in home- and community based waiver demonstration programs for selected eligibility groups in selected areas, or as a service included with the home health benefit. The personal care benefit includes services performed by a personal attendant to assist an individual with eating, bathing, dressing, and other activities of daily living. States have latitude in determining how the benefit will be delivered and supervised and may require authorization by a physician or supervision by a registered nurse.

According to surveys conducted by the Bureau of the Census, approximately 17 million Americans between the ages of 18 and 64 describe themselves as having a disability that limits their ability to work. About 8 million receive cash benefits under either the DI or SSI programs. Of the remaining 9 million disabled people who do not receive benefits, about 5 million report some earnings, of whom 3 million have low earnings. Some of those low-

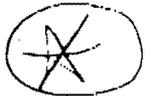
wage disabled workers receive employer-sponsored health insurance, either on their own or through a family member, or have an individual policy. Personal assistance services are generally not available through employer-sponsored insurance, however. For purposes of this estimate, CBO assumes that about one-quarter to one-half of the workers with disabilities go without health insurance entirely or are underinsured. Some disabled workers not eligible for cash benefits under the SSI program (and, hence, Medicaid) might be eligible for Medicaid benefits under other eligibility criteria. For example, states have the option of buying into Medicaid disabled workers whose incomes are under 250 percent of poverty.

S. 1858. The bill would establish the OPTIONS program for two categories of working people with disabilities: eligible working individuals with a disability (EWIDs) and SSDI OPTIONS program participants. EWIDs would be working individuals ages 18-64 requiring personal assistance services or prescription drugs and who do not receive disability benefits under Title II or Title XVI. Under the bill, states would perform eligibility determinations for EWIDs.

SSDI OPTIONS program participants would be individuals ages 18-64 eligible for disabled-worker cash benefits who work and elect to participate in the OPTIONS program. SSDI OPTIONS enrollees who have been entitled for less than 24 months would have to give up DI cash benefits in exchange for health benefits under the OPTIONS program. Participants entitled to DI cash benefits for more than 24 months could keep any cash benefits to which they are entitled under current law and still receive enhanced health benefits, provided they remain employed. (That means that they could continue to take advantage of the 9-month TWP and 3-month grace period of unlimited earnings, but would still be subject to suspensions of cash benefits thereafter.) However, more impairment-related work expenses (IRWEs), notably costs of a vehicle in rural areas and commuting costs in other areas, could be excluded from earnings in the determination of SGA than under current law; that provision might enable some beneficiaries to remain eligible for DI cash benefits for longer than they would under current law.

All OPTIONS participants would receive Medicaid work incentive services (personal assistance services and prescription drugs), if the state plan offers these benefits and work counseling and assistance services proposed under Title XI of the Social Security Act. Work counseling and assistance services would be financed from SSA's discretionary appropriation.

SSDI OPTIONS program participants would have the opportunity to buy into Medicare after two years of DI or OPTIONS participation. SSDI OPTIONS participants earning under 250



percent of poverty could receive Medicare benefits indefinitely (not just during the 3-year FPF) without having to pay any Part A premium, provided they continue working. SSDI OPTIONS participants earning more than 250 percent of poverty could receive Medicare benefits indefinitely by paying the Medicare Part A premium on a modest sliding scale basis. All SSDI OPTIONS participants would pay the Part B premium in full, as under current law. SSDI OPTIONS participants who stop working and revert to cash status could count any time spent in the OPTIONS program toward the 24-month wait for Medicare.

This bill would also amend Title XIX of the Social Security Act to allow states the option to provide Medicaid work incentive services to Qualified Eligible Working Individuals with a Disability (QEWIDs), which include OPTIONS program participants and SSI individuals under 1619(a) and 1619(b), and to Work Eligible Individuals (WEIs, current recipients of SSI or SSDI defined by states as being in transition to-work).—

If a state Medicaid program offers work incentive services, it must offer them to all QEWIDs and WEIs. The package of work incentive services must include at least pharmaceutical benefits and personal assistance services. Work incentive services that are not already provided under current law or under existing state programs (as described in the bill's maintenance of effort language) would be reimbursed under an enhanced match rate that is equal to an increase of 30 percent of the difference between the current federal match and 100 percent ($FMAP + .30 * (1 - FMAP)$), with a ceiling of 85 percent. States would not be allowed to impose cost-sharing on enrollees with incomes below 150 percent of poverty, but would be permitted to impose cost-sharing above that threshold. States could not require that personal assistance services be ordered by a physician.

The bill would add new waiver requirements on section 1115 demonstrations designed to reduce work disincentives affecting 5,000 or more persons. In determining cost neutrality of waiver demonstrations, HCFA would have to incorporate savings achieved in the SSDI and SSI programs into the calculation of budget neutrality. The bill would also extend through June 1999 the authority of the Social Security Administration to conduct research and demonstration projects that require waivers of current law. Additionally, the bill would require the Commissioner of Social Security to establish an outreach program for work incentive programs under OPTIONS or 1619(a) or 1619(b).

Cost of S. 1858. Enactment of this proposal would increase mandatory spending by \$5.4 billion and discretionary spending by \$1.4 billion over the 1999-2003 period. The largest component of spending under S. 1858 is in the Medicaid program, with additional five-year spending of \$5.2 billion, compared to current law. CBO's estimates of the number of

participants, cost per participant and total cost of the bill are described below. —

Number of Participants. CBO estimates that approximately 140,000 individuals would be eligible for benefits under the OPTIONS program in 2000. Of that number, 325,000 would be SSDI OPTIONS program participants and another 115,000 would be EWIDs (that is, workers with serious impairments who are nevertheless not collecting cash benefits). CBO estimates that an additional 540,000 individuals could be eligible for work incentive services if all states provided these benefits. Although all of these individuals could potentially be eligible for Medicaid work incentive services, not all would receive them because only a portion of states would offer this benefit and maintenance of effort requirements would prevent states that do offer the benefit from providing these services to all eligibles. CBO assumes that states with one-third of eligibles participate, and that maintenance of effort requirements are partially effective, resulting in 200,000 persons receiving work incentive services under the bill.

Eligible Working Individuals with a Disability (EWIDs). CBO assumes that about half of the 3 million low-income disabled workers without DI or SSI benefits are uninsured or underinsured, and would be interested in participating in the OPTIONS program as eligible working individuals. Since states would have discretion in screening these individuals for OPTIONS benefits, CBO assumes that only a small fraction of this group would meet the eligibility criteria. Therefore, approximately 115,000 individuals could be eligible for benefits if all states provided them in 2000; about 40,000 would receive services under the bill. A few of those people are assumed to have Medicaid coverage already.

SSDI OPTIONS Program Participants. It is unlikely that ^{future} current recipients of DI who have been entitled for less than 24 months; would give up cash benefits (which average more than \$700 per month) to secure work incentive services and extended Medicare benefits under the OPTIONS program. First, many such DI recipients are concurrent SSI recipients, and thus are already eligible for full Medicaid benefits, which in most states include some personal assistance services and prescription drugs. Second, if the enrollee signed up for OPTIONS during his or her first 24 months on the rolls, he or she would forfeit the right to a TWP and grace period while working.

Third, although some short-term DI-only recipients would have an incentive to trade cash for work incentive services immediately, they are likely to qualify for these benefits outside of the OPTIONS program. If a state offers these services, it must offer them to DI "work-ready" individuals. A short-term DI-only recipient would therefore seek the work incentive services outside of the OPTIONS program so as to not give up his or her cash benefit.

Finally, the remaining advantage of enrollment--the indefinite extension of Medicare coverage beyond the current-law EPE, at a zero or modest Part A premium--would remain available to the beneficiary if he or she chose to defer enrollment until after 24 months.

CBO assumes that DI recipients who have been entitled for more than 24 months would join OPTIONS since they would not give up cash or other benefits that they can get under current law. CBO assumes that 235,000 DI-only beneficiaries and 90,000 concurrent beneficiaries would enroll in SSDI OPTIONS in 2000. CBO assumes that few would earn significantly more than 250 percent of poverty (about \$20,000 for a single individual, or \$41,000 for a family of four, in 1998), the threshold at which the enrollee would begin to owe a premium for Part A coverage. For most of these enrollees, OPTIONS would be indistinguishable from current-law Medicare benefits; only a minority would leave the DI rolls and benefit from the indefinite extension of the EPE. Only about 85,000 of these beneficiaries actually would receive work incentive services due to the state participation and maintenance of effort requirements.

1619(a) and 1619(b) SSI beneficiaries: CBO projects that in 2000, there will be about 110,000 working SSI recipients in the 1619(a) or 1619(b) program, all of whom would be eligible for Medicaid benefits under current law. Only 10,000 of these beneficiaries would receive work incentive services due to the state participation and maintenance of effort requirements.

"Work ready" Individuals: CBO assumes that another 430,000 individuals would be considered "work ready" under the bill and would be eligible for work incentive services, if offered by the state of residence and not provided under current law. Those include approximately 250,000 SSI-only recipients who are working but earning less than SGA (and who are, therefore, in the regular SSI program rather than in one of the section 1619 programs). Many already receive prescription drug and personal assistance services under the Medicaid program. Depending upon the state definition of "work ready", some SSI individuals who are not working, but are deemed to have the potential to work, could also qualify. CBO assumes that about 70,000 such individuals could be eligible for work incentive services. Of SSDI recipients who are not working, but might be deemed to have potential to work, CBO assumes that about 110,000 could be eligible for work incentive services. In summary, only about 65,000 of individuals eligible under the "work ready" category would receive work incentive services due to the state participation and maintenance of effort requirements.

Cost of Benefits Per Participant. CBO estimates that Medicare spending for DI recipients

who work would average about \$2,900 per year in 2000. CBO projects that this amount would rise to \$4,400 per year by 2008. Those per capita rates are about two-thirds of the per capita rates for the average disabled recipient, since it is likely that disabled people who work are healthier than others on the rolls.

Under current law, the combined federal Medicaid per capita costs for prescription drugs and personal assistance services for the disabled are approximately \$5,800 per year. With the match rate enhancement available under the bill, CBO estimates that the combined federal spending for prescription drugs and personal assistance services under this program would be approximately \$7,000 per disabled beneficiary per year in 2000.

Work counseling and assistance services would include client evaluations and health insurance counseling. Counselors would be paid out of SSA's appropriation and would refer clients to vocational rehabilitation providers or to prospective employers. CBO assumes those costs would average about \$100 per year per enrollee.

Total Cost of S. 1858. CBO estimates that S. 1858 would increase federal Medicaid costs by \$1.2 billion in 2000, with five-year costs of approximately \$5.2 billion. CBO assumed that about one-third of states would take up the option to provide work incentive services to eligible individuals. Some of these individuals would already be eligible for Medicaid benefits (which generally include personal assistance services and prescription drugs) because of their SSI status or other Medicaid eligibility criteria and would be barred from getting work incentive services under S. 1858's maintenance of effort requirements. However, CBO assumes that these requirements would not be fully effective, and that states would be able to federalize some state-only programs and convert some current Medicaid beneficiaries' optional benefits to the enhanced match available under S. 1858. Getting an enhanced match on services states otherwise would have provided would protect states from financial loss associated with newly covered individuals.

CBO's Medicaid estimate accounts for the full cost of work incentive services for those not currently receiving those benefits under the Medicaid program. It also accounts for the marginal increase in federal costs attributable to states converting some optional prescription drug and personal assistance services for eligible persons from Medicaid to the enhanced match program. Although the bill gives states the ability to impose cost-sharing requirements on individuals earning more than 150 percent of poverty, CBO assumes that few newly-enrolled individuals would be affected by any requirements that states would impose, and would likely pay less than 5 percent of the cost of benefits. The estimate also takes into account increases in Medicaid administrative spending associated with new

eligibility determinations. (Under current law, when SSA does disability determinations at the behest of a state solely for the purpose of establishing Medicaid eligibility, SSA absorbs half the cost and the rest is split evenly between federal and state Medicaid outlays.)

CBO estimates that federal spending on Medicare would increase by approximately \$10 million in 2000, compared to current law, and by \$200 million over five years. CBO assumed that working SSDI recipients entitled for more than 24 months would join OPTIONS and qualify for extended Medicare benefits once they exhaust their regular coverage. For most SSDI OPTIONS participants, who would not earn enough to jeopardize their DI benefit, there would be no cost to the policy compared with current law, as they would have gotten Medicare coverage (including free part A coverage) in any case. For those few SSDI OPTIONS participants who will graduate from an EPE, there are Medicare costs compared with current law. Since very few of them would otherwise have bought into Medicare by paying the full actuarial premium for part A coverage, and since relatively few would pay a significant premium under S. 1858's proposed sliding scale based on income, those premiums are largely immaterial to CBO's estimate. Since CBO assumed that hardly any OPTIONS participants would waive their cash benefits, it estimates no DI savings.

The bill would direct that SSA conduct certain demonstration programs to test the effects of various work incentives. The bill would extend SSA's waiver authority, however, only through June 1999—not long enough to get any major projects off the ground. Therefore CBO has not included costs of demonstration projects in its estimate.

CBO estimates that S. 1858 would result in increases in SSA's discretionary spending. Costs for counseling about 440,000 OPTIONS participants at about \$500 per year each would be about \$0.2 billion a year. On the assumption that participating states request SSA to perform disability determinations for EWII's, SSA's share of costs for those determinations would be about \$0.3 billion in 2000, when the program would first get under way, and subside to about \$50 million a year thereafter. In total, SSA's discretionary costs would rise about \$0.5 billion in 2000 and \$0.3 billion a year thereafter, for a five-year total of \$1.4 billion.

Uncertainties in CBO's estimate. There are several factors that could make the costs of S. 1858 significantly higher or lower than CBO's estimate. Primarily, states' participation in this new, optional Medicaid program is uncertain. CBO's judgment that states with one-third of the eligible population would participate is based on an analysis of how many states would be fiscally no worse off if they offered the new benefits to more people but also enjoyed the enhanced match rate and shifted some current costs. The extent of that behavior could be larger or smaller than CBO assumed. Many more states might participate if they were

willing to incur higher state costs. On the other hand, some states might balk at the program's complexity, especially in the early years.

Another source of uncertainty is the size of the working disabled population. As discussed above, about 8 million people between the ages of 18 and 64 collect Social Security disability or SSI benefits, but 17 million in that age group report a work disability. That would imply 9 million potential applicants for S. 1858's enhanced Medicaid and other benefits. Those figures reflect one particular definition of disability used by the Bureau of the Census--namely, "work disability," defined as an impairment that prevents the respondent from working or limits the kind or amount of work he or she can do. In those same surveys, only 11 million, not 17 million, people describe themselves as meeting a narrower definition ("severe" work disability). But when a broader definition of disability--one resembling the definition in the Americans with Disabilities Act--is used, nearly 30 million people age 21 to 64 describe themselves as disabled.¹ These figures imply that the potential demand for benefits under S. 1858 among disabled people who are not collecting cash benefits could fall in a very wide range.

That uncertainty is magnified by the fact that S. 1858 contains no definition of disability, and would instead leave it to the states to determine eligibility. CBO's estimate assumes that states would delegate responsibility for determining initial eligibility to the Disability Determination Services (DDSs), which already do that task for the Social Security and SSI disability programs. The advantage, from the states' standpoint, is that they would then pay only a fraction of the cost of the disability determinations (whose cost runs about \$500 to \$700 each). The DDSs use the definition of disability that is contained in the Social Security Act. But states that chose to make their own determinations could use a much broader definition, potentially adding hundreds of thousands of people to enrollment. Also, the bill contains no direction regarding appeals processes.

States would not have to make a determination of disability for people already receiving DI or SSI benefits, of course. But states would decide whether those beneficiaries, if not already working, are "in a transition to work readiness or otherwise work eligible"--the definition of a WEI. That would afford states another tool to control enrollment.

CBO's estimate of S. 1858 include no effects on the SSI and DI programs. Potential effects

¹ The oft-cited figure of 40 million, or more, Americans with disabilities includes children and the elderly, whereas S. 1858 is targeted at those between the ages of 18 and 64.

are highly mixed. It is possible, for example, that giving people with severe impairments better access to personal care services and prescription drugs could enable them to avoid or delay going on SSI or DI. And it is possible that extending Medicare, for the handful of DI recipients who go back to work, would remove a source of anxiety and encourage them to stay at their new jobs longer. Therefore, S. 1858 could lead to some savings in the SSI and DI programs. On the other hand, S. 1858 would expand the definition of impairment-related work expenses (IRWEs), making it possible for some DI recipients to keep benefits that they would otherwise lose. And both SSI and DI benefits would be costlier if the outreach and counseling efforts required by S. 1858 led to more applications for benefits. Because these effects are highly uncertain, and work in opposite directions, CBO displays no SSI or DI effects in its estimate.

CBO makes no judgment regarding the requirement that the Secretary take into account savings in DI and SSI in considering requests for Section 1115 waivers. Uncertain effects on DI and SSI from S. 1858 notwithstanding, interagency implementation of this provision is likely to be ineffective. Additionally, spending under Section 1115 Medicaid demonstrations could expand more rapidly than under current law if savings from non-Medicaid programs could be used in budget neutrality determinations.

Summary of S. 1858 as introduced by Senators Jeffords, Kennedy, and Harkin

Group	Get (current law)	Eligible for under S. 1858	Budgetary effects?
1--"eligible working individuals with a disability" (nonrecipients of Title II disability benefits or SSI disability benefits who are working," as certified by states)	No OASDI or SSI cash. No Medicare or Medicaid, unless they happen to fall into some other program category.	No OASDI or SSI cash. No Medicare. Medicaid under sec. 1929A, if offered as a state option (technically, just "extra" services, i.e., personal care services plus prescription drugs, but not "core" Medicaid). Work counseling under sec. 1183 (discretionary)	Medicaid costs for sec. 1929A benefits less any premium contribution. Discretionary SSA costs for sec. 1183 counseling. HCFA and SSA costs for doing disability determinations, if done in accordance with sec. 1634 of S.S. Act. Possible DI or SSI savings, if enhanced health benefits forestall people from going on rolls; speculative.
2--SSDI OPTIONS participants (SSDI recipients who choose to enroll in OPTIONS; must be employed)	Cash benefits under DI; Medicare after 24 months on DI. If working, unlimited earnings for 9-month TWP, plus 3 months grace; then no cash benefits so long as earnings above SGA, though Medicare continues for 3 years (during the "extended period of eligibility," or EPE).	Medicaid under sec. 1929A, if offered as state option. Work counseling under sec. 1183. Indefinite Medicare (for as long as employment continues) under sec. 1818B. Must have been on DI (or OPTIONS) for 24 months for Medicare eligibility. May owe premium if income >250% of poverty. If enrolled in OPTIONS during first 24 months of entitlement, must waive DI cash; appears likely to be rare. If enrolled in OPTIONS after more than 24 months on rolls, no waiver required. Can exclude more IRWEs, notably those for preparing for work and traveling to work, in computing whether earnings < SGA.	Medicaid costs for sec. 1929A benefits less any premium contribution. Discretionary SSA costs for sec. 1183 counseling. Medicare costs (possibly offset by small premium receipts, and by "secondary payer" savings if beneficiary covered by employer plan) for extending coverage indefinitely (not just for 3 years) for DI recipients who return to work. Possible small DI savings from voluntary waivers of cash (unlikely) and induced returns to work. Small DI costs from expanding definition of IRWEs.
3--SSI 1619(a) and 1619(b) recipients (i.e., those with earnings > SGA)	Cash benefits under 1619(a). Ordinary Medicaid under both 1619(a) and 1619(b).	Medicaid (sec. 1929A).	Medicaid costs for sec. 1929A benefits less any premium contribution.
4--"work eligible individuals" (SSI and DI recipients who are not working, but are deemed "work-ready" by states)	Ordinary DI and SSI program rules apply.	Medicaid (sec. 1929A).	Medicaid costs for sec. 1929A benefits less any premium contribution.

NOTES:

Groups 1 and 2 are called "OPTIONS" participants. Groups 1, 2, and 3 are called "qualified eligible working individuals with a disability."

Sec. 1929A (enhanced Medicaid) services would cover a attendant care and prescription drugs. They would be optional for states; however, a state that covered any of the four groups above would have to cover all. Sec. 1929A services would be financed at an enhanced FMAP.

Sec. 1818B (enhanced Medicare) would extend Medicare coverage indefinitely so long as recipients remained employed (instead of ending it after the 36-month extended period of eligibility as under current law); the ordinary part B premium, and a modest income-related premium for part A, would be charged.

Sec. 1183 (work incentive counseling and assistance) would offer client evaluations and health-insurance counseling to eligible individuals; counselors would be paid, under contract, out of SSA's appropriation. Counselors would refer clients to vocational rehabilitation providers or employment prospects, but would not deliver or pay for such services directly (except to the extent already provided under current law).

"Title II disability benefits" encompass benefits for disabled workers (paid from the DI trust fund) and for disabled widow(er)s and disabled adult children (mostly paid from the OASI trust fund).

DI = disability insurance, TWP = trial work period, SGA = substantial gainful activity, IRWEs = impairment-related work expenses.

WORK INCLUSIVE IMPROVEMENT ACT OF 1998
As introduced on March 25, 1998

By: Fiscal year, in billions of dollars:

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	1999-2009
Mandatory											
Federal share of Medicaid											
Costs	1.1	1.2	1.2	1.3	1.5	1.7	1.9	2.1	2.3	2.6	5.1
Offsets	-0.2	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
Medicaid share of eligible expenditures	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Subtotal: Medicaid	1.2	1.2	1.2	1.3	1.5	1.7	1.9	2.1	2.3	2.6	5.3
Medicaid costs	0.3	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.2
Total mandatory	1.2	1.2	1.2	1.4	1.6	1.8	2.0	2.2	2.5	2.8	5.4
Discretionary											
Additional SSA costs	0.5	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.6	1.4

NOTE: "-" denotes "zero" or "less than \$10 million."

PRELIMINARY AND UNOFFICIAL.

FAX COVER



Income Maintenance Branch

Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503



To: DIANA FORTUNA

Organization: DPC

Fax Number: 6-~~33~~ 7431

From: JOANNE CLANCY

Date/Time: 6/18/98

Number of Pages: Cover + 20

Notes:

Diana--

Here are the cost estimates for NR. 3433.
I included SSA's estimate too. They used
very different assumptions in some cases, but
the numbers are still pretty small.

Call me if you have questions

- Joanne

Bunning-Kennelly
ticket that
passed
House

Estimated Title II and Title XVI program savings/revenue (+) or costs (-)
from H.R. 3433, fiscal years 1999-2008

(In millions of dollars)

Provision	Fiscal Year										Totals. 1999-2008
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	
Title II											
Ticket to work.....	-	-	3/	4/	4/	10	9	40	55	110	225
One-for-two demonstration project.....	-	-	-10	-10	-20	-25	-30	-30	-30	-30	-165
Additional two years of Medicare Extension of demonstration project authority.....	3/	3/	4/	4/	4/	4/	4/	4/	4/	4/	4/
Tightening of prisoner suspension provisions 1/.....	20	40	45	45	50	55	60	65	70	75	525
Revocation of clergy exemptions 2/.....	5	15	15	15	15	15	15	15	15	20	145
Total, Title II.....	25	55	50	50	45	55	50	90	110	175	710
Title XVI											
Ticket to work.....	-	-	5	5	5	15	10	15	40	65	200

1/ There also are Title XVI savings of less than \$2.5 million over the period.

2/ There also are HI tax revenues of \$35 million over the period.

3/ Cost of less than \$2.5 million.

4/ Savings of less than \$2.5 million.

Social Security Administration
Office of the Chief Actuary
May 29, 1999

SSA

ID: 402 3800674

JUN 18 1998

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PAGE 3

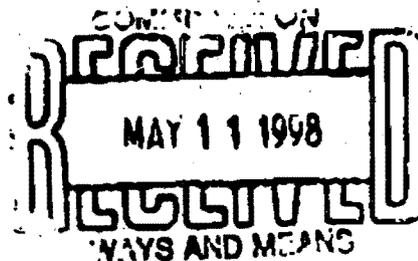


CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

May 8, 1998

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



Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 3433, the Ticket to Work and Self-Sufficiency Act of 1998.

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

Sincerely,

Paul Van de Water
for June E. O'Neill

Enclosure

cc: Honorable Charles B. Rangel
Ranking Minority Member



**CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE**

May 8, 1998

H.R. 3433

Ticket to Work and Self-Sufficiency Act of 1998

*As ordered reported by the House Committee on Ways and Means
on May 6, 1998.*

SUMMARY

H.R. 3433, the Ticket to Work and Self-Sufficiency Act of 1998, would revamp the system under which people collecting disability benefits from the Social Security and Supplemental Security Income programs receive vocational rehabilitation services. The bill would also require several demonstration projects, give certain members of the clergy another opportunity to enroll in the Social Security system, and tighten restrictions on the payment of Social Security benefits to certain prisoners. CBO estimates that the bill would add to the federal surplus by \$38 million over the 1999-2003 period; of that amount, \$11 million is in Social Security (which is legally off-budget) and the rest in other programs (which are on-budget).

H.R. 3433 contains no intergovernmental mandates, as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 3433 is summarized in the following table. The costs of this legislation fall within budget functions 570 (Medicare), 600 (Income Security), and 650 (Social Security).

Table 1. Summary of Estimated Budgetary Effects of H.R. 3433

	By Fiscal Year, in Millions of Dollars					
	1998	1999	2000	2001	2002	2003
DIRECT SPENDING						
Spending Under Current Law						
Old-Age, Survivors, and Disability Insurance	375,785	391,477	408,764	427,736	448,711	471,221
Supplemental Security Income	27,301	28,563	29,985	31,595	33,371	35,302
Medicare ^a	196,941	208,178	218,505	239,668	246,198	270,931
Medicaid	<u>100,506</u>	<u>108,418</u>	<u>115,014</u>	<u>122,594</u>	<u>130,891</u>	<u>140,742</u>
Total	700,533	736,636	772,268	821,593	859,171	918,196
Proposed Changes						
Old-Age, Survivors, and Disability Insurance	0	2	1	7	10	7
Supplemental Security Income	0	-1	-5	-6	-6	-8
Medicare ^a	0	0	0	b	b	2
Medicaid	0	b	b	b	b	b
Total	0	1	-4	1	5	1
Off-Budget (OASDI)	0	2	1	7	10	7
On-Budget	0	-1	-5	-6	-6	-6
Proposed Spending Under H.R. 3433						
Old-Age, Survivors, and Disability Insurance	375,785	391,479	408,765	427,743	448,721	471,228
Supplemental Security Income	27,301	28,562	29,980	31,589	33,365	35,294
Medicare ^a	196,941	208,178	218,505	239,668	246,198	270,933
Medicaid	<u>100,506</u>	<u>108,418</u>	<u>115,014</u>	<u>122,594</u>	<u>130,891</u>	<u>140,742</u>
Total	700,533	736,637	772,264	821,594	859,176	918,197
REVENUES						
Proposed Changes						
Off-Budget (OASDI)	0	3	7	9	9	10
On-Budget	0	b	1	1	1	1
Total	0	3	8	10	10	11
DEFICIT (-) OR SURPLUS						
Proposed Changes						
Off-Budget (OASDI)	0	b	7	2	-1	2
On-Budget	0	1	6	7	7	7
Total	0	2	12	9	6	9

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Note: Components may not sum to totals due to rounding.

OASDI - Old-Age, Survivors, and Disability Insurance.

a. Medicare consists of outlays of the Hospital Insurance and Supplementary Medical Insurance trust funds, less premiums.

b. Less than \$500,000

BASIS OF ESTIMATE

For purposes of estimating the budgetary effects of H.R. 3433, CBO assumes enactment in September 1998. CBO's estimate of the bill's effects, by provision, are detailed in the following table and explained below.

Ticket to Work and Self-Sufficiency Program (Section 2)

Section 2 of H.R. 3433 would change the way that vocational rehabilitation (VR) services are provided to recipients of Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) benefits. It would also require that SSA test the savings (or costs) of some alternative methods of treating earnings in the DI program.

Current Law. DI and SSI recipients currently receive VR services chiefly through state VR agencies. Data on their experience under those programs are sketchy. The Social Security Administration (SSA) attempts to spot good candidates for VR and refer them for services when it awards benefits, but it does not monitor what happens to them next. VR agencies accept only a fraction of the candidates referred. SSA reimburses the VR agencies for the cost of services rendered if the beneficiary has performed 9 consecutive months of substantial gainful activity (SGA, currently defined by regulation as earnings of more than \$500 a month). In 1996, SSA began recruiting alternate providers under the Referral System for Vocational Rehabilitation Providers (RSVP) program. Candidates must first be referred to and rejected by the state VR agencies, and the alternate providers face the same reimbursement system (that is, a single payment after 9 months of substantial work). Thus, VR for DI and SSI recipients remains fundamentally a state program.

Scattered clues suggest that approximately 10 percent to 15 percent of new DI and SSI recipients are referred to state VR agencies and that about 10 percent of those referred are accepted. Recently, SSA has made approximately 650,000 DI awards a year; thus, it is likely that about 60,000 to 90,000 a year were referred to VR and perhaps 6,000 received services. SSA has consistently paid for about 4,000 claims per year for VR services provided to DI recipients. SSA has also steadily paid about 4,000 claims for VR services to SSI recipients. Since about 2,000 claims are for people who collect benefits under both programs, total claims reimbursed are about 6,000 a year.

Table 2. Estimated Budgetary Effects of Provisions of H.R. 3433

	By Fiscal Year, in Millions of Dollars									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Section 2										
Tickets Program for Vocational Rehabilitation Clients-DI										
Payments to Program Manager	1	2	1	1	2	3	3	4	4	4
Milestone Payments to Providers	0	a	1	5	11	17	21	24	28	33
Incentive Payments to Providers	0	a	a	3	12	27	48	66	87	109
Gradual Phase-out of Current										
VR System	0	a	a	-3	-8	-14	-21	-32	-44	-58
Benefits Avoided	0	a	a	-4	-20	-48	-84	-98	-112	-126
Extra Benefits Paid	0	a	1	2	2	2	7	10	13	16
Subtotal, DI	1	2	3	5	1	-10	-26	-27	-24	-22
Resulting Medicare Savings ^b	0	0	a	a	1	1	1	-2	-9	-20
Total, Provision	1	2	3	5	1	-9	-25	-29	-33	-41
Tickets Program for Vocational Rehabilitation Clients-SSI										
Payments to Program Manager	a	1	a	1	1	1	2	2	2	2
Milestone Payments to Providers	0	a	1	3	6	9	10	12	14	16
Incentive Payments to Providers	0	a	a	1	3	7	12	17	22	28
Gradual Phase-out of Current										
VR System	0	a	a	-1	-4	-7	-11	-16	-22	-29
Benefits Avoided	0	a	a	-1	-5	-12	-22	-25	-29	-32
Extra Benefits Paid	0	0	0	0	0	0	0	0	0	0
Subtotal, SSI	a	1	1	2	a	-3	-8	-11	-13	-15
Resulting Medicaid Savings	c	c	c	c	c	c	c	c	c	c
Total, Provision	a	1	1	2	a	-3	-8	-11	-13	-15
"\$1-for-\$2" Demonstration Projects ^c										
Contractor Costs	0	a	4	5	6	6	4	4	4	4
DI Benefit Costs	0	0	3	8	13	18	19	18	18	18
Medicare Costs	0	0	0	0	2	4	7	9	9	9
Total, Provision	0	0	7	13	20	28	29	31	31	31
Section 3										
Extension of Medicare from 3 years to 5 years for clients suspended from DI who have used a ticket ^d	0	0	0	0	a	a	1	0	0	0
Section 5										
Extension of DI Demonstration Project Authority until June 10, 2001	3	5	5	3	a	0	0	0	0	0

Continued

Table 2. Continued

	By Fiscal Year, in Millions of Dollars									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Section 7										
Prisoner-Related Provisions										
Payments to Prison Officials--										
OASDI	2	7	7	8	9	10	10	10	10	10
Payments to Prison Officials--SSI	0	1	1	1	1	1	1	1	1	1
Savings in Benefits--OASDI	-3	-13	-15	-18	-20	-20	-20	-20	-20	-20
Savings in Benefits--SSI	-1	-6	-7	-8	-9	-10	-10	-10	-10	-10
Total, Provision	-3	-13	-15	-17	-20	-20	-20	-20	-20	-20
Section 8										
Two-Year Open Season for Enrollment by Clergy										
Off-Budget (OASDI) Revenues	3	7	9	9	10	10	10	11	11	11
On-Budget (HI) Revenues	1	2	2	2	2	2	2	2	3	3
Other On-Budget Revenues	a	-1	-1	-1	-1	-1	-1	-1	-1	-1
OASDI Benefits	a	a	a	a	a	a	a	a	a	a
Total, Provision (Effect on Deficit)	-3	-8	-10	-10	-11	-11	-11	-12	-12	-13
Total										
Outlays										
On-Budget	-1	-5	-6	-6	-6	-7	-9	-14	-22	-35
Off-Budget	2	1	7	10	7	4	-14	-15	-13	-11
Total	1	-4	1	5	1	-2	-23	-29	-35	-46
Revenues										
On-Budget	a	1	1	1	1	1	1	1	1	1
Off-Budget	3	7	9	9	10	10	10	11	11	11
Total	3	8	10	10	11	11	11	12	12	13
Deficit (-) or Surplus (+)										
On-Budget	1	6	7	7	7	8	10	15	23	36
Off-Budget	a	7	2	-1	2	6	24	26	24	22
Total	2	12	9	6	9	14	35	41	47	58

Note: Components may not sum to totals due to rounding.

a. Less than \$500,000.

b. These savings would occur under current Medicare law. Section 3 of the bill would also extend Medicare coverage for certain suspended recipients.

c. CBO expects that the vast majority of rehabilitated SSI recipients would continue to get Medicaid coverage through the 1619(b) program.

d. Under the proposal, the Medicare extension would cover only those recipients who returned to work and used a "ticket" under the new program. The provision would expire 7 years after enactment.

e. The bill would require SSA to test graduated reductions in benefits (such as "\$1-for-\$2" above \$85 or above SGA, currently \$500) on a sufficient scale and for a long enough period to permit valid statistical analysis.

Clearly, some DI and SSI recipients also return to work without the help of VR agencies. Research suggests that only 10 percent to 20 percent of DI recipients ever work after they start collecting benefits, and only 2 percent to 3 percent eventually have benefits withheld. In contrast, SSA reimburses claims for VR services for fewer than 1 percent of recipients. Thus, for each VR success, one or two other DI recipients go back to work and are suspended from the rolls without VR.

The DI program has several features that are meant to smooth beneficiaries' return to work. Applicants must show that they are incapable of substantial work in order to be awarded benefits. If they do work, the law permits them to earn unlimited amounts for a 9-month period (known as trial work) and a subsequent 3-month grace period before suspending benefits. During the next 3 years--a period known as the extended period of eligibility, or EPE--those beneficiaries may automatically return to the DI rolls if their earnings sink below \$500. Furthermore, Medicare benefits (for which DI beneficiaries qualify after two years on the rolls) also continue during the 3 years of extended eligibility.

The SSI disability program is restricted to people with low income and few resources. Although applicants for SSI benefits must meet the same disability criteria as in the DI program, the SSI program's subsequent treatment of earnings differs somewhat. SSI recipients who work get a reduced benefit (essentially, losing \$1 of benefits for each \$2 of earnings over \$85 a month) but do not give up their benefit entirely. If their earnings top \$500 but they are still medically disabled, they move into section 1619(a) status (and still collect a small cash benefit). If their earnings rise further, they enter 1619(b) status (where they collect no cash benefit but still qualify for Medicaid).

H.R. 3433. The bill would revamp the VR system by permitting nearly any recipient who desires VR to receive it, by permitting clients to choose from a variety of providers in addition to state VR agencies, and by stretching out reimbursements to providers for up to 5 years, contingent on their clients' sustained absence from the rolls.

Under H.R. 3433, SSA would issue tickets to DI and SSI beneficiaries that they could assign to approved VR providers, whether state, private for-profit, or nonprofit. The bill would grant wide latitude to SSA in deciding the terms and conditions of the tickets; SSA tentatively plans to issue tickets to new beneficiaries at the time of award, unless they are deemed likely to recover medically, and to current beneficiaries following a continuing disability review. By accepting a ticket, providers--labeled "networks" in the bill--would agree to supply services, such as training, assistive technology, physical therapy, or placement. A program manager, selected by SSA, would aid in recruiting providers and handling the nuts-and-bolts administration of the program.

Providers could choose between two forms of reimbursement from SSA. One system would be based solely on outcomes; the provider would receive 40 percent of the average DI or SSI benefit for up to 5 years, so long as the client stayed off the rolls. Some providers fear, though, that they would experience acute cash-flow problems under such a system. To address that concern, the bill also offers a blended system, dubbed the "milestones-outcome" system. Under that system, SSA would make some payments earlier, but would trim subsequent payments to ensure that the overall cost (calculated on a net present value basis) did not exceed the cost of a pure outcomes system.

The new program would be phased in gradually. H.R. 3433 calls for it to start in selected areas a year after enactment, and to operate nationwide six years later. Because new providers would continue to come on board even after the program starts operation in an area, CBO assumes that it would take nearly 10 years for the new program to run at its full potential.

CBO assumes that about 7 percent of newly-awarded beneficiaries would seek VR services if they were readily available, versus only about 1 percent who receive them under current law. Both the Transitional Employment Demonstration (TED, a demonstration conducted in the mid-1980s and confined to mentally retarded recipients) and Project Network (a demonstration begun in 1992 and open to both DI and SSI beneficiaries) suggested that about 5 percent of beneficiaries would enroll in VR if given the chance. CBO judged that the level of interest ultimately would slightly exceed 5 percent for two reasons. First, intake under Project Network developed bottlenecks, which may have discouraged some potential participants. Second, Project Network barred any recipients who were employed or self-employed from enrolling; no such bar would be in place under H.R. 3433, however, and those recipients would probably be interested in receiving services and would be attractive to providers.

Research suggests that getting VR raises the propensity to work, and only work can lead to an earnings-related suspension. Based on several econometric studies and on the results of the TED demonstration, CBO assumes that slightly over half of the extra VR recipients would work. That raw figure, however, can easily exaggerate the effectiveness of VR. The handful of beneficiaries who would sign up for VR are probably the most motivated, and many would have worked anyway. In fact, CBO assumes that one effect of H.R. 3433 would be to enable providers to be reimbursed for providing services for many people who would have worked anyway.

These expected effects can be illustrated by following the experiences of one hypothetical cohort of 650,000 disabled workers--the approximate volume of annual awards in 1992

through 1997. Under current law, about 6,000 would be served under the state VR programs; 4,000 of them would eventually generate a reimbursement to the state program, and would be suspended for at least a month. Another 9,000 would be suspended due to earnings, for at least one month, without any reimbursement to VR. Thus, total suspensions would be about 13,000, or about 2 percent of the cohort, under current law. CBO assumes that, if those beneficiaries could freely enroll in VR using a "ticket," about 7 percent or 47,000 would get VR services. Most of those VR clients would work, and many (about 12,000) would be suspended for at least one month, an increase of 8,000 in VR-reimbursed cases. However, CBO assumes that about 6,000 of these workers would have gone back to work unaided. Thus, for this cohort, net VR-related suspensions would be 2,000 higher.

In estimating H.R. 3433, CBO adjusted those hypothetical figures for its caseload projections and timing factors. First, CBO assumes that the volume of disabled-worker awards gradually climbs from 625,000 in 1998 to about 810,000 in 2005. Second, CBO also assumed that some extra rehabilitations would occur among the nearly 5 million current DI beneficiaries, not just among new awards, although current beneficiaries are generally poorer candidates for VR than new applicants with more recent work experience. Third, CBO adjusted the numbers for the gradual phase-in of the new system. Under the bill's schedule, assuming enactment by September 1998, the first services would be rendered at a handful of sites in fiscal year 2000. If those clients engaged in trial work in 2001, the first extra suspensions would occur in 2002. Each year, more areas would be brought into the new system.

Specifically, CBO assumed that the number of net additional suspensions--that is, suspensions that would not occur in the absence of the new program--would equal only 400 in 2002, 1,800 in 2003, and between 3,000 and 4,000 a year in 2004 through 2008. Gross suspensions that involve reimbursement to a VR provider would range between 4,000 and 5,000 a year under current law, but would be markedly higher--about 700 more in 2002 and about 9,000 more in 2008--under the proposal. And the number of suspensions involving no reimbursement to VR would drop from about 9,000 in 2002 to about 5,500 in 2008.

CBO also had to make assumptions about recidivism. Many studies have documented that DI recipients who leave the rolls often return. It is not clear whether recipients of VR services are more or less likely to return to the rolls than others; some evidence suggests that the extra boost provided by VR fades over time. Because H.R. 3433 proposes to pay providers for up to 5 years, but only if the recipient stays off the rolls, assumptions about recidivism are critical. Based on a variety of sources, CBO assumes that recipients suspended from the rolls have about a two-thirds chance of still being suspended one year later, about a one-half chance 3 years later (when, technically, their DI entitlement is terminated), and a 40 percent chance after 5 years.

Effects of the Tickets Program in DI. The budgetary consequences of H.R. 3433, from the standpoint of the DI program, would consist of seven effects:

- o Payments to the program manager--SSA would hire a program manager to coordinate issuance of tickets, the recruitment of providers, and other tasks. Based on a similar arrangement in the RSVP program, CBO assumes that payments to the program manager would amount to just a few million dollars a year.
- o Milestone payments to providers--As explained earlier, the bill would give providers a choice between a pure outcome-based system (in which providers would get only periodic payments during the period of suspension) and a blended outcome-milestone system (in which they could get some money earlier). CBO assumes that most providers would opt for the blended system, which CBO assumes to consist of \$500 after several months of work and a \$1,000 bonus on the date of suspension. Placements would be considerably easier for providers to achieve than suspensions. In 2002, milestone payments would be \$1 million for the first batch of 1,000 gross suspensions (mostly people enrolled in 2000, the first year of services) and another \$4 million for about 8,000 working clients (mostly people served in 2001) for a total of \$5 million. In 2008, these payments would be about \$14 million for 14,000 gross suspensions and another \$19 million for about 38,000 work efforts, or \$33 million total.
- o Incentive payments to providers--The incentive payments would occur over a period of up to 5 years if the beneficiary remains off the rolls. In the pure outcomes system, they would be 40 percent of average benefits. CBO assumes that most providers would opt for the blended payment system, under which--in return for getting some earlier milestone payments--they would accept incentive payments of 30 percent. In 2002, 1,000 suspended beneficiaries would each generate an incentive payment of 30 percent times about \$800 a month, or about \$3 million for the year. In fiscal year 2008, gross suspensions of rehabilitation clients over the 2004-2008 period are assumed to be about 50,000. Some of those would have returned to the rolls, and a few would have died; CBO assumes that 33,000 of the 50,000 would remain suspended. At an average benefit of about \$900 a month, incentive payments would total \$109 million.
- o Gradual phase-out of current VR system--CBO assumes that, under current law, the DI trust fund would reimburse claims for VR services (principally claims from state agencies) of about 4,000 at present (at an average cost of about \$11,000), growing to about 5,300 in 2008 (at an average cost of about \$14,000). The new program would

gradually replace the current-law system. Even by 2008, a few vestiges of the old system would remain; roughly 20 percent of services rendered in 2006, for example, might still lie outside ticket areas and therefore would generate reimbursements in 2008 (allowing one year for services and one year for trial work) under the old system. Thus, in 2008, the current-law VR program is expected to cost about \$70 million, and about 80 percent of that would have been superseded by the new system.

H.R. 3433 would grant state VR agencies the option of remaining in the current reimbursement system--that is, charging reimbursement for the full amount of costs incurred after 9 months of work. Whether or not those agencies would choose to remain, though, is largely immaterial to CBO's estimate; most clients would be served by other providers.

- o Benefits avoided--The various payments to providers discussed above all depend on the number of gross rehabilitations. The savings in DI benefits, in contrast, depend on the number of net or extra rehabilitations. That distinction is important: when providers serve clients who would have worked and eventually been suspended anyway, they do not generate savings in DI benefits.

In 2002, of the total 1,000 suspensions of ticket holders, only 400 would constitute extra rehabilitations. At an average benefit of about \$800 a month, savings would be \$4 million. By 2008, CBO assumes that there would have been a total of 53,000 gross rehabilitations over the 2002-2008 period of which 20,000 would represent extra rehabilitations. Under CBO's assumptions about recidivism, about 12,000 of those 20,000 would still be off the rolls; at an average benefit of about \$900, benefit savings would be about \$126 million.

- o Extra benefits paid--Some people might file for DI benefits in order to get VR services, or may even be encouraged to do so by prospective providers (for example, by an insurance company that helps to run their employer's private disability or workers' compensation coverage). For those filers, the entire benefit cost (for any time they spend on the rolls) and the VR cost (if they do eventually get suspended) would be a net cost to the DI program.

To some extent, SSA could minimize this problem by setting the terms and conditions under which it would issue tickets--for example, by denying them to beneficiaries who are expected to experience a medical recovery quite soon. But some such filers might still seep through. CBO assumes that, when fully phased in, about 500 such filers would be induced to apply each year, and half would in fact be rehabilitated

after a year or two on the rolls. By 2008, under the phase-in assumptions used by CBO, there would have been a total of 2,400 awards to induced filers; 1,400 would still be on the rolls; and benefits to them, assuming an average monthly check of \$900, would cost about \$16 million.

- o Resulting Medicare savings--DI recipients who return to work automatically continue to receive Medicare coverage for 3 years after their suspension from DI. By leading to the rehabilitation and suspension of more DI recipients, H.R. 3433 would be expected to generate some savings in Medicare. DI beneficiaries who are capable of working are probably healthier than other beneficiaries, and their per-capita Medicare cost therefore less than average.

Under CBO's assumption that the first services would be rendered in 2000 and the first resulting suspensions in 2002, Medicare savings would begin in 2005. Of the 400 extra suspensions in 2002, only 200 are still suspended when they complete their EPE in 2005, and Medicare savings would be a scant \$1 million. By 2008, 10,000 extra suspensions are assumed to have occurred over the 2002-2005 period; 5,000 would still be off the rolls; and \$20 million in Medicare savings would result.

On balance, over the 1999-2003 period, CBO posits a small net cost in the DI program from the proposed tickets, mainly because there would be very few extra rehabilitations but there would be some startup costs and a few dollars paid to induced filers. Later, CBO posits small net savings, chiefly because the DI benefit savings from the extra suspensions outweigh, by a slim margin, the costs of paying for those beneficiaries who are skimmed by the providers. Obviously, different assumptions about the relative sizes of these groups would change the conclusions.

Effects of the Tickets Program in SSI. H.R. 3433 would also bring SSI participants into the new tickets to work program. CBO estimated effects in the SSI program in a manner similar to its estimates for DI. There are a few notable differences.

The number of SSI recipients affected by the bill is generally assumed to be only half as many as in DI. Under current law, SSA generally pays for about 6,000 rehabilitations a year--4,000 in DI and 4,000 in SSI, of which 2,000 are concurrent. Under the bill, services rendered by providers to concurrent beneficiaries would essentially be compensated under the DI rules. Thus, to avoid double-counting concurrent beneficiaries, CBO generally assumed only half as many cases in its SSI estimates as in the analogous DI estimates.

Average benefits for disabled SSI beneficiaries are also only about half as large as in the DI program--in 2002, for example, about \$400 in SSI versus \$800 in DI. Therefore, all payments under the proposed system that are pegged to the average benefit, such as the incentive payments to providers, would be smaller in SSI. In fact, that provision has aroused concern that providers would be less willing to provide services to the SSI population. CBO implicitly assumes that providers would serve this group, perhaps emphasizing cheaper services with repeated interventions if necessary.

Because SSI is limited to beneficiaries with low income and few resources, CBO assumed that there would be few induced filers. CBO also assumed that most SSI beneficiaries affected by the bill would retain Medicaid coverage through section 1619(b).

The upshot of H.R. 3433 in the SSI program is a pattern that resembles that for DI: small early costs, giving way to small savings after 2003.

Demonstration Projects. Under current law, after completing the trial work period and the 3-month grace period (during which earnings are disregarded), a disabled worker gives up his or her entire benefit in any month that earnings exceed SGA (\$500). Both anecdotal and statistical evidence suggest that many beneficiaries balk at that, instead quitting work or holding their earnings just below the threshold. Some advocates favor, instead, cutting benefits by \$1 for every \$2 of earnings over \$500 a month. More modestly, some favor a treatment of earnings more like the SSI program's--a cut of \$1 in benefits for every \$2 of earnings over \$85 a month.

It is very likely that such proposals would encourage more people who are already on the DI rolls to work. Although fewer beneficiaries would be suspended (i.e., have their benefit reduced to zero), many might have their benefit substantially reduced. A major concern about such proposals is that they would encourage an unknown number of people to file for benefits. Survey data suggest that there are millions of severely impaired people who are nevertheless working and not collecting DI. Filing for benefits, and working part-time, might improve their standards of living. That incentive would be much stronger if the DI program liberalized its treatment of earnings. The SSA Actuary's office in 1994 estimated that applying a \$1-for-\$2 policy for earnings above \$500 would cost \$5 billion in extra DI benefits over a 5-year period and that setting the threshold at \$85 would cost \$2 billion.

H.R. 3433 would require SSA to conduct demonstrations to test the effects of a \$1 reduction in benefits for each \$2 of earnings. It would require that SSA conduct the demonstrations on a wide enough scale, and for a long enough period, to permit valid analysis of the results. CBO assumed that, to comply with those criteria, the demonstrations would have to include

perhaps half a dozen small states, that the intake phase of the project would have to last three or four years to permit observation of the expected induced filers and that the incentives themselves would have to be promised to the beneficiaries for an indefinite period. Because the demonstrations would pose formidable issues of design and administration, CBO assumes they would not get under way until 2001. CBO also assumes that the demonstration would be conducted in areas with and without the tickets to work and self-sufficiency, to enable the effect of the incentives to be isolated from the effects of the new VR program. Even a relatively small-scale demonstration might thereby apply to approximately 2 percent to 3 percent of the nation. Multiplying that percentage times the DI benefit costs contained in the Actuaries' 1994 memo suggests that the demonstration would, after intake is complete, cost almost \$20 million in extra DI benefits a year. It would also lead to slightly higher Medicare costs, since the induced filers would qualify for Medicare after two years on the DI rolls. Finally, CBO assumes that running the demonstrations and collecting and analyzing data would be handled by an expert contractor, at a cost of several million dollars a year. In sum, the \$1-for-\$2 demonstration projects mandated by the bill are estimated to cost \$190 million over the 2001-2008 period.

Extended Medicare Coverage (Section 3)

As noted before, DI recipients who give up their cash benefits because of earnings can continue to get Medicare for 3 years. H.R. 3433 proposes to lengthen that period to 5 years. The extended coverage would only be available to beneficiaries who had registered a ticket with a VR provider. Furthermore, the coverage would expire 7 years after enactment (that is, in September 2005, under CBO's assumption).

Since CBO assumes that the first batch of VR clients under the new tickets program would be suspended in 2002, their 3-year period of extended Medicare eligibility under current law would expire in 2005. Therefore, the proposed extension would expire before it would have significant costs. CBO assumes costs of just \$1 million in 2005.

Other Provisions

The other provisions of H.R. 3433 are mostly technical corrections and clarifications to the Social Security Act. Those technical corrections have passed the House twice previously, in September 1996 (H.R. 4039) and April 1997 (H.R. 1048). As pointed out in previous CBO estimates, most do not have budgetary implications. Three sections do have budgetary effects.

Demonstration Project Authority (Section 5). SSA has the authority to conduct certain research and demonstration projects that occasionally require waivers of provisions of Title II of the Social Security Act. That waiver authority expired on June 10, 1996. This bill would extend it until June 10, 2001. This extension would be the fifth since the waiver authority was enacted in 1980. This general waiver authority should not be confused with the so-called \$1-for-\$2 demonstrations that would be required by Section 2 of this bill; those demonstrations are costlier and longer-lasting than the modest projects that SSA would likely conduct on its own.

When the waiver authority has been in effect, SSA has generally spent between \$2 million and \$4 million annually on the affected projects. Because the proposed extension would be for 3 years, CBO judges that it would lead to outlays of \$15 million, chiefly in fiscal years 2000 and 2001.

Provisions Affecting Prisoners (Section 7). H.R. 3433 would also strengthen restrictions on the payment of Social Security benefits to prisoners. Current law sets strict limits on the payment of SSI benefits to incarcerated people and somewhat milder limits on payments of OASDI. SSI recipients who are in prison for a full month--regardless of whether they are convicted--are to have their benefits suspended while they are incarcerated. OASDI recipients who have been convicted of an offense carrying a maximum sentence of 1 year or more are to have their benefits suspended. Those who are convicted of lesser crimes, and those who are in jail awaiting trial, may still collect OASDI benefits. Those provisions are enforced chiefly by an exchange of computerized data between the Social Security Administration and the Federal Bureau of Prisons, state prisons, and some county jails. Those agreements are voluntary and, until recently, involved no payments to the institutions.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 changed that arrangement by directing SSA to pay institutions for reporting information that led to the identification of ineligible SSI recipients. The payment is \$400 if the institution reports information within 30 days of confinement and \$200 if the report is made 30 to 90 days after confinement. The law also exempts matching agreements between SSA and correctional institutions from certain provisions of the Privacy Act.

This bill would establish analogous arrangements for the OASDI program. It would also drop the requirement that OASDI benefits be suspended only if the maximum sentence for the offense is 1 year or more. (A conviction would still be required; inmates who are in jail while they await trial could continue to collect benefits.) CBO estimated the effects of this provision, like its predecessor in the welfare reform law, by analyzing data from several sources that suggest about 4 percent to 5 percent of prisoners were receiving Social Security,

SSI benefits, or both before incarceration. Reports from SSA's Inspector General showed that some of those prisoners were overlooked under matching arrangements either because their institution had not signed an agreement, had not renewed it promptly, or did not submit data on schedule.

CBO estimates that, over the 1999-2003 period, the provision in H.R. 3433 would lead to payments of \$32 million to correctional institutions out of the OASDI trust funds and benefit savings of \$69 million, for a net saving of \$37 million. CBO also expects that the broader arrangement, by doubling the pool of potential payments, would encourage more correctional institutions to submit information accurately and promptly and would therefore lead to spillover savings in the SSI program amounting to nearly \$30 million over the 1999-2003 period.

Open Season for Clergy to Enroll in Social Security (Section 8). Under current law, ministers of a church are generally treated as self-employed individuals for the purpose of the Social Security payroll tax. However, ministers who are opposed to participating in the program on religious principles may reject coverage by filing with the Internal Revenue Service before the tax filing date for their second year of work in the ministry. H.R. 3433 would give those ministers a chance to revoke their exemptions. It would give them a two-year window--ending on the tax filing deadline for the second taxable year beginning after December 31, 1998--to exercise that option.

In 1977 and 1986, the clergy were offered a similar opportunity to opt back into Social Security. Based on that experience, CBO estimates that about 3,500 ministers would take advantage of the opportunity. CBO estimates that the clergy who elect coverage would pay about \$3 million in Social Security (OASDI) taxes, which are off-budget, in 1999 and \$10 million a year thereafter. They would also pay Hospital Insurance (HI) taxes, which are on-budget, of about \$2 million a year. Finally, income tax revenues would drop slightly because, as self-employed individuals, ministers paying Social Security could deduct a portion of that tax when computing income tax.

PAY-AS-YOU-GO CONSIDERATIONS:

The Balanced Budget and Emergency Deficit Control Act of 1985 establishes pay-as-you-go procedures for legislation affecting direct spending or receipts. The projected changes in direct spending are shown in the table below for fiscal years 1999-2008. Only changes affecting on-budget outlays and receipts (that is, those in non-Social Security programs) affect the pay-as-you-go scorecard. For purposes of enforcing pay-as-you-go procedures,

only the effects in the current year, budget year, and the succeeding four years are counted.

Table 3. Summary of Pay-As-You-Go Effects of H.R. 3433

	By Fiscal Year, in Millions of Dollars									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Change in Outlays	-1	-5	-6	-6	-6	-7	-9	-14	-22	-35
Change in Receipts	a	1	1	1	1	1	1	1	1	1

Note: Components may not sum to totals due to rounding.
a. Less than \$500,000.

Social Security outlays and receipts do not appear on the pay-as-you-go scorecard, but the House of Representatives tracks them separately. That tally includes effects only for the year in which the legislation takes effect and the four subsequent years; for H.R. 3433, the relevant years are 1998 through 2002. It also includes balances carried over from laws enacted in previous years, such as the Contract with America Advancement Act (Public Law 104-121) enacted in 1996. Under the rules of the House, the Social Security scorecard includes only tax receipts and benefit outlays of the Social Security trust funds. Therefore, outlays for purposes other than benefits--such as the payments to VR providers and to prison officials that would occur under H.R. 3433--do not appear on the scorecard.

Table 4. CBO Estimate of Current Status of the Social Security Scorecard in the House of Representatives

	By Fiscal Year, in Millions of Dollars				
	1998	1999	2000	2001	2002
Scorecard at Start of 1998					
OASDI Taxes	146	80	--	--	--
OASDI Benefits	-77	-114	75	--	--
Net Effect	223	194	-75	--	--
Ticket to Work and Self-Sufficiency Act of 1998 (H.R. 3433)					
OASDI Taxes	--	8	9	9	9
OASDI Benefits	0	-3	-13	-11	-12
Net Effect	0	11	22	20	21
Scorecard Assuming Enactment of H.R. 3433					
OASDI Taxes	146	88	9	9	9
OASDI Benefits	-77	-117	62	-11	-12
Net Effect	223	205	-53	20	21

Note: Components may not sum to totals due to rounding.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 3433 contains no intergovernmental mandates as defined in UMRA and would impose no costs on state, local, or tribal governments. Although state VR agencies would lose their monopoly--or, technically, their "right of first refusal"--to serve SSA clients, the budgetary impact of this change would be minimal. In addition, state and local prisons would collect additional payments for providing certain computerized data to SSA that CBO estimates would total \$35 million over the 1999 -2003 period.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

H.R. 3433 contains no private-sector mandates as defined in UMRA.

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