

## TALKING POINTS -- PERSONAL ASSISTANCE SERVICES

- ◆ **The Clinton Administration has a strong commitment to and has made enormous progress in reducing unnecessary nursing home use and promoting and expanding home and community based services.** For example:
  - Streamlined HCBS waiver application/approval process; in 1997 waiver spending grew by 44%, while nursing home spending only grew by 4.8%;
  - Secretary Shalala issued strong principles on long-term care in 1995, reinforcing our commitment to home and community based care; and
  - Issued revised regulations for Medicaid personal care that will allow much more flexibility and consumer direction.
  
- ◆ **The President and Vice President met with disability groups in September 1997 to discuss PAS and other issues. As a result, HHS established a Home and Community Based Services Work Group, co-chaired by Bob Williams and Sally Richardson.** The general goals of the group are to study and make recommendations about how to reduce the institutional bias in Medicaid long-term care spending and service delivery to promote home and community-based care, with a particular emphasis on consumer directed services.
  
- ◆ **The HCBS Work Group has been very active and accomplished a great deal, and is launching a number of new initiatives and reforms that we expect to bear fruit in the coming months.** Among the accomplishments:
  - *Contracted with University of California at San Francisco to conduct an independent study of the institutional bias in Medicaid.* The draft study was reviewed by the Blue Ribbon Panel on PAS, and will be available in final form in the next few weeks. The report contains 75 policy recommendations on Medicaid personal care services, home and community-based waiver services, and home health services. Options can be grouped into four categories: (1) those requiring statutory change, (2) those requiring regulatory change, (3) those which can be accomplished through issuance of guidelines, and (4) those which necessitate a study or convening of a panel of experts on an issue. Roughly 13 recommendations require statutory change; 32 require regulatory change, 13 can be accomplished through manual guidelines, and 42 recommendations require a study or convening of a panel of experts. It is important to note that about one quarter of the recommendations presented by the UCSF team as needed regulatory or statutory, or policy changes are, in fact, things that are already allowable under the Medicaid program. Further, many states are already using Medicaid to offer services that the UCSF team suggests HHS ought to allow them to offer.

A major recommendation was that personal care services should be a mandatory Medicaid service, like nursing home care. While 34 states already provide personal care, and most of the others do so under HCBS waivers, the Administration and Congress are not likely to add new, unfunded Medicaid mandates to Title XIX. However, the Work Group is stepping up technical assistance for states and consumers to ensure that states make maximum use of current flexibility to provide personal care under Medicaid.

The report also includes a series of recommendations to clarify that personal care and home and community based waiver services: can be delivered by live-in caregivers; should not be restricted to in-home supports; should be used to provide respite for caregivers; should be more consumer directed; and several similar options.

Because many of these recommendations are, in fact, policies that are already in place, and many states already use personal care and waivers to provide these services, the *State Medicaid Manual transmittal* on the new personal care regulations will be expanded to clarify that these activities are, indeed, permissible (and have been for a long time). *The SMM transmittal will be completed and sent out in the Fall.*

- *Also, the Work Group is continuing to review the UCSF study, to determine what additional actions can be taken. The focus will be on recommendations which increase program flexibility without increasing program costs and, especially, those which can be accomplished through the issuance of guidelines.*

- *Contracting for Primer on Medicaid home and community based services.* The UCSF report is a strong indicator that many people are unaware of the flexibility that already exists in Medicaid, and current practices in many states. The **Primer** will explain in clear language all that is allowable under the Medicaid long-term care program. It will discuss what flexibility States have under the personal care services option (for example, States can implement consumer-directed personal care services programs) and the HCB waiver program and provide examples of what other States have done. As the Primer is developed, it will be reviewed by consumers and state officials, to ensure that it meets its goals of being easily understood and useful to people in the field. The Work Group expects to disseminate the Primer to states, consumers, providers, and other interested parties by the end of the year. It will include specific suggestions for states, targeted at expanding home and community based services and reducing unnecessary nursing home use. Concrete examples of state innovations will be described.

- ***Continuing to move ahead on the Cash and Counseling demonstration***, to test the possibility of providing consumers with more control over their own PAS by giving them cash, vouchers, or similar vehicles, plus counseling, so they can hire, train, and manage their own service providers.
- ***Conducting a durable medical equipment demonstration*** in collaboration with independent living centers to allow more flexibility in purchasing and budgeting for assistive devices. The announcement seeking proposals for this demonstration was made public in the first week of May.
- ***Recommending legislative change to allow home and community based services to be a state plan option, instead of a waiver.*** The Administration recommended this last year, and will continue to do so.
- ***Drafted announcement for “date certain demonstration.”*** HHS is finalizing a solicitation for a grants program to assist States to develop mechanisms to work with individuals and their families prior to admission to a nursing facility to consider community-based alternatives and/or to develop mechanisms to transition individuals currently in nursing facilities to the community if that is their choice. Grant awards will be made by September 30.
- ***Establishing a technical assistance focus, through a contract, to disseminate information and assist states and consumers in efforts to promote the use of home and community based services and consumer directed PAS.*** HHS will award a contract by August to provide assistance and information on model practices and ways to expand and promote home and community based services and minimize reliance on nursing homes. The technical assistance will be provided in the form of written materials, conferences and forums, electronic communications, and other means. HCFA technical assistance to states which are trying to expand HCBS and consumer directed care will continue.
  - One particular focus of the technical assistance efforts will be to ensure that ***information about the Helen L. case is disseminated widely.*** The goal will be to inform states and consumers about the implications of the Third Circuit Court decision that Title II of the ADA requires PAS to be provided in the most integrated setting, and identify activities to raise ADA issues about home and community based services throughout the country.
- ***Contracting for an analysis of the MDS, to increase knowledge about nursing home residents’ characteristics,*** to enable states and the federal government to better target efforts to move people out of nursing homes.

*The Work Group has completed a study of programs that train people on the welfare rolls to become PAS providers.* Work Group members reviewed training programs and developed a list of critical elements of good training programs to prepare welfare workers to be PAS providers. This study will be distributed widely in June. It is currently under review by the Work Group. In the Fall, the Work Group is planning to hold a small meeting of experts in PAS and welfare to discuss future activities.

*The Work Group has also been involved in a number of other activities:*

- disseminating information from an extensive series of interviews with consumers;
- disseminating to all HCFA regional waiver coordinators and state waiver staff a HCBS waiver manual developed by the Atlanta regional staff;
- posting on the Internet and otherwise disseminating a series of reports on maximizing consumer direction in personal assistance services;
- completing the "Mentoring Project," in which states that are farther along in home and community based care "mentor" states that are not as far ahead;
- finalizing a study of the California In Home Services and Supports program and disseminating the results; and
- stepping up an already active research agenda on HCBS.

## TALKING POINTS -- RETURN TO WORK

- ◆ **In March, the President signed an Executive Order on Employment of People with Disabilities.** People with disabilities report that the fear of losing essential health and long-term care services covered under Medicare and Medicaid, is an important factor in preventing them from leaving the federal income support programs (Supplemental Security Income and Social Security Disability Income) and trying to work. HHS is conducting research on what types of incentives could have a significant impact on helping these individuals enter the work force.
- ***The Secretary of HHS has written to each of the Governors to inform them of the new provision under the BBA,*** which allows states to offer Medicaid services to people with disabilities who are able to work and earn more than the currently allowed limits. This will enable people with disabilities to earn middle income salaries, but retain the health and long term care they need.
- **WE NEED YOUR HELP** in publicizing the availability of this new Medicaid option, and encouraging states to include it in their Medicaid state plans.
- ***The Administration supported and Congress enacted a provision that allows HCBS waivers to provide supported employment to all participants with mental retardation or mental illness,*** not just those recipients who were formerly institutionalized. A number of states have already picked up on this, and HHS will provide technical assistance to other states who want to do so.
- ***HHS has a solid research agenda underway.*** A recent HHS study conducted with SSA reviewed the research on the link between health care coverage and the decision to work. While few empirical studies were identified, the available evidence suggests that health care access is one important factor in the decision to seek work. Another recently completed study confirmed that at least some Section 1619 participants deliberately restrain their earnings so they can keep Medicaid. HHS is also looking at the impact of Medicaid expansions in Tennessee and Oregon to determine whether improved health care access led to greater numbers of people with disabilities entering the work force. Finally, at Secretary Shalala's request, Bob Williams' office is initiating a new research study to examine why some people with disabilities are able to successfully enter the work force and/or use existing work incentives while others are not.
- ***Independent living centers and other consumer service organizations need to fill an important void: they must familiarize themselves with the current work incentives for SSI and SSDI recipients, find out how they work and how to access them, and help consumers use the work incentives.*** On average, fewer than one percent of SSI and SSDI recipients use the work incentives that are currently available.

Macdonald Kafka  
Hughey Oxford  
Spomer

5/15 - ADAPT, NCIL  
CT, JL, Bill, Bob, Mary, Ruth, Marca

Race, SSA - We give high visibility to these w/ legislative vehicle

MC Home Health - disaster → comm bad

Hearing - missed opportunity - ok but make sure safe as nsg home

Radio address

Know re R's, but why won't D's introduce algo?  
- D's just say don't trust R's

Chris: be very surprised if no B in 7 in next PB

BBA (early?)  
What's Moving

States will get at least 1/10b unrestrict \$ from tobacco

PBOR

ME Comm - help them focus on res betg not just \$

CBO - Cant get mtg

Marca - next yr?

CT - July budget process begins

- Commits to meet + work

- if it's last thing I do @ w/lt

~~Bob~~ He you told that to HCFA

Spt HCFA budget - don't say NAM scumbag

~~Bob~~ - Regional mtgs BV set up - tried to restart + eldnt

Mississippi - 98% nsg home - not just legal - ene waivers

→ Highlight BBA @ NGA in Milw

Chris -  
PC vs PAS

CD on PBOR

Danny case

\* Talk to NGA

\* Mtg on Helen L (Self-eval)

\* Greenwich for Better comm re budget

\* my address

Radio address  
NGA - Aug

Mike - We Need:

① Pres should say: People should know where they live

② Marca - BBA @ NGA

Kafka - must set mood - LT svcs carved out

③ Inupl ADA in all HHS prog/svcs - wld help w/ legs

5/11/98 5:50pm



# ADAPT

Action News Bulletin

cc Danny Mendelson  
OMB

From Digna Fortuna

# FAX URGENT

To: Bob White

From: ADAPT - at Federal  
Building in Memphis.  
US marshals are getting  
ugly - lots of media

attention  
gore not responding



# ADAPT

## Action News Bulletin

May 13, 1998

Contact: Michael Auberger (901) 528-1800, Room M-4  
Marsha Katz (901) 522-9700, Room 312

### Sundquist Epitomizes Flaws in "States' Rights" Vice President Gore, Native Son of First Worst State

500 members of ADAPT had their belief in states' rights tested by Governor Don Sundquist's refusal to support Tennesseans with disabilities, young and old. Despite strong support for ADAPT from Memphis Mayor W. W. Herenton and Shelby County Mayor Jim Rout, Sundquist refused to work for home and community based services that could keep Tennessee citizens out of nursing homes and institutions.

"Governors like Sundquist who choose to ignore the cost effectiveness and rightness of home and community based services, and instead continue to sentence their citizens to death in nursing homes, leave us with only one solution—federal legislation that guarantees choice for all Americans. We'll just have to go to another level," concluded Michael Auberger, national ADAPT organizer.

ADAPT's legislation, H. R. 2020, also known as the Medicaid Community Attendant Services Act of 1997 or MiCASA (Spanish for My House), would set minimum standards for all the states. H. R. 2020 is co-sponsored by Minority Leader Richard Gephardt and Speaker of the House Newt Gingrich. It currently has 62 additional co-sponsors, split evenly between Democrats and Republicans, and allows citizens to choose home and community based services over nursing homes.

Despite its broad bipartisan support, the Clinton Administration has yet to endorse H. R. 2020. Tennessee Native Son, Vice President Al Gore, was invited to address the disability community in Memphis, but refused to meet with ADAPT to discuss the issues. Gore hails from the nation's First Worst state in investing tax dollars in institutionalizing persons with disabilities, young and old, rather than offering them the choice to live with needed services in their own homes. "I don't understand how Vice President Gore can sleep at night knowing about all the persons trapped and dying in Tennessee nursing homes. He hasn't lifted a finger to help us. Is he another Sundquist?" asked Dawn Russell of Memphis.

"Another influential Tennessean, Nancy Ann Min DeParle, Administrator of HCFA (Health Care Financing Administration) needs to take a strong public position in favor of H. R. 2020. She must help stop the warehousing and deaths of men, women, and children with disabilities in the nation's nursing homes and other institutions." added Bob Liston, an ADAPT organizer from Michigan.

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**201 South Cherokee Denver Colorado**



# **ADAPT**

**action news bulletin**

The current long term care system in the United States has an institutional bias. 80% of all long term care dollars are spent on nursing homes and other institutions, leaving only 20% for all home and community based options. People with disabilities old and young, and their families do not have a REAL choice when selecting long term care services.

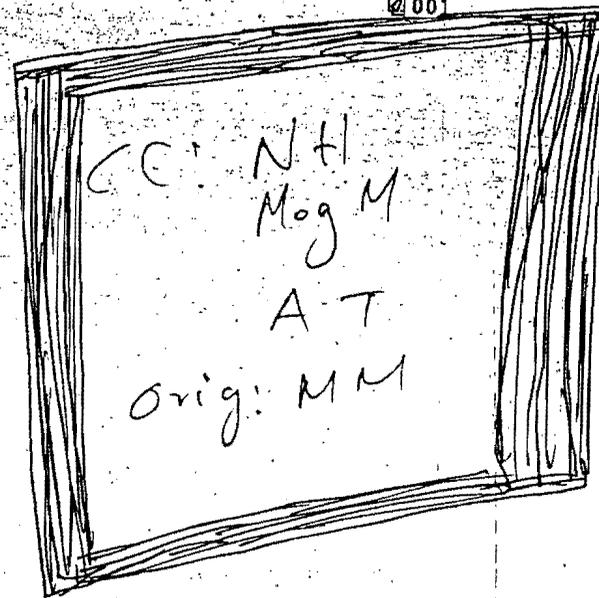
ADAPT demands that Tennessee's native son Vice-President Al Gore and the Clinton Administration do the following:

- 1) Endorse the passage of HR 2020, the Medicaid Community Attendant Services Act, MiCASA.
- 2) Meet with representatives of ADAPT by July 4, 1998 to develop a plan of action that will result in a national program of personal attendant services.
- 3) Direct Donna Shalala, Secretary of Health and Human Services to take all necessary actions by November 5, 1998 that will result in 10,000 new people with disabilities receiving personal attendant services.
- 4) Direct Tennessean Nancy Ann Min DeParle, Administrator of the Health Care Financing Administration, to use the \$2 million appropriated by Congress for its intended use, a pilot project with ADAPT on consumer controlled attendant services.
- 5) Develop with ADAPT, a written position paper on personal attendant services, making this position public on September 15, 1998 by holding a press conference with ADAPT.

**American Disabled for Attendant Programs Today**  
**We're ADAPT. We're back. Get used to it.**

THE WHITE HOUSE  
WASHINGTON

May 6, 1998



**TO:** Karl Scholz, Gillian Hunter, Janet Holtzblatt  
Jon Gruber, Phil Ellis  
Mark Iwry  
Gary Claxton  
Danny Mendelson, Mark Miller

**FROM:** Jeanne Lambrew<sup>jml</sup> and Chris Jennings

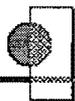
**RE: DISCUSSION OF TAX PROPOSALS**

In anticipation of a debate about tax incentives for health, we would like to have a staff-level policy discussion on Friday at 10:30am in Room 239. The goal of this meeting is to discuss specific cost estimates, coverage implications, and other pros / cons of the following proposals:

1. HR 3475: Deductibility of individual health insurance (attached)
2. Immediately phasing in the self-employed tax deductibility
- 3. Proposal for a personal assistance tax deduction / credit being considered as part of the work incentives for people with disabilities *Janet*
4. List of "ideas" (attached), particularly the incentives for small businesses
5. Any other ideas that you have heard about on the Hill.

Note: This was originally planned as a policy / political discussion with Chris and some of the legislative people, but we have changed it to be a staff discussion of policy issues to prepare for the policy / political discussion which will take place late next week. You probably don't need to attend and can send the appropriate staff to this discussion. Please call Jeanne with the names, birthdates and SS#s of staff.

Thanks.



Joanne Cianci

05/01/98 05:32:25 PM

Def - compromise -  
limits activity  
> 12 mos.  
not "unable to work"

Record Type: Record

To: Diana Fortuna/OPD/EOP  
cc: melinda d. haskins/omb/eop  
bcc:  
Subject: Re: RTW Update -- Treasury

The Treasury position will probably be something like "Do not oppose, but offer to work with the Committee to raise concerns about the proposal and to improve impairment related tax benefits for all individual." There are a couple of reasons for this. First, there are some similarities in structure to the tax credit for personal assistant services proposed in the Health Security Act. Second, in reviewing this provision, they found some problems with/ways to improve the design of the current law treatment of impairment related expenses (currently only those who itemize deductions benefit).

A position memo has been forwarded to the Deputy Assistant Secretary. Once this goes "up the chain" they will share it with us. Treasury expects to have a position by Wednesday.

This may be more information than you want now, but here are some of Treasury's concerns:

- Definition of "Qualifying Expenses" (Capital expenditures <depreciable goods> are excluded -- this is a larger issue that must be discussed in Treasury)
- Definition of "handicapped" (does not specify a length of time -- could someone who broke their leg conceivably get the credit?) - no distinction
- IRS cannot enforce (one possible mechanism would be to require additional documentation to be attached to the tax return) no doc
- The way it is designed -- subtract the credit off of the itemized deductions -- makes those with high incomes better off.
- Effective date -- January 1, 1998 may be too soon. This is in part a Y2K issue.
- Interaction of this credit with the alternative minimum tax (This is a "tax nerd" question she did not try to explain it to me).

Lowell Down Trees @TF

Def of disability -

Diana Fortuna

B-K: tax credit that expanded current law provisions  
only liked @ EITC for those previous SSI/DI  
Waltzblatt met w/ BK; & we met; scrapped  
Nora Mooney/Archer - credit for IRWE

Diana Fortuna

05/01/98 02:57:19 PM

Record Type: Record

To: Joanne Cianci/OMB/EOP@EOP  
cc: Melinda D. Haskins/OMB/EOP@EOP  
bcc:  
Subject: Re: RTW Update -- Treasury

Proposed Mon - no taxes; may resolve later in Archer tax bill  
- same def of dis + IRWE  
- but credit allows anyone w/ tax liability to benefit  
- 50% of 1st \$10k - credit  
- symmetrically

Wow -- I'm amazed they don't oppose.

Prob - limit double-dipping credit + ded - too generous  
Doc - need some; HSA had

Def of PAS -  
Treas will expand to include cap exp.

HSA - 50% of 1st \$1,500  
- phased out @ 50k; gone @ 70k  
- ded + credit  
\$537 mil 5 yrs

Elig ind - close to SSI/DI  
- unable to reg think who par  
she likes - let abt to work  
@ least 12 mos

No sap till the floor, I assume, which is usual policy, right, Melinda? But I think we should try to be ready with something to say on Wednesday, if necessary. Can they have some kind of preliminary position ready by then, do you think? Melinda, does this sound right?

Joanne Cianci



Joanne Cianci

05/01/98 12:05:46 PM

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Record Type: Record

To: Melinda D. Haskins/OMB/EOP, Diana Fortuna/OPD/EOP

cc:

Subject: RTW Update -- Treasury

As you know, the markup for the Bunning-Kennelly bill is tentatively set for May 6.

Treasury is working on a memo to be cleared through Rubin on their position on the tax credit. Treasury is not opposed to the tax credit but has some concerns about the way it is designed. They are willing to work with the committee to address these. Specifically, they would like to increase the generosity of the tax (under current tax law the allowable expenses are probably much smaller than the committee presumed) and to narrow the eligibility (stricter definition of disability). They also have some concerns related to compliance (i.e., IRS cannot and should not have to verify the disability). They have not shared any of their estimates with me yet.

Treasury would like to know our schedule for taking a position on the bill, specifically if and when we plan to issue a SAP.

*Current Law*

Also include the calculation of the reasonably estimated loss claimed.

**Ordinary loss not allowed.** You cannot choose to claim an ordinary loss if:

- 1) Any part of the deposit is federally insured,
- 2) You own at least 1% of the financial institution,
- 3) You are an officer of the financial institution, or
- 4) You are related to such an owner or officer.

*Any other?*

**Repayments of Income**

If you had to repay an amount that you included in income in an earlier year, you may be able to deduct the amount you repaid. If the amount you had to repay was ordinary income of \$3,000 or less, the deduction is subject to the 2% limit. If it is more than \$3,000, see *Repayments Under Claim of Right*, later.

**Repayments of Social Security Benefits**

If box 5 (net benefits for 1997) of all your Forms SSA-1099, *Social Security Benefit Statement*, and Forms RRB-1099, *Payments By the Railroad Retirement Board*, has a negative figure, you may be able to take a miscellaneous deduction. The miscellaneous deduction would be for the amount of the negative figure that represents an amount you included in gross income in an earlier year.

The amount in box 5 of Form SSA-1099 is the net amount of benefits paid to you for the year. It is the result of subtracting the figure in box 4 (benefits repaid to SSA in 1997) from the figure in box 3 (benefits paid in 1997). The amount in box 5 of Form RRB-1099 is the net amount of the SSEB (social security equivalent benefit) portion of tier 1 benefits paid to you in 1997. It is the result of subtracting the amount in box 4 (SSEB portion of Tier 1 repaid to RRB in 1997) from the amount in box 3 (gross SSEB portion of Tier 1 paid in 1997).

*RRBE  
all  
to SP*

*BK  
lower?  
HSA*

*BK  
cost?  
No  
41-151  
Syn??*

**CAUTION** If the deduction is more than \$3,000, you will have to use a special computation to figure your tax. Get *Publication 915, Social Security and Equivalent Railroad Retirement Benefits*, for additional information.

**Safe Deposit Box Rent**

You can deduct safe deposit box rent if you use the box to store taxable income-producing stocks, bonds, or investment-related papers and documents. You cannot deduct the rent if you use the box only for jewelry or other personal items or for tax-exempt securities.

**Service Charges on Dividend Reinvestment Plans**

You can deduct service charges you pay as a subscriber in a dividend reinvestment plan. These service charges include payments for:

- 1) Holding shares acquired through a plan,
- 2) Collecting and reinvesting cash dividends, and

- 3) Keeping individual records and providing detailed statements of accounts.

**Tax Preparation Fees**

You can usually deduct tax preparation fees in the year you pay them. Thus, on your 1997 return, you can deduct fees paid in 1997 for preparing your 1996 return. These fees include the cost of tax preparation software programs and tax publications. It also includes any fee you paid for electronic filing of your return.

Deduct expenses of preparing tax schedules relating to profit or loss from business (Schedule C or C-EZ), rentals or royalties (Schedule E), or farm income and expenses (Schedule F) on the appropriate schedule. Deduct expenses of preparing the remainder of the return on line 21, Schedule A (Form 1040).

**Trustee's Administrative Fees for IRA**

Trustee's administrative fees that are billed separately and paid by you in connection with your IRA are deductible. They are deductible (if they are ordinary and necessary) as a miscellaneous deduction on Schedule A (Form 1040). See *Publication 590, Individual Retirement Arrangements (IRAs)* for more information.

**Deductions Not Subject to the 2% Limit**

You can deduct the following expenses as miscellaneous itemized deductions. They are not subject to the 2% limit. Report these expenses on line 27, Schedule A (Form 1040).

**List of Deductions**

- Amortizable premium on taxable bonds
- Federal estate tax on income in respect of a decedent
- Gambling losses up to the amount of gambling winnings
- Impairment-related work expenses of persons with disabilities
- Repayments under a claim of right if more than \$3,000
- Unrecovered investment in a pension

*Must be itemized  
Must be ordinary + nec.  
Expenses you depreciate - no  
but exp if you bought  
Must be place of work  
(car)*

**Amortizable Premium on Taxable Bonds**

A premium is the amount you pay for a bond that is more than the face value of the bond. You can choose to amortize the premium on taxable bonds.

**Bond purchased before October 23, 1986.** The amortization of the premium is a miscellaneous itemized deduction not subject to the 2% limit.

**Bond acquired after October 22, 1986, and before January 1, 1988.** The amortization of the premium is investment interest expense subject to the investment

interest limit, unless you choose to treat it as an offset to interest income on the bond.

**Bond acquired after December 31, 1987.** The amortization of the premium is an offset to interest income on the bond rather than a separate interest deduction item.

**More information.** See *Bond Premium Amortization* in chapter 3 of Publication 550.

### Federal Estate Tax on Income In Respect of a Decedent

You can deduct the federal estate tax attributable to income in respect of a decedent that you as a beneficiary include in your gross income. Income in respect of the decedent is gross income that the decedent would have received had death not occurred and that was not properly includible in the decedent's final income tax return. Get Publication 559, *Survivors, Executors, and Administrators*, for information about figuring the amount of this deduction.

### Gambling Losses Up to the Amount of Gambling Winnings

You must report the full amount of your gambling winnings on line 21, Form 1040. You deduct your gambling losses on line 27, Schedule A (Form 1040). You cannot deduct gambling losses that are more than your winnings.



*You cannot reduce your gambling winnings by your gambling losses and report the difference. You must report the full amount of your winnings as income and claim your losses (up to the amount of winnings) as an itemized deduction. Therefore, your records should show your winnings separately from your losses. Only gambling losses incurred during the year can be deducted on Schedule A (Form 1040).*

**Diary of winnings and losses.** You must keep an accurate diary or similar record of your losses and winnings. Your diary should contain at least the following information:

- 1) The date and type of your specific wager or wagering activity,
- 2) The name and address or location of the gambling establishment,
- 3) The names of other persons present with you at the gambling establishment, and
- 4) The amount(s) you won or lost.

**Proof of winnings and losses.** In addition to your diary, you should also have other documentation. You can generally prove your winnings and losses through Form W-2G, *Certain Gambling Winnings*, Form 5754, *Statement by Person(s) Receiving Gambling Winnings*, wagering tickets, canceled checks, credit records, bank withdrawals, and statements of actual winnings or payment slips provided to you by the gambling establishment.

For specific wagering transactions, you can use the following items to support your winnings and losses:

**Keno:** Copies of the keno tickets you purchased that were validated by the gambling establishment, copies of your casino credit records, and copies of your casino check cashing records.

**Slot machines:** A record of the machine number and all winnings by date and time the machine was played.

**Table games** (twenty-one (blackjack), craps, poker, baccarat, roulette, wheel of fortune, etc.): The number of the table at which you were playing. Casino credit card data indicating whether the credit was issued in the pit or at the cashier's cage.

**Bingo:** A record of the number of games played, cost of tickets purchased and amounts collected on winning tickets. Supplemental records include any receipts from the casino, parlor, etc.

**Racing** (horse, harness, dog, etc.): A record of the races, amounts of wagers, amounts collected on winning tickets and amounts lost on losing tickets. Supplemental records include unredeemed tickets and payment records from the racetrack.

**Lotteries:** A record of ticket purchases, dates, winnings and losses. Supplemental records include unredeemed tickets, payment slips and winnings statements.



*These recordkeeping suggestions are intended as general guidelines to help you establish your winnings and losses. They are not all inclusive. Your tax liability depends on your particular facts and circumstances.*

### Impairment-Related Work Expenses

If you have a physical or mental disability that limits your being employed, or substantially limits one or more of your major life activities, such as performing manual tasks, walking, speaking, breathing, learning, and working, you can deduct your impairment-related work expenses.

Impairment-related work expenses are ordinary and necessary business expenses for attendant care services at your place of work and other expenses in connection with your place of work that are necessary for you to be able to work.

**Where to report.** If you are an employee, you enter impairment-related work expenses on Form 2106 or 2106-EZ. From the amount on line 10 of Form 2106, or line 6 of Form 2106-EZ, you enter the amount that is related to your impairment on line 27, Schedule A (Form 1040). Enter the amount that is unrelated to your impairment on line 20, Schedule A (Form 1040).

### Repayments Under Claim of Right

If you had to repay more than \$3,000 that you included in your income in an earlier year because at the time you thought you had an unrestricted right to it, you may be able to deduct the amount you repaid, or take a

**OFFICE OF MANAGEMENT AND BUDGET****Legislative Reference Division  
Labor-Welfare-Personnel Branch****Telecopier Transmittal Sheet****URGENT****FROM: Melinda Haskins****395-3923****DATE:** 5/5/98**TIME:** 4:15 pm.**Pages sent (including transmittal sheet):** 2**COMMENTS:**

Here is the revised <sup>HHS</sup> cost estimate  
for the Medicare-related portions of HR 3433.

**TO:** Diane Fortuna**PLEASE CALL THE PERSON(S) NAMED ABOVE FOR IMMEDIATE PICK-UP.**

395 6148

From: Clare McFarland  
To: Washington.DC1.EJohnson4, Washington.DC1.CProvost,...  
Date: 5/5/98 2:23pm  
Subject: Updated Numbers for Bunning Bill

These are my updated numbers for the Bunning Bill. The following assumptions were made:

The bill would extend premium-free HI for 2 years after the end of the EPE and would allow Part B coverage after paying the Part B premium.

The Part B numbers are NET of premium income.

FY (in millions)	HI	SMI
99	0	0
00	10	10
01	10	10
02	10	10
03	10	10

CC: SMussey



For Chris Jennings, Jeanne Lambrew & Diana Fortune from  
Bob Williams. The CASA testimony before it was cut due to time  
constraints. Background info for meeting w/ NCIL + CCD on Fri. May 15.

## INTRODUCTION

We are pleased to be here today to talk about the President's commitment to expanding and promoting consumer-directed home and community-based services so people with disabilities can live their lives to the fullest potential. It is consistent with our views about the basic rights of all Americans to control and direct their own lives. It is consistent with our strong and rigorous support for equal rights for people with disabilities, as articulated in the Americans with Disabilities Act.

Like everyone here today, the Administration feels strongly about empowering people with disabilities -- including children, working age adults, and older people who need help with basic daily activities -- and their families, by increasing their independence and quality of life. One of the best ways to do this is to provide opportunities for individuals to choose to decrease their reliance on nursing homes, by increasing their options to choose self-directed personal assistance in home and community-based settings.

We will use our time today to discuss our multi-faceted approach to achieving these goals, recognizing that while we won't achieve our goals all at once, we can be aggressive about making real progress toward them. We would like to explain the Administration's commitment to this issue and the activities currently taking place with an HHS work group on home and community-based services. And we would like to discuss our broader strategy, which includes legislative, regulatory, research/demonstration, and other activities.

## THE ADMINISTRATION'S COMMITMENT

In May of 1995, after a series of meetings with individuals from the disability community, Secretary Shalala issued a set of principles supporting home and community-based care. She reaffirmed her support for emphasizing home and community-based care services and offering consumers the maximum amount of choice, control and flexibility in how these services are organized and delivered. Since that time, HCFA has increased its technical assistance to States to assist them in developing home and community-based waiver programs and other options to foster care in the community. We continue to be guided by these principles.

This past September, the President and Vice President met with a group of disability community representatives and Federal officials, including Bruce Vladeck, then Administrator of HCFA and Bob Williams, Deputy Assistant Secretary for Planning and Evaluation, to discuss how to move forward on the community's highest priorities. The President has a longstanding interest in addressing the challenges facing people with disabilities who need long term care services and this Administration has a continuing commitment to increase the availability of home and community based personal assistance services. At that meeting, the President expressed appreciation that the Community Attendant Services Act (CASA) bill had been introduced by the Speaker, noting that it will help focus attention on the expansion of home and community based care. He was particularly pleased that it would enable us to have a discussion about how to move more toward a system where "the money can follow the person," no matter in what setting he or she chooses to receive the

services needed. Finally, he noted that a lot of the activity and decision-making regarding home and community-based care and personal assistance services (PAS) is happening in the States. He stressed the importance of enlisting the help of those States that are moving in the right direction, to provide leadership in educating and helping others who are not so far along.

## **HHS WORK GROUP**

As a result of the meeting with the President, and in an effort to pull together all our activities in this area, Bob Williams, HHS's Deputy Assistant Secretary for Disability, Aging, and Long-Term Care Policy, and Sally Richardson were asked to co-chair a work group on home and community based services. The goals of that work group, which began meeting in September, are to review all available information and make recommendations about how to reduce the institutional bias in Medicaid long-term care services and spending and promote home and community-based care. Specifically, we are working to:

- Identify and address the "institutional bias" in the Medicaid program -- so fewer people are forced to move into nursing homes because it is the only way they can get long term care services;
- Provide more program opportunities for consumers and their families to choose the setting in which long term care services are received, with increased flexibility for the "money to follow the person," as opposed to the payment determining the setting in which a person receives services; and,
- Promote consumer direction of home and community based/personal assistance services.

Our work group members include HHS and other Administration officials interested in the issue, as well as an expanded group of "constituency partners" -- representatives of consumer groups, providers, and State agencies -- with whom we consult to ensure that the work group's activities and products take a variety of perspectives into account. The work group is moving ahead on a number of fronts.

### ***Overcoming Institutional Bias***

We are exploring a range of demonstration strategies, including opportunities we can offer States to modify their Medicaid programs and try some new ways of helping people who want to and are able to live in the community. We are happy to announce that we will soon be asking States to submit proposals to begin to develop a research design to identify individuals who could successfully move out of nursing homes into the community and to develop the services that would be needed to support these individuals in the community. This solicitation is in response to the commitment made by President Clinton to this issue and the Congressional directive in the FY 1998 Labor/HHS Appropriations Bill. We believe that we will be able to fund research in 3 to 5 States.

Another component of this work involves using HCFA data to improve our understanding of the numbers and characteristics of nursing home residents who may be good candidates for moving back to the community and what they would need in the way of supports. We will then be better able to help the States design strategies that succeed when these individuals attempt to move into the community.

We are also developing strategies to address the President's charge that States should learn from each other how to support and promote home and community based services under 1915(c) Medicaid waivers. Some States are much further along than others in developing innovative and cost-effective service delivery models for home and community-based services. Staff have been talking to a wide range of experts in the aging, disability, and long-term care fields in order to hear what they have learned. We have gotten positive feedback from a growing number of States about the value of developing a "State to State" technical assistance strategy.

We learned from our constituency partners that some States are not fully aware of the flexibility available to them under current regulations. Therefore, we want to clarify some of the things that States can do right now to reduce the institutional bias. We are planning to produce a primer on Medicaid that explains to State officials and consumers what is already available under Medicaid's personal care option, home and community-based waivers, as well as other Medicaid services. This primer will be clearly stated, so readers can understand what is allowable within the existing framework of Medicaid. The primer will also include some examples of States that have used the flexibility of Medicaid to do some excellent work in reducing nursing home use and increasing community supports.

Finally, last year's CASA bill required a study of the "institutional bias" in the Medicaid program. HHS commissioned an independent contractor -- the University of California at San Francisco -- to conduct such a study. A few weeks ago we received the contractor's draft report. Let me note that this report has already been reviewed by a Blue Ribbon Panel on Personal Assistance Services that includes many consumers with disabilities and other Medicaid and personal assistance services experts.

The report reviews the Medicaid statute and regulations, as well as policy guidance from HCFA, and offers a series of policy options to address the "institutional bias" in Medicaid. The majority of the recommendations would involve statutory changes and many of these changes would involve significant new costs. We are now developing a list of potential regulatory and policy changes on which we can take some more immediate action, while we continue to review long-term legislative options.

## **ADVISORY COMMISSION'S CONSUMER BILL OF RIGHTS**

We understand that a high priority for individuals with disabilities is to ensure that consumer protections are in place that assure access to specialists, continuity of care, and internal and external appeal rights when health plans make decisions that are disputed by its enrollees.

As you know, the President endorsed the Consumer Bill of Rights and Responsibilities, recommended by his Advisory Commission on Consumer Protection and Quality in the Health Care Industry, and challenged Congress to make these important rights apply to consumers of all health plans. The Bill of Rights included important protections such as access to specialists for individuals with chronic care needs, for example: (1) traditional care for consumers who are undergoing a course of treatment for a chronic or disabling condition (or who are in the second or third trimester of pregnancy) at the time they involuntarily change health plans or at a time when a provider is terminated by a plan, and (2) a fair and efficient internal and external appeals process for resolving differences with their health plans and health care providers.

On February 20th, the President directed HHS, as well as other Executive Branch agencies, to bring their programs into compliance with the Consumer Bill of Rights. This Department reviewed the Medicare and Medicaid programs for compliance with the Consumer Bill of Rights. Based on our review, the President praised the Department for how far along these two programs were in complying with the Consumer Bill of Rights and he directed us to bring the two programs into virtual compliance as quickly as possible. The President is extremely committed to making the Consumer Bill of Rights real for all Americans.

#### **EXPANDED SETTINGS & ELIGIBILITY FOR RECEIVING SERVICES (LEGISLATION)**

On the legislative front, we were pleased that Congress included in the BBA our proposal for a new State option to allow certain workers with disabilities the ability to purchase Medicaid. Losing health coverage can devastate anyone. Losing health care and personal assistance services is even more devastating for some people with disabilities -- to the point where they are afraid to even try to work, because if they lose SSI or SSDI eligibility, and thus health care, they lose their life line. The new BBA provision should enable many individuals to make a real transition to work. Two days ago, we mailed to State Medicaid Directors a letter that revised the definition of income for the purpose of calculating the eligibility standard under this provision. Under our revised definition, States will determine eligibility based on income net of income disregards.

Also included in the BBA was our proposal to allow States to include prevocational, supported employment, and educational services for all home and community-based services waiver recipients with developmental disabilities. Before this provision was enacted, only those who were formerly institutionalized could receive these services through a home and community-based services waiver.

Finally, the BBA establishes a new type of service provider called Program of All-Inclusive Care For the Elderly (PACE). States may elect to provide PACE program services to individuals who are

Medicare and Medicaid eligible and are enrolled in a PACE program agreement. PACE provides for a coordinated set of services to frail elderly individuals living in the community.

**EXPANDING SETTINGS & ELIGIBILITY FOR RECEIVING SERVICES  
(REGULATION & POLICY)**

On the regulatory and policy fronts, this Administration has been very supportive of expansions in home and community based services under the Medicaid 1915(c) waivers. All States are now operating at least one and sometimes several home and community based waivers. Many provide additional supports with other Medicaid services as well. Thirteen States provide attendant care under their home and community-based waiver programs, while thirty-nine States provide personal care under their home and community-based waiver programs. The waiver program has flourished and grown under President Clinton's leadership, and currently there are 226 approved home and community-based waiver programs. We expect the program to continue to expand at an even greater pace as we work with States to find new ways to promote the use of existing services in States that have not provided them yet. In July of 1997, the State Medicaid Directors a letter that promoted the use of Medicaid home and community-based waivers.

We also recently issued revised regulations to increase the responsiveness of the Medicaid personal care option to better meet the needs of people with disabilities. There are currently 31 States providing personal services under their State plans. Individuals are now permitted to receive services both in the home, and outside the home. The new regulation eliminates the requirement that a registered nurse must supervise personal care services, thus reducing cost and making the service more consumer responsive and less "medicalized."

***Consumer-Directed Purchasing***

Our home and community based care and PAS research agenda is a key part of efforts to help ourselves, and help States and consumers, to find out what works, for whom, how well, and at what cost.

We are promoting our home and community based services agenda by working with States to develop and implement Medicaid demonstrations under the 1115 authority of the Social Security Act. Some focus on the integration of acute and long term care, such as the projects underway in Minnesota and the District of Columbia. Others, such as the newly-approved Colorado home health demonstration address different aspects. Colorado's demonstration will permit home health services to be provided in settings other than the home, such as schools, work sites, or day treatment centers. Wisconsin and Rhode Island have applied for 1115 waivers to serve beneficiaries under age 65 with physical disabilities and adults with developmental disabilities respectively. Four States working with the Robert Wood Johnson Foundation have applied for 1115 waivers to offer consumers cash allowances and counseling to purchase their own attendant services. We are currently reviewing

these waivers and expect to complete our review shortly. We are very interested in finding new ways of doing business in Medicaid and encourage States to bring us their ideas and proposals.

## CONCLUSION

We believe it is critically important to continue to develop models both at the State and Federal level that support and encourage the move from reliance on institutional care to a broader array of consumer-directed home and community-based services.

We embrace these goals and will continue to work toward them. The challenge, of course, is to balance our goal of providing more flexibility and choice for people with disabilities, with the need to ensure that any legislation is affordable. Preliminary cost estimates raise the very real questions about whether the balance has yet been achieved. However, we remain committed to working together with you and other interested parties to craft an affordable, consumer-responsive system, that takes advantage of and promotes flexibility in our current programs, to help people obtain and keep the help they need to live as independently as possible.

In conclusion, we would like for all of us to remember that people with disabilities are a very diverse group of individuals. They are children, working-age adults, and the elderly. They have developmental disabilities, emotional or cognitive disabilities, and physical disabilities. This is not a group of people for which a "one solution fits all" answer is appropriate. These individuals need more opportunities, more choices on where and how they are to receive services. Nursing homes, intermediate care facilities for the mentally retarded should be available, but home and community based services must also be available. We cannot afford to have any bias in service delivery.

**DRAFT Outline for the Administrator's Talking Points**

**INTRODUCTION**

- As Secretary Shalala said, access to health care and long term care can be crucial to job access for persons with disabilities. At HCFA we are mindful of the critical role that our programs, Medicare and Medicaid, can play in providing this essential link for persons with disabilities.
- HCFA has been pursuing a number of activities aimed generally at increasing consumer choice, independence and quality of life for all persons with disability. I will focus my discussion today on those that we see as being of most benefit to disabled individuals who want to work.
- Our work has encompassed legislative, regulatory, research/demonstration, and other activities.

**LEGISLATIVE - BBA**

- On the legislative front, HCFA has been working with the States to implement the new provision in the Balanced Budget Act that gives States new authority to allow working individuals with disabilities with incomes up to 250% of the federal poverty level to buy into Medicaid.
- We've interpreted the income threshold based on net family income. This means that an individual with an income of \$40,000 can qualify to buy into the full array of Medicaid services.
- We believe the new BBA working disabled provision will provide an even greater opportunity for workers with disabilities to maintain health coverage by expanding and simplifying States' abilities to allow individuals with disabilities to return to work and maintain their Medicaid coverage.
- As the Secretary has promised, HCFA and the Department of Health and Human Services will do everything they can to encourage States to adopt this optional provision because it is so important to achieving our goal of helping people who want work and can work, to work, by providing that critical link to affordable health care.
- We will immediately engage the States about this matter by meeting with State Medicaid Directors and by writing to the Governors. We will facilitate the sharing of best practices

in this area among States.

## **REGULATORY -**

- We know that the availability of Personal Care Services is also a critical element in enabling a person to work. Personal Care Services are an optional service under Medicaid. At last count, 31 States do offer this optional service.
- This past September the Department published a regulation on personal care services under Medicaid to provide more flexibility to States to encourage the expansion of this option.
- This final rule gives States the option to expand the availability of personal care services by allowing services to be provided outside the home. In addition, the regulation removed the requirement that registered nurses supervise the provision of personal care services.
- Other States provide personal care services through Home and Community Based Services Waivers -- which I'll discuss in a minute.
- As a result, almost all States provide personal care services under their Medicaid programs and these services can now go outside the home -- including into employment settings.

## **RESEARCH/DEMONSTRATIONS**

- One of the crucial tasks currently before HCFA and the Department is to determine why the existing tools we have to encourage individuals to go back to work are not being used.
- We need much better information on what motivates individuals to return to work, as well as what services these individuals need in order to stay working.
- Our research and demonstration agenda in this area will provide us with more data and information to help us better understand the health care needs of and obstacles faced by working individuals with disabilities.
- Specifically, let me mention 4 demonstrations whose results and evaluations will help us plan future activities:
  1. **cash & counseling**
    - + this demonstration will test the concept of providing cash to individuals and allowing them to choose and purchase the personal assistance services they need.
    - + information and counseling will be provided to assist consumers to make

informed choices

- + FL, NY, NJ, AK are the States that will be testing this concept

2. **"date certain"**

- + HCFA is sponsoring a grants program to assist States to develop mechanisms to work with individuals and their families prior to admission to an institution to consider community-based alternatives and/or mechanisms to transition individuals currently in institutions to the community if that is their choice.
- + the objective of this program is to identify and remedy barriers to community-based care.
- + community based alternatives can include services which will assist individuals to return to work (e.g., prevocational and supported employment services)
- + we expect to issue the grant solicitation before summer and to award grants to 3-5 States in September

3. **Consumer-Directed DME Purchasing -- Medicare**

- + In Medicare, we will be releasing a Program Announcement for a demonstration of consumer-directed choice and purchase of durable medical equipment, such as wheelchairs.
- + Having the right equipment can facilitate a person's ability to perform activities of daily living, including work.
- + Centers for Independent Living (CIL) will be partners in the demonstration.
- + We expect to award developmental funds to four CILs this fall.

4. **Dual Eligibles Demonstrations**

- + This past month, HCFA awarded 4 grants to 3 States to help improve care for low income Medicare beneficiaries who are also eligible for Medicaid.
- + Projects are being funded in Florida, Wisconsin and Maryland to address the needs of these "dually eligible" beneficiaries.
- + These grants will help us learn how to better coordinate care between Medicare and Medicaid, help disabled beneficiaries move from nursing homes into the community, and target needs of people likely to become dually eligible as they use up their own assets on medical care.

- Also, as the Secretary mentioned, we are providing technical assistance to States, like Wisconsin, that are interested in exploring options and developing concepts around the goal of employing persons with disabilities. We are seeing a growing interest in this area.

**OTHER ACTIVITIES**

### Home and Community-Based Waivers

- The Medicaid program has evolved to better meet the needs of the disabled population, particularly with respect to the provision of home and community based services.
- States are taking advantage of the home and community based waivers under Medicaid -- 1915(c) waivers -- to explore innovative approaches to delivering long term care in community or home settings.
- Some time ago, we made it easier for States to obtain these waivers by eliminating the long-standing "cold bed" rule. This had been a test of whether the state maintained sufficient bed capacity in its institutions to serve those who would be on the waiver in case the waiver failed.
- In 1995, Secretary Shalala issued a set of principles supporting home and community-based care. She reaffirmed her support for emphasizing home and community-based care services and offering consumers the maximum amount of choice, control and flexibility in how these services are organized and delivered.
- Since that time HCFA has actively promoted these waivers, increased its technical assistance to States and developed streamlined waiver applications to facilitate States' efforts to provide more home and community-based care in lieu of institutionalization.
- We have seen a substantial growth in the number of waivers requested and approved. We now have 226 approved and many States have multiple waivers. Thirteen states provide attendant care in their waiver; 39 states provide personal care services in their waiver; and 21 states provide pre-vocational and supported employment services to enable persons to enter the workforce.
- Keeping people out of institutions is certainly a step along the route to better serving those individuals who want to be employed. These waivers are an important tool in our arsenal.

### Home and Community Based Services Workgroup

- Before closing, I'd like to mention one other activity that is underway and will help inform the future debate about what activities we need to undertake to move us further down this road. I'm referring to the Home and Community-Based Services Workgroup.
- This past Fall, the President met with Representatives from ADAPT to discuss increasing access to home and community based services, including personal care services under Medicaid.
- Secretary Shalala established a workgroup in response to the President's meeting with

ADAPT to address specific issues regarding home and community based services.

- This workgroup is chaired by Bob Williams from ASPE and Sally Richardson, Director of HCFA's Center for Medicaid and State Operations. I'd like to ask Sally to stand so that all of you can see her. I must tell you that it is she, not I, that is owed the credit for much of the activity that has taken place, and is taking place, in HCFA with regard to the subject we're discussing today. Thank you Sally.
- The purpose of the Department workgroup is to consider all available information and make recommendations about how to reduce the institutional bias and promote home and community-based services under the Medicaid program.
- In addition to HHS offices and agencies, other Federal agencies and our constituency partners, including advocacy organizations, are involved in providing input on various issues addressed by the workgroup.
- The Department contracted with the University of California at San Francisco to study "institutional bias" in the Medicaid program. A final report is due by May 1 following review by an Advisory Group comprised of persons with disabilities, as well as, other disability experts. As we review the recommendations of the contractor, I'm sure we will be able to incorporate many of them into our future planning efforts.
- As I mentioned, we will soon release a solicitation seeking State proposals to test the "date certain" concept of moving persons from institutions to the community. The work on that proposal has emanated from this workgroup.
- We also are currently planning to contract for development of a "primer" on Medicaid for individuals with disabilities, detailing what States can do under current law and provide examples to help States better use the options they currently have available to them.
- In summary, I would say that we have been and will continue trying to facilitate States' leadership in expanding home and community-based supports and consumer-directed personal assistance services.
- In closing, I think you can see that we have a multi-faceted approach to achieving our goals. While we recognize that we won't achieve our goals all at once, we can be aggressive about making real progress toward them.

## Draft Talking Points for Peggy Hamburg's April 22 Presentation to the Presidential Task Force on Employment of Adults with Disabilities

- ◆ I am Margaret Hamburg, Assistant Secretary for Planning and Evaluation in HHS.
  - I am honored to appear here today, as you undertake the important challenge of increasing work opportunities for people with disabilities.
  - My office provides analysis and advice to Secretary Shalala on the policy challenges facing the Department of Health and Human Services. Bob Williams, my Deputy Assistant Secretary for Disability, Aging, and Long-Term Care has helped me keep our disability research and policy work moving steadily forward, and focused on the important issues of the day.
  - We know this Task Force will address health and long-term care supports for people with disabilities who want to work. Without access to this coverage, many people with disabilities would be unable to live in the community at all, much less participate in the work force. We hope our presentations on this panel can help inform this effort.
  - In fact, as Secretary Shalala told us earlier, the fear of losing health coverage is a great concern to many people with disabilities who want to work. As most of you here know all too well, giving up SSI and SSDI benefits to go to work can also mean losing health coverage.
- ◆ The work of this task force is important to HHS.
  - We know that people with disabilities want to work -- they tell us so in survey after survey;

- Yet, over 70% of people with disabilities are not even in the work force at all, and this is simply unacceptable;
  - I know that few people with disabilities use the work incentives now available, and even fewer are actually able to leave the rolls and go to work each year -- my colleagues at SSA tell me that fewer than 8500 of the over 4.4 million people on SSDI and only about 300 of the 3.3 million on SSI leave the rolls each year; and
  - Also, I understand that there is concern that too many young people with severe disabilities leave school and go directly onto the SSI rolls because they think there is no way they will ever be able to do real work.
- ◆ I will use the analytical and policy strength of my office to shed light on these problems and help craft solutions.
  - ◆ This morning I will briefly summarize a few key issues about people with disabilities that I think are particularly relevant to your deliberations.
  - ◆ Let's start by taking a look at what current research tells us about working age adults with disabilities -- by functional status, employment rates, and some health issues like insurance coverage and health care utilization.

### **Disability Characteristics**

- ◆ **[Show slide #1]** First, I want to show you the prevalence of disability in the population. As you can see, one in five working age adults, 30 million Americans between the ages of 18 and 65, have a disability.
  - A relatively small proportion of the working age population, 4 percent, or 6 million, are disabled enough to meet the disability

eligibility requirements of the SSA income support programs SSI and SSDI. It is this group that experiences the highest rate of unemployment, and it is these individuals who face some of the most significant challenges as they seek the health and long-term care coverage they need while they engage in meaningful work.

- ◆ **[Show slide #2]** This next slide shows functional characteristics of working age people with disabilities. The great majority of such individuals -- 77% or over 23 million people -- have disabilities such as mental retardation, mental illness or musculo-skeletal problems, but are still able to carry out basic activities.
  - About 23% or 4.5 million people have moderate limitations -- and need assistance with one or two routine activities of daily life like bathing, dressing -- or shopping or preparing meals.
  - About 2.3 million need help with at least three of these activities. People in this group are most likely to need long-term supports, such as personal assistance services.

### **Employment Status**

- ◆ **[Slide #3]** The next slide examines the employment rates of people with and without disabilities. Clearly, the more disabled a person is, the less chance he or she is working. Almost 80% of Americans without disabilities are employed. As you can see, the employment rate decreases, as the severity of the disability goes up. Only 18% of those with significant disabilities are in the work force.

### **Education**

- ◆ The last slide showed that employment rates go down as the level of disability goes up. What explains this? The next slide examines the role that education might play. After all this is a significant predictor

for the non-disabled population.

- ◆ **[Slide #4]** I think this slide shows an important point— even when people with disabilities have comparable levels of education to people without disabilities, they are markedly less likely to be employed. This is so at every educational level. What is very troubling is that less than half of people with significant disabilities who have a college education are employed.
- ◆ **[Slide #5]** In the next slide, we see that people with disabilities who work tend to earn substantially less than their non-disabled counterparts. People with significant disabilities are the lowest earners of all.

## Health Care

- ◆ Next I would like to share with you some statistics on health care and people with disabilities and how they compare to people without disabilities.
- ◆ **[Slide #6]** In this slide we see that people with disabilities have more hospital stays than the non-disabled. Fewer than 4% of working age adults had one or more hospital stay in 1994. For those with functional disabilities, a quarter of them had at least one hospital stay.
- ◆ **[Slide #7]** In the next slide, we also see that people with disabilities visit the doctor three times more, on average, than those without disabilities. People with significant disabilities had 85% more doctor visits than those without disabilities.
- ◆ **[Slide #8]** Not unexpectedly, people with disabilities have higher health care expenditures than the non-disabled.

## Health Insurance

- ◆ [Slide #9] In the last slide, we see another important fact that bears upon your deliberations.
  - People with disabilities who are employed rely primarily on private insurance. For people who are not employed, Medicaid and Medicare provide the safety net, that for many can mean the difference between life and death.

## Putting it All Together

- ◆ In summary the data tell an important story:
  - The employment rate for working age adults with disabilities is extremely low. Those who work earn much less than non-disabled people.
  - Health care use and costs for people with disabilities are much higher than for those without disabilities.
  - People with significant disabilities are the least likely to work and the most likely to have high health care costs.
  - People with disabilities who are employed rely heavily on private health insurance.
  - People with disabilities who are not in the labor force rely heavily on public insurance.
- ◆ Further, we know that:
  - People with disabilities say they are afraid to leave the SSA rolls and risk losing health benefits.

- Despite the fact that there are work incentives that specifically permit people on SSI or SSDI to go to work but still keep Medicaid or Medicare within certain limits; but participation in these programs is very low.

### **More Research is Needed**

- ◆ Our information raises a number of important questions that need to be addressed:
  - Why are some people with disabilities able to go to work without ever entering the Social Security disability system? Is it something about the individuals, the service systems, or both?
  - Why is participation in our work incentive programs so woefully low? Is it a function of lack of outreach? What are the characteristics of people who use them successfully and those who do not?
  - What role does access to a secure source of health care play in the decision to work?
  - Who among the population with disabilities need PAS and what role do these services play in the decision to work?
  - What more can be done to link service systems that address the education, training, employment and health care systems, with the ultimate aim of getting more people into good jobs earning a living wage?

### **Current ASPE Research to Address these Questions**

- ◆ I'm pleased to report that my office has a solid research agenda underway to address some of these questions.

- ◆ First, our **employment studies**. We started a few years ago with a study to review the evidence that supports the proposition that people do not seek work because they fear losing health coverage. While there are few empirical studies to date, they do suggest that health care access is an important factor in the decision to seek work.
  - In a follow up study last year, we looked at participants in the SSI 1619 work incentive program -- which allows people to keep Medicaid when they go to work, if they earn below about \$20,000 per year.
  - You won't be surprised by the preliminary findings: there is a group of 1619 participants who deliberately restrain their earnings so they can keep Medicaid.
  - The same researchers at the Lewin Group are looking at labor force participation and earnings levels of people with disabilities before and after substantial Medicaid expansions in the "natural laboratories" of Tennessee and Oregon.
  
- ◆ Also, we must understand the impact of welfare reform on the nearly 40% of former AFDC recipients reporting a disability. We want states to be able to help many of these "hard to serve" people get into and stay in the work force.
  - Bob Williams co-chairs an Interdepartmental Work Group on Welfare Reform and Disability. That group is pulling together the research -- past, present, and future -- to help understand the characteristics and needs of this special population.
  - ASPE is also supporting two important studies in this area. First, we are surveying states to see how they treat people with disabilities under TANF. We are particularly concerned about

the extent to which states are enabling people with disabilities to enter the work force with appropriate supports. We will have a report by the end of the year.

- We are also adding a disability component to a major study of the impact of welfare reform on poor families with children. Through a comprehensive family survey, as well as intensive longitudinal case studies, we will examine how people with disabilities and their families are doing as a result of welfare reform.

### **Planned Research**

- ◆ I believe we have a good research program underway to get some answers, but we still have a long way to go.
- ◆ As the Secretary said, we are beginning new studies that will move us much closer to the critical answers we need.
  - First, we are planning to study why some people with severe disabilities are able to work while others are not. What are the characteristics of those who work and the systems that serve them, versus those who do not?
  - Second, the Disability Survey is a rich source of information on work. The latest data will be ready for analysis in the next few months and we will use it to better understand earnings, barriers, accommodations and health care spending and utilization.
  - I know that the Executive Order clearly states that we need good data to address the challenges we face. We are eager to work with you to achieve that goal. The Disability Survey, the first ever comprehensive survey of Americans with disabilities, is a good start. I'm proud of the role my

office has played in developing it.

- And finally, we must get a better understanding of why so few people use the available work incentive programs to leave the rolls and go to work. We will study state and local success stories and identify key factors responsible for their success, and we will talk to consumers who use the programs.

### **Conclusion**

- ◆ Thank you for this opportunity to share our findings and activities. I welcome your feedback on our ambitious research agenda. I look forward to combining efforts with you in the coming months and years, as we seek ways to offer people with disabilities the same opportunities afforded those without disabilities to be independent, productive Americans.

K-J - from K-J

## Synopsis of the Work Incentives Improvement Act of 1998

- This week we will introduce the Work Incentives Improvement Act of 1998. This bill is intended to reform and improve the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) work incentives to assist persons with disabilities to overcome the barriers to work.
- Current policies to encourage and support the dream of persons with disabilities to work and live independently need substantial reform. Many of these fellow citizens want to work, but less than 1/2 of 1% of the beneficiaries leave the Social Security rolls and become self-sufficient.
- Their attempts to work are undermined by the inability to obtain affordable health care and the loss of cash assistance. Such assistance is critical to living independently and an inability to obtain it makes them highly unlikely to become or remain self-sufficient.
- Today, 7.5 million disabled Americans depend on assistance from Social Security. The cost to the taxpayer is \$73 billion annually and will continue to increase at 6 percent a year. Social Security disability payments are the fourth largest entitlement expenditure by the federal government.
- If 75,000 of the 7.5 million Americans with disabilities, just one percent, become successfully employed, savings in cash assistance would total \$3.5 billion over the work life of the individual.
- The Work Incentives Improvement Act:
  - provides continued Medicare coverage, and a reasonable premium rate for SSDI beneficiaries who go to work;
  - strengthens current State Medicaid Waiver projects that provide health services and supports to persons with disabilities who want to work; and
  - offers a new option to states to use Medicaid to cover personal assistance services and prescription drugs for persons with disabilities who need these services in order to work.
- This legislation supports the development of demonstration projects which will gradually phase out the loss of cash benefits as a worker's income rises, instead of the current cash cut-off that so many disabled persons who return to work face today.
- Finally, this legislation will also enable Congress to obtain the kind of information it needs to undertake more comprehensive reform of disability work incentive programs.
- Work is a central part of the American dream, and Congress has an opportunity to provide cost-effective assistance to help disabled Americans pursue a career.

**Summary  
of the  
Work Incentive Improvement Act of 1998**

**March 25, 1998**

On March 25, 1998 Senators Jeffords and Kennedy will introduce the Work Incentive Improvement Act of 1998 (WIIA). Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) beneficiaries' lose cash benefits and health insurance when they become employed. WIIA creates incentives for these beneficiaries to work by continuing access to health insurance and providing other incentives compatible with employment. It will also assist individuals who would be eligible for cash benefits and federal insurance coverage but work, to have access to affordable health coverage when they wish to work.

The legislation contains costs by allowing individuals to buy-in to Medicare under certain circumstances; reduces escalating expenditures in the SSI and SSDI programs; and gives the States the option of providing key services connected to employment to provide greater opportunities to its disability populations, which will reduce the strain on State public assistance programs.

**Background**

***Social Security Disability Insurance Recipients.*** Under current law an individual receiving SSDI and Medicare may return to work and receive cash benefits for a 9 month Trial Work Period (TWP), working at the level of Substantial Gainful Activity (SGA): defined as \$500/month, plus a 3 month "grace period." Also, an SSDI beneficiary who waits 24 months from the "onset of a disability," becomes eligible for Medicare, Parts A and B. In the 13th month of work: (a) the individual loses cash benefits; (b) Medicare Part A benefits that provide acute illness and injury coverage continue at no cost; and (3) the beneficiary may purchase Medicare Part B Hospital Insurance benefits for 39 months following the end of the TWP at the same rate as retired, uninsured Medicare beneficiaries: about \$43/month.

At the completion of the 39 month period, the beneficiary pays for both Part A and Part B at the same rate as retired and uninsured Medicare beneficiaries, more than \$375/month. This is too expensive for many persons with disabilities. In fact, out of the more than 3.5 million SSDI beneficiaries, only 114 individuals took advantage of the buy-in during fiscal year 1996. In addition, some of the most important services to enable a person with a disability to return to work are not available to them under current law, such as personal assistance services and prescription drug coverage.

***Supplemental Security Insurance Recipients.*** Under current law an individual receiving SSI and Medicaid may begin or return to work and receive cash benefits under the Section 1619 Program administered by Social Security. Cash benefits are reduced on a sliding scale based on

a formula that reduces the monthly cash benefit check by \$1 for every \$2 earned above SSI's SGA level: defined as \$85/month, with a \$20 monthly earnings disregard. The beneficiary is also able to continue receiving Medicaid with net earnings up to 250% of poverty. ✓

### **THE OPTIONS PROGRAM**

#### **An Opportunity to Fully Integrate Through Occupations**

When an eligible SSDI beneficiary has identified an employment opportunity, they would be eligible to enter the Opportunity to Fully Integrate Through Occupations (OPTIONS) Program. A Work Incentive Counseling and Assistance Program would educate and guide the beneficiary through the process.

Under the WIA, SSDI beneficiaries, with the help of Social Security Field Office personnel, would be able to sign an OPTIONS form. Long-term beneficiaries (those who have been SSDI beneficiaries for longer than 24 months) would not suspend their cash benefits but would remain under the restrictions of SGA of \$500/month in earnings in order to continue to receive cash benefits. An OPTIONS form would be available at SSA, Vocational Rehabilitation, job training and referral centers and other federal and state offices that are responsible for elements of existing disability programs. SSDI beneficiaries may sign at any time following a determination of eligibility.

Those individuals requesting OPTIONS participation and in need of job training, vocational rehabilitation or other services to facilitate their reentry to the workforce would, upon request, be immediately referred (as under current law) to State or private vocational rehabilitation providers, or to other job training services. Those SSDI long term beneficiaries who are ready to return to work would be eligible for Medicare Part A and Part B coverage on the month <sup>is new?</sup> following their eligibility determination and signing a form. As an OPTIONS participant, the individual would also be eligible for services established under a State Medicaid buy-in option. ?

1619 A and B participants would be considered for benefits under OPTIONS without having to enter the program, as 1619 A and B is considered the "work options program" for SSI beneficiaries.

Following determination of eligibility under SSDI, new beneficiaries (those receiving cash assistance but in the 24 month waiting period for Medicare) would be offered eligibility to the OPTIONS program. Upon choosing to be an OPTIONS participant, health benefits included under the State Medicaid buy-in program would be made available, as long as the participant meets the state's definition of "eligibility".

Note: If an OPTIONS participant in the 24 month waiting period ceased working, or did not begin working, s/he would return to their prior benefits eligibility status before exercising OPTIONS. Thus, if an OPTIONS participant was eligible for cash benefits, signs up for

**OPTIONS**, and leaves work for any reason, the individual would return to cash benefit eligibility.

**Effects of the Legislation**

*There are four categories of persons with disabilities who would benefit.\**

1. **Work-eligible individuals who are between 16 to 65 years old. SSDI or SSI beneficiaries who intend to begin or return to work, and are in need of Personal Assistance Services (PAS) and prescription drug coverage.**
2. **Individuals who are receiving SSDI cash benefits, but have not completed the initial waiting period of 24-months for Medicare benefits.**
3. **SSDI beneficiaries who are receiving cash benefits and are covered by Medicare.**
4. **Working persons with disabilities. Individuals who are determined by the State to need PAS or prescription drugs in order to be able to work. This category does not include individuals who are currently receiving SSDI, but does include those individuals who are currently in SSI's 1619 program and need PAS.**

MA with w/d w/c

MA with w/d w/c

Only ones elig for MA begin?

**How the Incentives Would Work for Each of the 4 Categories**

1. **Work-eligible individuals who are between 16 to 65 years old. States would have the option to offer personal assistance services and prescription drug coverage to non-working SSDI or SSI beneficiaries who intend to begin or return to work as defined by the state, under a new State Medicaid work incentive option called State Work Options Program (SWOP). States would have the option to establish a co-payment for each service for participants who have incomes 150% above poverty. States would be required to give priority to those 16-25 years of age.**
2. **Individuals who are receiving SSDI cash benefits, but have not completed the initial waiting period of 24-months for Medicare benefits. Following determination of eligibility under SSDI, newly determined beneficiaries would be offered eligibility to the OPTIONS program when they have identified an employment opportunity. If a new beneficiary chooses to participate, the State provides PAS and prescription drugs under SWOP if the new beneficiary meets the State eligibility criteria. A State may require participants to pay a copayment if their earned income is above 150 percent of poverty.**

don't trade cash for with any amount

See next pg

If the participant terminates employment for any reason during the waiting period for Medicare, they would resume their former status in the waiting period, with credit given for time worked toward the 24 month waiting period requirement for Medicare coverage.

- 3. SSDI beneficiaries who are receiving cash benefits and are covered by Medicare.** For those persons receiving SSDI cash benefits for more than 24 months, who enter the OPTIONS program, cash benefits would cease, but the individual would be eligible for:
- Medicare Part A for free up to 250% of poverty (earned net income). Beyond this, Part A premiums will be based on a sliding-scale of 10 percent of amounts in excess of 250% of poverty (earned net income).
  - Medicare Part B for the regular premium amounts paid.
  - Any available State Medicaid buy-in (as established by the WIA under SWOP or under current State waiver authority).
  - An ability to deduct from the level of earned income (gross), the costs of "those items necessary for traveling to and from work", "durable Medical Equipment (DME)", and costs associated with the purchase of an automobile in an area where the Commissioner of Social Security determines that public transportation is not readily available.
  - Provisions regarding the \$500 SGA suspension of cash benefits following 13 months of work still apply in order to maintain cash benefits.
- 4. Working persons with disabilities**
- By joining the OPTIONS program, working persons with disabilities who are determined by the State to need PAS and /or prescription drugs in order to work, and meet the State's definition of work, would be able to purchase these services under the State's Medicaid Work Option Program (SWOP), if available.
  - SSI beneficiaries who are participating in 1619 A and B will be able to purchase PAS under the SWOP, without having to enroll in the OPTIONS program, if these benefits are not currently available under the Medicaid State plan.
  - **It is required throughout the bill that all OPTIONS participants must enroll in employee-sponsored health insurance in order to be eligible for this program.**

#### **Medical Insurance Coverage under the OPTIONS Program**

**Medicare Buy-In.** For Medicare Part A, if an OPTIONS participant's adjusted net income reaches 250% of poverty, s/he would pay a portion of the Part A premium, based on 10% of the monthly net earned income above 250% of poverty. Premium amounts would be capped at the premium rate for 65+ Medicare beneficiaries. This Medicare Part A buy-in program would be

available as long as the individual remained working above SGA. For Part B the recipient would continue to pay the same level of premiums as required under the law.

Amounts would be paid monthly and reconciled at the end of the year by the beneficiary based on 10 percent of net earned income above 250% of poverty. Refunds or obligations to the beneficiary would be calculated and distributed by the IRS. All beneficiaries would have to enroll in employer-sponsored health insurance in order to be eligible for the OPTIONS program.

**Medicare Coverage Continuation/Termination.** All OPTIONS participants with earned income under 250 percent of poverty would receive free Medicare Part A, and Part B for the regular premium amounts paid. Coverage would begin no later than one month following the signing of an OPTIONS form.

If the beneficiary fails to pay premiums for Medicare coverage following a 90 day grace period, and for 180 days where the Secretary determines that there was good cause for failure to pay, Medicare coverage will be terminated on the first day of the month following the periods above.

**Private Plans First, Medicare and Medicaid as Payor of Last Resort.** OPTIONS participants would be required to utilize employer-sponsored health insurance plans (when available). Medicare and Medicaid would always be considered the payers of last resort.

Note: In the event that there are exclusionary periods in the employer-sponsored health plan, the obligation to subsidize Medicare premiums would remain a responsibility of the employer during that exclusionary period.

### **Prohibitions**

- **Work activities will not trigger a Continuing Disability Review.**
- **Work activities cannot be used as evidence that a disability has ceased.**
- **Termination of work activities does not presume an inability to work.**

### **State Work Options Program (SWOP)**

OPTIONS participants, SSI/SSDI non-working persons who are "preparing to work," and 1619 A and B participants, who are in need of additional services drugs would be able to buy-in to a SWOP under Medicaid. If States choose to set up a SWOP, at a minimum PAS and pharmaceutical benefits would be required. Any cost-sharing above 150% of poverty would be in accordance with State policy.

If an OPTIONS participant leaves employment for any reason, coverage would continue under the SWOP consistent with State policies and procedures.

## Waivers

**Requirement for Response by HCFA to State Waiver Proposals.** HCFA would be required to respond to State 1115 waiver requests for programs that encourage a return to work by persons with disabilities no later than 90 days from the date of receipt by HCFA.

### **Broadening HCFA Criteria for Approval of Section 1115 Waivers.**

#### Language Reads:

"In determining budget neutrality under the provisions of Medicaid Section 1115 waivers which are for the purpose of reducing work disincentives for persons with disabilities, the Secretary [of HHS] shall take into account reductions in payments made to persons with disabilities under Title II and Title XVI of the Social Security Act and other reductions in federal expenditures made to, or on behalf of, such individuals when such reduced expenditures are a result of earnings by such persons with disabilities."

Such language would better reflect the cost-savings involved when Section 1115 waivers meet the medical needs of persons with disabilities.

### **Expansion of Deductible Items Under the Impairment Related Work Expenses**

For those OPTIONS participants who are still receiving cash benefits, Impairment Related Work Expenses (IRWEs) would be expanded to include items connected with "preparation for, and traveling to and from work, orientation and mobility services, and Durable Medical Equipment."

The expansion of items (automobiles, wheelchair motors, etc.) falling under the deduction would provide an incentive for long term beneficiaries to return to work. These individuals would be more likely to remain below the SGA level and continue to receive cash payments until their income level rises such and cash assistance becomes unnecessary.

SSA  
Cost

### **Work Incentive Counseling and Assistance Program**

The bill directs the Commissioner of Social Security to establish a Work Incentive Counseling and Assistance Program at the community level, to assist in the outreach for and coordination of the OPTIONS program.

SSA

SSA will educate and provide ongoing personnel development to new and existing work counselors in the community, including public and private providers and counselors in vocational rehabilitation, independent living centers, social services centers, and the Social Security field offices. Identified counselors will advise the individual in choosing whether to participate in the OPTIONS program as well as assisting in the coordination and interaction of the new work

Cost

incentives, the disabled consumer, available V.R. and job training services and Social Security to facilitate the individual's eventual return to work.

**Demonstration Program: Sliding Scale Cash Benefit Offset for SSDI Beneficiaries\*\*\***

The Commissioner of SSA may conduct demonstrations to determine the most effective methodology for implementing an earned income offset for SSDI benefits that result in a gradual decrease in cash assistance as earnings increase that are: national in scope; conducted on a State, regional, or national level; conducted by public agencies or private, not-for profit organizations; using calculations made on other than a monthly basis; using calculations in increments larger than \$1 loss in benefits for each \$2 in earned income: e.g., \$50 reduction in cash assistance for \$100 in earnings; using electronic funds transfer and other information technology to streamline the administration of such offset; and offering beneficiaries information and advice regarding such sliding scale offset through personal computer software.

SSA  
Cost

The all-or-nothing design of the SSDI program prevents most beneficiaries from attempting to go to work. Unlike the SSI program, where recipients who attempt work and lose only \$1 in cash assistance for every \$2 in earned income and can continue receiving Medicaid acute medical care, personal assistance, and prescription medication coverage (up to State limits), SSDI beneficiaries lose all cash assistance after earnings reach \$500 per month (assuming in this example that the Trial Work Period has expired). Further exasperating the situation, SSDI beneficiaries receive free Medicare (which, because it does not cover personal assistance and prescription medications is a lesser benefit than Medicaid) for only 36 months. After then, they pay the full Part A premium, currently \$330 monthly, to continue coverage.

The result is that the vast majority of SSDI beneficiaries find that working to their maximum capacity under the current SSDI work incentives rules is so costly they financially cannot afford to work. They are financially and medically rewarded for remaining on benefits and punished for attempting work. A difficulty remains in administering the existing sliding scale benefit offset in the SSI program. The demonstrations conducted under this authority shall determine the most effective way of implementing sliding scale benefit offsets using variations in the amount of the offset as a proportion of earned income; the duration of the offset period; and the method of determining the amount of income earned by beneficiaries. Demonstrations shall use state-of-the-art information technology and electronic funds transfer technology to streamline the reporting of data and the implementation of the offsets. In addition, personal computer software shall be developed and made available to beneficiaries, their families, guardians, and advocates, to inform beneficiaries of these new work incentives and to assist beneficiaries in making informed decisions regarding work.

OK W/SSA?

\*\*\* This will permanently authorize Social Security Demonstration Project Authority for the States.

## **Evaluation of the OPTIONS Program**

**Report and Recommendations to Congress.** Not later than 12 months after the date of enactment of the act, the Commissioner of Social Security and the Secretary of HHS shall jointly evaluate and report to Congress on the incentive program and the demonstration projects. Included in this evaluation would be recommendations to Congress for administrative and/or legislative changes to better enable individuals with disabilities to enter or reenter the workforce.

### ***Maintenance of Data/Mandate to Report to Congress the Success of "Option" Incentives.***

No later than three months (establishment), again at five months (progress report) and seven months (recommendations as to permanently authorizing the program), Social Security, National Council on Disability in consultation with the Secretary of Health and Human Services and stakeholders would report to Congress data determining the success of the "OPTIONS" work incentives.

*Butch*

### **Effective Date/Implementation**

Social Security is required to begin to offer these incentives no more than twelve months from the date of enactment into law.

### **Sunset**

This legislation is a ten-year entitlement program and will sunset in ten years if it is not permanently authorized.